Information Impact on Home-Based Palliative Care Admissions

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Information Impact on Home-Based Palliative Care Admissions

A Doctor of Nursing Practice Project Presented to the Faculty of the

Department of Nursing

West Chester University

West Chester, PA

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Nursing Practice

By

Donna L. Rugh

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Dedication

To my husband and children for being the most amazing cheerleaders and support during my endless pursuit of this degree. We can do anything, together. I love you all; always and forever, no matter what.

To my parents who never gave up on me and taught me to love, even when it is hard.

To my patients, past, present, and future, who have taught me so many lessons about life, illness, and the sweetness we can find - even in the goodbyes.

To nursing and nurses, our patients are better for the work we do. May we continue to learn and become champions of palliative care in all settings.
Abstract

Patients appropriate for Home-Based Palliative Care services are fragile with increased risk for mortality and hospital readmissions. Utilization of Home-Based Palliative Care skilled nursing services have been proven to decrease these risks and improve quality of life. Information deficits negatively impact nurse clinical decision making during the admission process, potentially misguiding the nurse resulting in a non-admission to service. This project focused on the impact of both nurse education and clinical information sharing at admission. Pre and post data was compared to examine the impact of these interventions on non-admissions rates for the reasons of “no skilled need” or “not homebound” statuses. A nested nurse survey was utilized to investigate nursing knowledge, skill, and comfort level related to Home-Based Palliative Care admissions. The After Visit Summary was identified as the tool to improve clinical information sharing. The average conversion rate of referrals to admissions increased from 69% to 77% during the project period. Pre and follow up nurse survey data were compared using an independent t-test, showing statistically significant improvement in nursing skill and a trend toward significant improvement in comfort level. The After Visit Summary was not consistently shared, implying nurse education was nearly entirely responsible for reducing non admissions to Home-Based Palliative Care for the reasons of “no skilled need” and “not home bound” from 16.7% in the comparison period to 0% during the intervention period.

Keywords: Home-Based Palliative Care, Palliative Care at Home, Home Health Nursing, Palliative Care Nursing, Home Health Admission
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Chapter 1

Introduction and Background

Chapter one introduces the topics of Home Health Care services, Palliative Care, and the nursing implications and patient outcomes at the intersection of these two specialties from a broad overview and the author’s local perspective. This introduction will be divided into sections; a) Key Concepts, b) Nursing Implications d) Background e) Significance d) Delaware County Accountable Care Organization (DVACO), (f) Clinical Question, and (g)Project Goals.

Key Concepts

Home Health

The term Home Health (HH) is used to denote skilled health care services provided in a patient’s home. HH care is provided by healthcare agencies who employ licensed staff to provide such care. The Center for Medicare and Medicaid Services (CMS) (2023) and other payors reimburse the agency for services rendered either in full or in part according to contracted payment models. To receive payment, the agency must ensure patients are eligible to receive services, follow strict regulatory guidelines, and ensure timely submission of documentation of services (CMS, 2023).

Palliative Care

Palliative Care (PC) is specialty care “focused on providing relief from the symptoms and stress of serious illness” (Center to Advance Palliative Care [CAPC], nd). PC can be provided in conjunction with curative medical efforts, which distinguishes the specialty from hospice (HO). PC providers receive special training in pain and symptom management and focus on improving quality of life for patients with serious diagnoses. PC patients are typically medically complex and many HH agencies have developed specialty programs within their HH service lines to care
for this special patient population (CAPC, nd). The World Health Organization (WHO) (2018, preface) states “Palliative Care is an ethical responsibility of health care organizations… it is imperative that palliative care be provided in the community”.

Nursing Implications

Medicare charting and eligibility requirements for HH and HO are much different. HH documentation is more labor intensive due to the detailed Outcome and Assessment Information Set (OASIS) requirements which is used to evaluate outcomes of HH care (CMS, nd). In terms of eligibility, the differences are many and not practical to review in this manuscript. It is worth noting, however, the Home-Based Palliative Care (HBPC) program at Main Line Health (MLH) is staffed by nurses who also care for hospice patients to ensure continuity of care at the end of life. Thus, these nurses must be educated in both HH and HO admission criteria and start of care (SOC) documentation.

Background

The United States Department of Health and Human Services Office of Disease Prevention and Health Promotion’s (OASH) Healthy People 2030 national objectives focus on reducing preventable acute care hospital admissions. This document highlights patient populations that fit under the serious illness diagnosis and palliative care umbrella such as dementia, heart failure, chronic obstructive pulmonary disease, cancer, and chronic kidney disease (OASH, nd.) As such, MLH’s strategic plan recognizes “Home as the Hub of Care” working to reduce rehospitalizations and partnering patients with necessary home health services.

MLH HomeCare and Hospice (MLH HCHC) is comprised of three service lines: Home Health Care, Hospice, and Home-Based Palliative Nurse Practitioner Practice. Within the HH
service line, are specialty nursing teams including oncology, heart failure and palliative care. The entity offers skilled nursing, therapy, psychosocial and home health aide services. This project will focus on the HBPC skilled nursing specialty team. The MLH HCH referral conversion to admission rate for HBPC averages 69%, below the entity target rate of 80%.

**Significance**

Prompt admission to HH services from an acute care stay is proven to reduce 30-day hospital readmissions (Smith, et al., 2021). Patients ordered but not admitted to HH services from an acute care stay have a 19% higher mortality rate (Demiralp et al., 2021). HBPC is proven to decrease healthcare spending, increase quality of life for patients, and increase hospice enrollment while decreasing rehospitalizations (Paramanandam, et al., 2020, Roberts et al., 2021, World Health Organization [WHO], 2018).

In fiscal year 2023, 347 patients were not admitted to MLH HBPC services. Of these patients, 284 were discharged from an acute care stay. The most common reasons for non-admission were patient elected hospice care, patient refused, no skilled need, and not home bound. To evaluate the impact of non-admissions to HBPC within the author’s practice area, a small sample of 15 non-admissions for no skilled need from June-August 2023 were reviewed for outcomes within 30 days. This review revealed two patients died without hospice, one patient was admitted to hospice from another agency, three patients did not receive home health services and were readmitted to the hospital or emergency room within 30 days. Of patients who received a visit from a palliative care nurse practitioner, two patients were readmitted to the hospital within 30 days while five patients who received palliative nurse practitioner services did not experience hospital readmission. Only two patients that did not receive home health services were not readmitted. A review of non-admission data from September 2022 through September
2023 revealed a 21% mortality rate and a 20% readmission rate within 30 days of non-admission further emphasizing the need to examine this phenomenon from an operational and process improvement standpoint. This data leaves the author questioning *did these patients potentially have a skilled need?*

**Delaware Valley Accountable Care Organization (DVACO)**

Seeking a solution for beneficiaries who may not qualify for a HH episode of care due to non-home bound status, the DVACO developed a Palliative Conditions waiver. The DVACO is an accountable care organization participating in the Center for Medicare and Medicaid Services “Shared Savings Program” (MSP) who “holds performance-based contracts with private payors” (DVACO, nd). The DVACO has partnered with MLH and another local health care organization to improve the delivery of fiscally responsible patient care by focusing on quality and population health projects and programs with these providers (DVACO, nd). The Palliative Conditions waiver was designed by the DVACO to provide four to five skilled home care visits to patients with Medicare or Medicaid insurance who would otherwise not be admitted despite having a skilled need (Mirsch, 2023). Admission to service under the conditions of this waiver was part of the intervention for this Doctor of Nursing Practice (DNP) Project.

**Clinical Question**

Evaluating non-admitted referrals and subsequent patient outcomes within this Primary Investigator’s (PI) practice area, this nurse experienced heightened awareness and growing concern for these non-admitted patients. Clinical chart review and follow up continued to reflect negative patient outcomes that may have been prevented if HH services were in place. The DVACO noticed similar findings among beneficiaries served by MLH acute care hospitals, raising increased urgency to focus on this concern (Mirsch, 2023). Thus, the provocative
question was born: In home based palliative care, how does education on home health admission criteria and a standard practice for the provision of clinical information prior to the start of care visit impact admission rates to traditional home health services or the DVACO Palliative Conditions Waiver Program within nine weeks?

Goals of Project

Quantitative patient focused goals of this project were to increase admissions to HBPC services by 10% over baseline and monitor the use of the Palliative Conditions waiver for DVACO beneficiaries. Outcomes for non-admitted patients continued to be reviewed. This project sought both quantitative and qualitative data from nurses as it relates to their knowledge, skills, and comfort levels around HH admissions and the HBPC patient population.

Summary of Chapter

This chapter introduces and discusses the importance of actualized HH services on patient outcomes. Patients must meet strict admission criteria, based on federal and local regulations, to receive HH services. If patients are non-admitted, poor patient outcomes including increased emergency room use and re-hospitalization within 30 days is likely to occur. This author, along with organizational stakeholders, were curious if increased attention to clinical information sharing and re-education for staff completing these admissions or introduction and use of the DVACO Palliative Conditions waiver would increase admissions to the HBPC specialty HH service line at MLH.
Chapter 2

Literature Review

Introduction

Chapter two includes a discussion of the theoretical framework and a review of the literature on the impact HBPC skilled nursing services have on patient outcomes and the important role the SOC nurse has on determining the outcome of these referrals during the admission visit. This literature review is divided into the following sections: a) Nurse lived experience related to the home care admission process b) Patient outcomes related to denial of home care admission to skilled home health services c) The impact of HBPC on patient and health system outcomes.

Theoretical Framework

The theoretical change framework utilized for this project was Kurt Lewin’s Change or Force Field Theory. Lewin’s theory has existed for eight decades, and utilizes three stages: Unfreeze, Change, and Refreeze (Finkelman, 2022). According to Finkelman (2022), this theory creates a space to challenge an established process by engaging stakeholders early on and navigating resistance to create unity around the need for the change and the intervention; this is the Unfreezing stage. In the Change stage, the project’s intervention, or process change takes place. In the Refreezing stage, evaluation of the change occurs along with a comparison against the historical process and outcomes related to the identified problem.

Lewin’s approach is seeded in collaboration and evaluation, further ensuring connection with all staff along the organizational continuum and increasing buy-in from stakeholders (Finkelman, 2022). Manchester et al, (2014) discuss the success of evidence-based practice (EBP) projects using Lewin’s framework in healthcare. In two successful community-based
geriatric educational projects using Lewin’s Change Theory as their framework, Manchester et al, (2014) surmised “this combined framework may lend support to the applied practice aspects of implementation science” (p. 83). Of note, Lewin’s model does not lend itself to capturing the subjective nature of the human experience during change (Finkelman, 2022).

For this project, in the Unfreezing stage, this author met with organizational stakeholders from multiple departments to ensure buy in, collaborate on the intervention, and navigate resistance. In the Change stage, a dual intervention was launched. The first intervention was mandatory staff education from subject matter experts on HH admission criteria and a new admission waiver. The second intervention was the initiation of standardized clinical information sharing with the nurse completing the admission. In the Refreeze stage, evaluation of non-admissions, waiver admissions, and patient outcomes took place. It is important to note this project included a nested evaluation of staff nurses to account for human factors: nurse knowledge, skill, and attitudes (KSA) or comfort level with HBPC admissions.

**Literature Review**

**Search Strategy**

An extensive literature search was conducted using the Cumulated Index to Nursing and Allied Health Literature (CINHAL) Complete, Medline and PubMed data bases with the key words: Home Health Care, Home Care, Home Care Nursing, Palliative Care at Home, Admission, Nurse Attitudes, Perceptions, Opinions or Thoughts, and Clinical Information. The years searched were 2018-2023. One exclusionary term was utilized: Nursing Homes.

A total of 223 studies were retrieved, 39 were relevant, and 12 remained after review. Additional hand searching was completed utilizing Google Scholar and citation lists from the initial literature search to reach a total of 16 studies. In addition to a review of the literature,
guidelines, and information from the CMS, CAPC, and other reputable sources were reviewed and utilized to provide context and background.

**Terms, Concepts, & Definitions**

In addition to the broad concepts of HH and PC discussed in Chapter One, understanding the definitions and concepts discussed below are imperative to the context and related outcomes of this DNP project.

**Home Health Care Benefit**

CMS outlines the rules of eligibility and payment related to HH services. CMS (2023) eligibility criteria states to initiate care, a medical provider must certify the patient has a condition that requires intermittent skilled care in their home. To qualify for skilled nursing care, patients and/or their caregiver(s) must require ongoing education, monitoring or training related to medications, wounds, airways, lines, drains, or ostomies. Skilled nursing care also includes symptom management and disease process education. CMS (2023) also mandates that patients receiving home health services be home bound. This means the patient’s health condition must generally keep the patient from leaving their home and that doing so would require maximum and exhausting effort. Exceptions to home bound status include attending unique celebrations, religious functions, and obtaining additional medical care.

**Conditions of Participation (COPs) and Conditions for Coverage (CfCs).** According to CMS (nd), CfCs and COPs are regulatory guidelines a HH agency must meet and uphold to provide care for patients under the Medicare HH benefit. The standards focus on clinical and financial quality and safety (CMS, nd). CMS COPs also require HH agency clinical staff receive rigorous training on CfCs and COPs as they relate to the service line their patients receive care from, in both HH and HO.
**Outcome and Assessment Information Set (OASIS-E).** The OASIS-E is the CMS data collection tool used to obtain patient related information. The OASIS-E is completed at the SOC and discharge visit and is unique to the HH benefit only. The information is transmitted to CMS and data is used for a variety of publicly reported HH agency quality and performance measures (CMS, nd).

**Home Based Palliative Care.** HBPC is defined by CAPC (nd) as “specialist care delivered to seriously ill patients in the setting that a patient calls home” (CAPC, nd, p.5). PC can be provided in conjunction with curative care and focuses on quality of life and reduction of symptom burden. HBPC falls under the CMS COPs and CfCs of HH. At MLH, HBPC is staffed by the same nurses who care for HO patients to ensure continuity of care during end of life. Patients are eligible to receive care under this service line if the medical prognosis related to a serious illness (for example: heart failure, cancer, dementia) is approximately one year or less.

**Low Utilization Payment Adjustment (LUPA).** In most HH payment groups, LUPAs occur when a patient receiving HH services actualizes four or less skilled clinician visits during an admission (or episode of care) to HH services. In most cases, when a LUPA is detected by CMS, payment for services rendered is reduced (CMS, nd). HH agency staff are educated on avoidance of LUPAs due to the fiscal implications to the agency’s financial health.

**Admission or Start of Care.** For this project’s purposes, the terms admission and SOC were used interchangeably. The SOC visit is when the patient facing registered nurse (RN) first meets the patient and their caregivers/family. The SOC visit may take over an hour to complete. Among other tasks, this RN determines if the patient meets eligibility criteria to receive HH services, obtains consents for service, processes a medication reconciliation, and completes a home safety assessment (Sokolow et al., 2021). If the RN feels the patient does not meet
eligibility for HH services, the patient is not admitted to care and the RN processes the chart as a “non-admission” by selecting a reason from a drop-down list in the agency’s electronic medical record (EMR).

**Lived Experiences of Nurses**

Of the 16 studies retrieved, four focused on the experience of the HH nurse at the SOC and three focused on the role of the RN in HBPC. According to Sockolow et al. (2018) thematic analysis of a HH RN focus group case study, the HH RN completes 22 discreet tasks during a SOC visit. 11 of these tasks are linked to the individual patient’s clinical information. The SOC visit is the most intense visit the HH RN will complete during the episode of care. A significant amount of time is spent completing the required 16-page CMS OASIS-E SOC data set documentation that captures demographic, functional ability, symptoms, and self-care performance to be compared by CMS to the equally tedious CMS OASIS-E discharge set (CMS, 2022).

HH nurses reported 28 discreet total tasks during an entire HH episode of care, further underscoring the importance of the comprehensive SOC visit. However, in an observational mixed method study, Sockolow et al. (2021) notes the RN’s clinical decision of admitting or not admitting a patient to an episode of care under the HH benefit is significantly impacted by “information deficits” and avoiding regulatory concerns such as a LUPA. As the nurse obtains information during their visit, this informs the nurse’s critical decision making. The RN plans the episode of care once it is determined the patient meets criteria for admission. However, after meeting the patient and completing their evaluation, the RN may determine the patient does not meet criteria for care (Gladsom, 2001; Sockolow et al., 2021). Information deficits may create an opportunity for skewed RN clinical decision making, error, and staff dissatisfaction (Rosen et al.,
Rosen et al. (2018) report patient safety is dependent on the confidence and coordination among medical team members.

Gladsom (2021) points out the pressures of providing HBPC are even greater than traditional HH. Beyond the significant burdens of HH nursing clinical decision making and discreet task as pointed out by Sockolow (2018), studies by Gladsom (2021) and Zhu (2022) agree, poignantly adding that the Palliative Care RN innately focuses on the level of distress and symptom burden of each patient. Hemberg and Bergdahl (2019), Killackey et al. (2020) and Gladsom (2021), concur, the HBPC RN is often left to experience moral distress between clinical decision making related to planning the episode of care and ensuring the delivery of quality palliative care in the home setting. PC does not have a specialized reimbursement rate in the eyes of the payor; however, the nature of PC is more taxing to the nurse than traditional HH care (Hemberg and Bergdahl, 2019; Killackey et al., 2020).

**Patient Outcomes without planned HH Services**

Of the 16 studies reviewed, two retrospective studies, one systematic review and one retrospective cohort study elaborated on statistics and best practices related to the impact HH has on patient outcomes. Hasmemlu et al. (2023, p.2) discussed HH services as a “crucial component” in the clinical practice guidelines for care of patients with heart failure and the same is included in the Smith et al (2021) study for patients with diabetes. Demiralp et al. (2021) state completed HH referrals resulted in $170M in health care savings in 2015.

Non-admission to HH after an acute care stay is associated with increased mortality, 30-day readmission rates, and healthcare spending (Demiralp et al., 2021; Smith et al., 2021). The Agency for Healthcare Research and Quality (AHRQ) echoes this sentiment stating, “being discharged from the hospital can be dangerous” (AHRQ, 2019, para.1) calling for safer
medication reconciliation, communication, and education as steps to improve patient outcomes; all of which are potentially accomplished by admitting patients to care under the HH benefit.

CMS COPs instruct the HH agency to initiate care within 48 hours of patient discharge from an acute care stay or from receipt of the prescriber order provided the patient is agreeable to care (CMS, nd). Patients non admitted to the expected HH episode of care had 40% higher readmission rate in the Smith et al. (2021) review of Medicare recipients in 2015 diagnosed with diabetes and a 29% overall higher readmission rate in the Demiralp et al. (2021) study of Medicare recipients in 2016 (not specific to diagnosis). Misra-Hebert et al. (2021) had similar findings in their retrospective cohort study, citing a 30% lower risk of 30-day readmission for patients receiving HH services. Demiralp et al. (2021) report a 19% increase in mortality rate for patients who do not receive expected HH care after a discharge from an acute care episode.

The Impact of HBPC

The positive impact of HBPC on patient care was overwhelmingly supported by seven studies in the literature review. One randomized controlled single-blind mixed method study, three systematic reviews, one retrospective propensity study, one qualitative systematic review, and one basic research study unanimously agree that HBPC is associated with positive patient outcomes. Trends witnessed in this author’s practice setting and clinical experience mirror these findings.

HBPC is a key driver in reducing hospitalization rates and decreased spending of health care dollars (Saunders et al., 2019; Yosik et al., 2019; Killackey et al., 2020; Paramanandam et al., 2020; Evans et al., 2021; Roberts et al., 2021). HBPC is also associated with improved physical, social, emotional, and spiritual symptom management, and increased patient satisfaction (Seymour, 2018; Saunders et al., 2019; Evans et al., 2021; Roberts et al., 2021).
Lastly, HBPC is proven to reduce over-medicalized deaths with a focus on advance care planning (ACP) and high conversion rate from HH services to HO care at home without an acute care readmission (Seymour, 2018; Saunders et al., 2019; Evans et al., 2021; Roberts et al., 2021).

**Gaps in Literature**

This literature review prodigiously supports the positive impact HH and HBPC on both patients and the health care system. The literature provides insight into the technicality of the HH SOC tasks (Sokolow et al., 2019) and the importance of critical clinical information sharing with the RN completing this visit (Sokolow, 2021). The literature does not specifically outline best practice guidelines for necessary information at the SOC, creating a gap in the literature.

The nurse completing the SOC visit makes an independent clinical decision to admit or non-admit a patient to the HH episode of care (Sokolow, et al., 2021) amidst completing over 20 other tasks (Sokolow, et al., 2019). Although non-admission reasons such as refusal of services are discussed in the literature, (Demiralp, et al., 2021; Smith et al., 2021) there is little discussion regarding other non-admission reasons related to lack of skilled need or non-home bound status which are clearly outlined in the COPs for HH and frequently experienced in the author’s practice setting. Gaps in the literature and known limitations of these studies are created by small sample size.

It is obvious that moral distress plays a role in the RN experience with HBPC patients (Hemberg and Bergdahl, 2019; Killackey et al., 2020). However, little research exists to identify clear connections in how nurse knowledge, skills, and attitudes (KSAs) impact RN decisions at SOC for HBPC patients or if this is further impacted for nurses also caring for HO patients within their case mix. This is important because there is a well understood connection between
positive nurse KSAs and patient outcomes (Rosen et al., 2018). Gaps in the literature exist due to the subjective nature of qualitative research and lack of research completed within the HH space.

Summary of Chapter

This chapter focuses on examining the literature as it pertains to the critical issue: In home based palliative care, how does education on HH admission criteria and a standard practice for the provision of clinical information prior to the SOC visit impact admission rates to traditional HH services or the DVACO Palliative Conditions Waiver Program within nine weeks? Lewin’s Change theory was applied to challenge the norm and unfreeze current practice, a dual intervention was launched in hopes of creating change, and time was taken to refreeze the process and compare new outcomes to historical data.
Chapter 3

Methodology

Introduction

This chapter will discuss the methods used in this DNP project. This chapter will be divided into six parts a) Setting, b) Population, c) Instrument, d) Data collection and analysis, e) Protection of Human Subjects and f) Resources, personnel, and technology. A complete overview of the methodology will be explained.

Setting

The setting for this DNP project was MLH HCH agency. MLH HCH services patients in Southeastern Pennsylvania throughout Chester, Montgomery, Delaware, and Philadelphia counties. The HH service line has a specialty nursing team that cares for patients with palliative needs, or HBPC. All referred patients must first meet CMS guidelines to be eligible for services; this requires the patient to have a skilled need and be home bound. The agency applies further criteria for selection to this specialty service line, including diagnosis of a serious illness with limited prognosis. HBPC focuses on improving the overall quality of life for these patients by “providing [patients with] relief from the symptoms, pain, and stress that living with a serious illness can bring” (Main Line Health, nd.). Patients are intermittently cared for in the place they call home by the same team of clinicians caring for hospice patients. Care is interdisciplinary and includes nursing, therapy, and psychosocial disciplines to focus on the whole person.

Referrals for service are received from medical providers at hospital discharge or ambulatory visit via phone, fax, or the health system’s EMR, EPIC™. The referral is processed by a central access department, entered into the agency EMR, Home Care Home Based (HCHB), and pushed via automated workflow to an office-based nurse who reviews the referral and
clinical data for appropriateness. The referral is then assigned to the correct nursing team and service line for admission. The office team of nurses and schedulers arrange an evaluation visit with the patient and assign a patient facing nurse to complete the SOC. The nurse will call the patient to set up an evaluation appointment and makes the decision to admit the patient to care during that visit understanding the agency must follow all state and federal regulations for care.

All staff have access to the health system EMR, EPIC™, and the entity EMR, HCHB. Patient facing staff have EPIC™ access in a read only fashion and access this EMR via an electronic tablet. Accessing EPIC™ via a tablet can result in less navigation capability than access via laptops or desktops. Patient-facing staff are assigned to patient charts in the entity EMR, allowing access to the uploaded referral attachments. Office staff can access clinical data from the referral via EPIC™ or HCHB without the same difficulty. There was no protocol in place to provide patient facing staff access to clinical information prior to the SOC visit.

**Population/Sample**

This project focused on referral outcomes to one of MLH HCH specialty HH service lines; HBPC, known throughout the entity as “P-Bridge”. Nurses staffing this specialty service line also care for hospice patients. Across the service area, there are 50 nurses on staff, divided into five teams based on geography. The PI is a master’s prepared registered nurse, certified in Hospice and Palliative Care and Pain Management. The PI is employed by MLH HCH as a nurse manager for the Hospice and Palliative Care Division with direct responsibility for one of the teams completing HBPC admissions.

Patient referrals were immediately identified for inclusion via the entity EMR workflow. Primary inclusion criteria included referral to HBPC and discharge from a hospitalization.
Exclusion criteria included duplicate referrals or referrals made in error for palliative care instead of hospice. Patients were not recruited for participation, but rather identified via the EMR for inclusion.

This project also included a nested survey of nurses to examine KSAs related to admitting and caring for HBPC patients. All nurses were required, as part of their paid workday, to attend education related to home care criteria for care, DVACO waiver, and the new process for clinical information sharing.

**Instrument**

The after-visit summary (AVS) was identified and utilized as the clinical information communication tool for this project. A systemic review and meta-analysis by Becker et al (2021), confirmed communication tools at discharge focused on disease teaching, medication adherence, and follow up instructions are paramount for positive patient outcomes. At MLH, all patients discharged from a hospital admission receive an AVS; this is reviewed with them by the nurse completing the discharge. The AVS identifies all applicable changes in medications, wound care, and follow up steps while individualized to the patient. Becker et al., (2021) discuss the importance of continuity of communication tools among health care providers to improve transitions in care. The office Care Team Coordinators (CTC) were instructed to email the AVS to the HBPC nurse completing a HBPC SOC as part of the project’s intervention.

The second part of the intervention was education (Appendix G). All office and field nurses attended an educational session via a Virtual Microsoft Teams™ meeting. The presentation included a PowerPoint™ reviewing the problem, qualifying home health admission criteria, the AVS, and the DVACO Palliative Conditions Waiver Program taught by subject matter experts and the PI. This meeting was recorded for staff reference. A nested survey of
nursing staff was conducted to determine what KSAs may play a role in non-admission frequency before and after the education, and after the 9-week period (See Appendix A, B, C).

Nurses completing a HBPC SOC who found the patient to have a skilled need, but not be homebound were educated to call in to the office before non-admitting the patient. The office was instructed to assist in determining if the patient met criteria for admission under the DVACO Palliative Conditions waiver. Operational stakeholders and leadership created an internal workflow that ensured the chart was identified properly, the payor was changed, and visits were plotted to meet waiver criteria. The author, along with other nurse managers, served as a resource for problem solving to ensure accurate admission and waiver implementation.

**Data Collection & Analysis**

An analytical dashboard monitoring HBPC referrals was created by a MLH Data Analyst after collaboration with the author. This dashboard captured demographic and episodic data related to referrals that could be evaluated at the individual and aggregate level. This dashboard was fluid, compiling both historical and real-time data tracking actual admissions, non-admissions, and DVACO waiver admissions in real time. Data collection compared admission rates for a 9-week period pre and post intervention. Data was analyzed for statistical significance. Non admitted referrals for the reasons of “no skilled need”, “not home bound”, “death”, and “admitted to hospital” were followed via chart review by the author and evaluated for outcomes. Chart reviews evaluated for 30-day re-hospitalization and death.

**Protection of Human Subjects/ Institutional Review Board (IRB)**

Permission to complete this DNP project at MLH within the HCH space was granted by Terre Mirsch MS, BSN, RN, CHPN, CHPCA (Executive Director, MLH HCH) and Susan Harrigan MSN, RN (Director of Nursing, MLH HCH) and found to be exempt from MLH IRB
approval by Amy Callahan DNP, RN (MLH System Director, Nursing Administration) (See Appendix D and E). IRB approval was granted by West Chester University of Pennsylvania’s (WCUPA) IRB (See Appendix F). Institutional Review Board (IRB) and approval from MLH was obtained in October 2023 and from West Chester University in November 2023.

**Resources, Personnel & Technology**

Personnel for this project were employed by MLH HCH and included Central Access, HBPC, and authorization department staff. Participation in this initiative was an expectation of employment. The technology used included two EMRs, EPIC™ and HCHB. Microsoft 365™ technology was also utilized including Outlook™, PowerPoint™, Excel™, Teams™, and Forms™. A data analyst was assigned to this project by MLH HCH senior leadership to assist with data tracking and statistical analysis of project outcomes.

**Summary of Chapter**

To standardize exchange of clinical information to the nurse completing the HBPC SOC, it was determined that the AVS would be shared. Data collection and benchmarking for this project was compiled via the HCHB analytics HBPC dashboard and chart reviews in EPIC™. Nurse KSAs was evaluated via an MS Teams™ Form. All data was analyzed by the PI and an in-house data analyst. Benchmarking was used to compare pre and post intervention admission rates. An independent samples T-test was used to determine statistical significance between pre, post, and follow up survey responses.
Chapter 4

Results

Introduction

This DNP project focused on the impact of nurse education, clinical information sharing and the influence on non-admissions to HBPC skilled nursing services for the reasons of non-skilled need or not homebound statuses. A nested survey was utilized to investigate pre, post, and follow-up KSAs of nursing staff completing these admissions during the 9-week project intervention period of December 11, 2023-February 12, 2024. This chapter will review data collection and statistical results related to admission outcomes and 30-day hospital readmission and mortality data gathered from the MLH HCH EMR HCHB analytic dashboard and the MLH EMR, EPIC™, respectively. Additionally, this chapter will review nested survey results from pre, post and follow up Microsoft Forms™ surveys completed by nursing staff. A statistical analysis of the nested surveys was performed using an independent samples T-test.

Data Collection

Comparison Period

This quality improvement project collected retrospective and live data via a data analytics report from HCHB called the P-Bridge Dashboard. The dashboard defaults to the past 15 months and can be programmed to include or exclude data by days, weeks, months, or quarters. Data was captured for referral volumes, total admission conversion rates, and non-admit reasons. Data can be examined in aggregate and at the patient level.

In the comparison period, September 1, 2022, through September 30, 2023, the average conversion rate from referral to admission was 69%. Patients were not admitted for over 20 different reasons. Many of these are related to patient choice or change in clinical condition. The
only two choices that are influenced by the clinical decision making of the nurse were the patient is non-home bound (n= 12) and the patient has no skilled need (n=46), the overall total patients non admitted in the comparison period was 347.

Additional data was requested to evaluate the outcomes of these non-admitted patients during the comparison period of September 2022 through September 2023. EPIC™ analysts compared HBPC referral by patient name and date of birth via the EPIC™ database warehouse for outcomes specifically related to hospital readmission and mortality rates. The outcomes revealed a 21% mortality rate and a 20% hospital readmission rate within 30 days of non-admission to HBPC skilled nursing services.

Figure 1

Comparison Period Conversion Rates

Intervention Period

The 9-week intervention period for this DNP project was December 11, 2023, through February 11, 2024. Staff education sessions to review criteria necessary for admission to HH services along with the DVACO waiver occurred during the week of December 3, 2023. The
HCHB P-Bridge Dashboard was used to track admission conversion rates. The results detail each week of the intervention period. The overall average conversion rate for the intervention period was 77%. There were 55 patients who were not admitted to HBPC.

Patients were not admitted for 15 different reasons. There were zero patients non admitted for no skilled need and zero patients non admitted for non-home bound status. Six patients died prior to admission (two died in the hospital prior to discharge, one was discharged and readmitted the same day and died in the emergency room, three died within 24 hours of discharge home). Eight patients were hospitalized: four of these patients were referred by community providers such as a Primary Care Provider and then admitted to the hospital within 24 hours of referral, two patients were discharged and readmitted to the hospital after 72 hours at home, one patient was not discharged, and one is listed in error. There were no patients admitted under the Palliative Waiver during the intervention period.

EPIC™ analysis comparing referrals by name and date of birth was requested to examine 30-day readmission rates and deaths related for patients who were admitted and non-admitted to HBPC. The outcomes revealed a 31% mortality rate and a 24% hospital readmission rate within 30 days of non-admission to HBPC skilled nursing services.

**Figure 2**

*Intervention Period Conversion Rates*
Nested Nurse Survey

A nested survey of nurses who attended the educational intervention was launched via Microsoft Forms™. Participants responded to a series of questions using a 5-point Likert Scale Response. The survey included the following questions: Rate your knowledge of HH admission criteria, rate your skill level in completing HBPC admissions, rate your comfort level in admitting patients to HBPC. The follow up survey included additional questions to measure the impact of the AVS on nurse decision making for admission and the frequency with which nurses received the AVS via email.

The presurvey was released to attendees of the education before the class began and the post survey immediately following the educational session. The follow up survey was launched at the end of the intervention period via an email link and QR code via staff meetings. In total, 33 nurses completed the pre-survey, 24 completed the post-survey and 14 completed the follow up survey. All surveys were anonymous. Data was compiled into a master spreadsheet and Likert Scale answers were averaged and analyzed for statistical significance using an independent samples T-test.

Statistical Results
Conversion Rate

This project focuses on a key performance indicator, the conversion rate of a referral to admission versus non-admission. In the comparison period the conversion rate was 69%. In the project period, the conversion rate was 77%. Using raw analysis, this is a percentage increase of 8%.

Non-Admission Reasons

The education intervention for this project focused specifically on defining skilled need and home bound status and what qualifies patients for admission under those two requirements. In the comparison period, 58 patients were not admitted for not meeting criteria: non-home bound (n= 12 (3.5%)) and no skilled need (n=46 (13.25%)) for a total of 15.75% of total non-admission reasons. In the intervention period, there were zero patients non admitted for either non-home bound or no skilled need.

30-day outcomes

Additional data was requested to evaluate the outcomes of non-admitted patients during the project period of December 11, 2023, through February 11, 2024. EPIC™ analysists compared HBPC referral by patient name and date of birth via the EPIC™ database warehouse for outcomes specifically related to hospital readmission and mortality rates. The outcomes revealed a 31% mortality rate and a 23.6% hospital readmission rate within 30 days of non-admission to HBPC skilled nursing services.

Nested Nurse Survey

The nested nurse survey was evaluated for statistical significance using an independent samples T-test, thus accounting for unequal variance due to differences in sample size and
Inability to compare scores from individual learners due to anonymity. For this DNP project a p-value of <0.05 was statistically significant.

Clinicians reported comfort, skill, and knowledge of HH admission criteria was captured at multiple time points. Independent samples t-tests were performed to compare average Likert scores on each metric from baseline to the post survey as well as from baseline to the follow-up survey (Figure 3). Clinician comfort levels significantly increased from baseline (M=3.79, SD=0.72) to follow-up (M=4.29, SD= 0.82) \( [t(28), -2.07, p = .048] \). Skill level trended towards significance from baseline (M=3.76, SD=0.79) to follow-up (M=4.14, SD= 0.53) \( [t(36), -1.94, p = .060] \). Increases in scores observed from baseline to the first post survey did not reach the threshold of statistical significance for the three metrics assessed. A potential limitation is the sample sizes, which can increase the chance of either Type I or Type II errors.

**Figure 3**

*Comparative Nested Survey Likert Score Averages by Domain*
When asked if they are receiving the AVS from the office via email in the follow up survey, six nurses responded “never”, one responded “rarely”, three responded “sometimes”, two responded both “often” and “always”. On average, the same group of nurses rated the AVS a 4.07 on a 5-point Likert scale when rating the response to “how helpful the AVS is in guiding my clinical decision making when it comes to establishing skilled need.”

Quantitative descriptive data collected from open ended questions asked on the post and follow up surveys were reviewed and categorized. There were 17 comments in total out of 38 responses. Eleven of those comments reflected a positive experience with the educational session and a better understanding of the Home Health benefit, skilled need, and homebound status. Six comments were specific questions or requests for additional information. One nurse commented “Thank you for clarifying the homebound status. I think we missed a good number of patients because we didn’t understand.”

**Summary of Chapter**

Data from the project period revealed a complete elimination of non-admissions for the reasons “no skilled need” and “not home bound”. Dashboard results showed HBPC admissions met or exceeded the 80% benchmark four of the nine weeks during the intervention period, increasing the average conversion rate of referrals to admissions to 77% during the project period. The author noted consistency in AVS delivery from office-based nurses to patient-facing nurses as an area of improvement for leaders to ensure clinical information is disseminated consistently. Statistical analysis of nurse survey results highlights the need for continued staff education on HH admission criteria during orientation and reeducation when benchmarking results lag. Improvement in nurse comfort levels in completing HBPC admissions was statistically significant when pre survey results were compared to follow up survey results.
Chapter 5

Discussion

Introduction

This chapter will provide discussion around the author’s DNP project. This chapter is divided into three sections: a) Review of the problem, b) Limitations of the project, c) Implications for nursing practice, education, and research.

Review of the Problem

Non-admission to HH services after an acute care stay is associated with increased mortality, 30-day readmission rates, and healthcare spending (Demiralp et al., 2021; Smith et al., 2021). The AHRQ echoes this sentiment stating, “being discharged from the hospital can be dangerous” (AHRQ, 2019, para.1) calling for safer medication reconciliation, communication, and education as steps to improve patient outcomes; all of which are potentially accomplished by admitting patients to care under the HH benefit. In the PI’s practice setting, a decrease in referral to admission rates resulted in 21% mortality rate and 20% readmission rate in the comparison period. The benchmark for referral conversion was 80%, and the agency averaged a 69% conversion rate during the comparison period.

The author recognized there was no standard method to communicate clinical information to patient facing nurses completing HBPC admissions. In addition, the author had a hunch that nursing staff experienced confusion around admission criteria to HBPC, a HH benefit, because this nursing staff also cared for hospice patients which holds a different set of admission criteria. This project specifically targeted the concepts of “no skilled need” and “not homebound” for clinician determined reasons for non-admission to HBPC services. During the comparison period, 16.7% of non-admissions to HBPC services were for these two reasons
combined. A dual intervention was launched to tackle clinical information sharing utilizing the AVS and staff education sessions aimed at increasing staff understanding of HH admission criteria.

This DNP project resulted in overall increased admissions to HBPC, culminating in a 77% admission rate. There were 55 patients non-admitted to HBPC services during the intervention period. Zero patients were non-admitted for the reasons of “no skilled need” or “not home bound”, which was a resounding success for this work. Staff nurses reported statistically significant improvement in comfort with HBPC admissions and trended near statistically significant improvement in knowledge of HBPC admission criteria from pre-intervention survey to follow up survey. Overall, 30-day readmission and mortality rates of non-admitted patients did not improve with incidence of 24% and 31% respectively, further highlighting the need for actualized HBPC referrals.

Limitations of the Project

There were a few limitations with this project. First, the nurse surveys were deidentified. This made it impossible to follow up and measure outcomes related to individual nurses. Second, nurse survey sample sizes differed between the three nurse survey groups making statistical analysis challenging. Although nurses were asked to complete this survey via email and in person reminders, incentives may have helped increase responses. Nurses were unaware this project was a DNP project.

Review of non-admitted patients who were deceased within 30 days of referral revealed that some patients never left the hospital. These referrals could never be actualized. However, the EPIC™ data mining process does not easily or reliably allow for exclusion of these patients. When independently reviewed, the PI found six cases of patients with HBPC referrals who died
in the hospital but were not removed from the EPIC™ data set when evaluating for mortality rates.

Lastly, the AVS was not always shared with the nurse completing the SOC. This inconsistency may have inadvertently influenced nurse KSA’s related to HBPC admissions. Only 15% of nurses responding to the follow-up survey reported “always” or “often” receiving the AVS. The PI was unaware of the gap in this practice until the follow-up survey was completed.

**Implications for Nursing Practice, Education and Research**

The results of this project echo the results of literature supporting the use of Lewin’s Change Theory to structure and guide evidence-based practice (EBP) projects. The three stages: Unfreeze, Change, and Refreeze (Finkelman, 2022) created intentional space to challenge the formerly established process by engaging stakeholders and staff in the change early in the intervention period. In the Unfreezing stage, presenting the patient mortality and readmission statistics that nurse clinical decision making may influence, created unity around the need for the change and the intervention. In the Change stage, patient-facing staff engaged more with the new process than office staff. In the Refreezing stage, evaluations revealed overall success and opportunities for continued change and growth.

The literature discusses access and use of HBPC services as a proven strategy to reduce over-medicalized deaths with a focus on advance care planning and high conversion rate from HH services to hospice care at home without an acute care readmission (Seymour, 2018; Saunders et al., 2019; Evans et al., 2021; Roberts et al., 2021). Overall, 30-day readmission (24%) and mortality rates (31%) for the 55 non-admitted patients during the intervention period continue to highlight these facts. Further research is needed to understand, evaluate, and navigate barriers to actualizing these services for seriously ill patients and their families.
Conclusion

Evidence shows utilizing Lewin’s Change Theory for EBP projects works. This project successfully eliminated non admissions of patients to HBPC services for reasons related to nurse clinical decision making during the SOC visit. This change was likely accomplished largely by educational sessions as AVS sharing was not reliable. Recommendations for replicating this project include identification of survey participants, a longer intervention period, more frequent check ins with participants, and a process to exclude referrals that are unable to be actualized from data sources. Overall, this quality improvement project supports the need for monitoring benchmarks and providing education to staff across the continuum of tenure to ensure optimal patient outcomes in HBPC.


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Nursing, 24(6), E258–E264. Advance online publication.

https://doi.org/10.1097/NJH.00000000000000898
Appendices

Appendix A

HBPC Nurse Pre-Survey

Please answer the following questions:

* Required

1. How long have you worked in your current position? *
   - Under 1 year
   - 2-5 years
   - 6-10 years
   - Over 10 years

2. How long have you worked in the hospice and palliative care specialty? *
   - Under 1 year
   - 2-5 years
   - 6-10 years
   - Over 10 years

3. Please rate your KNOWLEDGE of home health admission criteria: *
   - No Knowledge
   - 1
   - 2
   - 3
   - 4
   - 5
   - Expert Knowledge
4. Please rate your SKILL LEVEL in completing admissions to HBPC (PBridge): *

1  2  3  4  5  No Skill  Expert Skill

5. Please rate your COMFORT LEVEL in admitting patients to HBPC (PBridge) services: *

1  2  3  4  5  No Comfort  Expert Comfort

6. Please rate your KNOWLEDGE of caring for patients receiving home based palliative care (PBridge) services: *

1  2  3  4  5  No Knowledge  Expert Knowledge

7. Please rate your SKILL LEVEL in caring for patients receiving home based palliative care (PBridge) services: *

1  2  3  4  5  No Skill  Expert Skill

8. Please rate your COMFORT LEVEL in caring for patients admitted to home based palliative care (PBridge) services: *

1  2  3  4  5  No Comfort  Expert Comfort
Appendix B

HBPC Nurse Post-Survey

HBPC Nurse Survey (Post)

After today's education, please answer the following questions:

* Required

1. Please rate your KNOWLEDGE of home health admission criteria *

   No Knowledge 1 2 3 4 5 Expert Knowledge

2. Please rate your SKILL LEVEL in completing admissions to HBPC (PBridge) *

   No Skill 1 2 3 4 5 Expert Skill

3. Please rate your COMFORT Level in admitting patients to HBPC (Pbridge) *

   No Comfort 1 2 3 4 5 Expert Comfort
4. Please add any comments you might have related to your knowledge, skill, or comfort levels of admitting or caring for patients receiving HBPC (PBridge) services. *
Appendix C
HBPC Nurse Survey Follow-Up

Since attending the educational sessions on Palliative Bridge Admission Opportunities in December

* Required

1. Please indicate your job role *
   - Field-Based RN
   - Office-Based RN

2. I receive the After Visit Summary from the office via email *
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

3. I use EPIC Care Link on my tablet to access the After Visit Summary *
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
4. How helpful the After Visit Summary is in guiding my clinical decision making when it comes to establishing skilled need. *

[Star Rating]

Not helpful Most helpful

5. I send the After Visit Summary to the RN completing the PSOC or PROC *

- Never
- Rarely
- Sometimes
- Often
- Always

6. Field RNs call in to the office to discuss patient eligibility for PSOC or PROC when there is a question of skilled need or home bound status *

- Never
- Rarely
- Sometimes
- Often
- Always

7. The ease of sending the After Visit Summary (AVS) via email to staff is *

[Star Rating]

The most difficult task in my day The easiest task in my day

8. Please add any comments you might have related to the process of clinical information sharing of the After Visit Summary prior to PSOC or PROC *

9. I have considered admitting a patient to service via the Palliative Waiver program *
10. Why have you not considered admitting a patient to service via the Palliative Waiver program? *

11. Please rate your KNOWLEDGE of home health admission criteria *

12. Please rate your SKILL LEVEL in completing admissions to HBPC (PBridge) *

13. Please rate your COMFORT Level in admitting patients to HBPC (Pbridge) *

14. Please add any comments you might have related to your knowledge, skill, or comfort levels of admitting or caring for patients receiving HBPC (PBridge) services. *
Appendix D
Entity Approval

Evidence-Based Practice Proposal

This “Proposal” is a tool designed to capture information about your project. The information you provide will help determine whether your proposed project is a performance improvement, an evidence-based practice (EBP), or research project. Please provide enough information to define the nature of the project and define the intervention planned for the selected population. You will need to develop a PICOT question and provide it below. Ideally EBP projects are time limited and should be completed within one year. The time frame may vary and may be longer depending on the nature of the project.

After completing all sections of the proposal, forward the tool to the individuals listed below. Following their review, you may receive questions back that require clarification or additional information. The goal of the review is to identify if the project falls within the scope of an evidence-based practice or performance improvement project. If the proposal falls into a “grey area” and appears to have elements of a research study, the abstract proposal will be sent by the author to the MLH IRB office for their review. The IRB will evaluate the Abstract Proposal and make a determination regarding the nature of the proposed project.

Does your project involve retrospective chart reviews? If this is the case, then this is considered research and an IRB proposal would need to be completed.

Send completed “EBP Abstract Proposal” To:
System Director, Magnet & Professional Excellence – Amy Callahan, DNP, RN, CallahanA@mlhs.org

Fellowship Projects: please submit to the fellowship coordinator prior to submitting to designated individuals who are required to provide approval via their signature.

Clinical Ladder Applicants / Projects: please review with your designated clinical ladder representative, campus lead, or CNE prior to submitting to designated individuals who are required to provide approval via their signature.
**PICOT QUESTION:** Does nurse education on home health admission criteria and a standardized practice for the provision of relevant clinical information prior to the start of care visit impact admission rates to home based palliative care (HBPC) home health services or the DVACO Palliative Conditions Waiver Program over 8 weeks?

**PICOT Question:**

- **Population/Patient Problem:** Home Based Palliative Care patients
- **Intervention:** Nurse Education on home health admission criteria and standardized practice of sharing relevant clinical information with nursing staff
- **Comparison:** current state
- **Outcome:** Impact on admissions to traditional HH episode or DVACO Palliative Conditions Waiver Program
- **Time:** 8 weeks

Write out formal PICOT Question using the template below as a guide. In home based palliative care (P), how does education on home health admission criteria and a standard practice for the provision of clinical information prior to the start of care visit (I) compared to current state (C) impact (O) admission rates to traditional home health services or the DVACO Palliative Conditions Waiver Program (T) within 8 weeks?*

**Date of Submission:** 9/25/23

**Title:** Information Impact on Home Based Palliative Care Admissions

**Author(s):** Donna Rugh

**Contact Information for Author(s):** rughd@mlhs.org

**Hospital Name:** HomeCare/Hospice

**Unit Name/Department:**

**Manager Name:** ______Susan Harrigan_________

**Nurse Manager Signature:** ______Susan Harrigan MSN, RN Director

**Nursing Vice President Name:** ______Terre Mirsch_____

**Nursing Vice President Signature:** Terre Mirsch, MS, BSN, RN. CHPCA, CHPN Executive Director
Proposal:

Directions: Please provide a clear explanation of your project in terms that can be understood by non-nursing healthcare providers who may be reading and reviewing this abstract. Keep the proposal concise (less than 300 words). Please answer all the sections below.

Purpose and Rationale: The World Health Organization (WHO) (2018, preface) states “Palliative Care is an ethical responsibility of health care organizations” and “it is imperative that palliative care be provided in the community”. MLH HomeCare and Hospice has a home health service line dedicated to skilled home-based palliative care nursing (HBPC). Admission to care under this service line is regulated by the same criteria as traditional home care benefits (CAPC, nd). MLH HomeCare and Hospice referral conversion rate for admission to HBPC averages 70%, below the entity target rate of 80%. MLH’s strategic plan recognizes “Home as the Hub of Care” working to reduce rehospitalizations and partnering patients with necessary home health services.

Synthesis of Evidence: Prompt admission to home care services from an acute care stay is proven to reduce 30-day hospital readmissions (Smith, et al., 2021). Patients ordered but not admitted to home health services from an acute care stay have a 19% higher mortality rate (Demiralp et al., 2021). HBPC is proven to decrease healthcare spending, increase quality of life for patients, and increase hospice enrollment while decreasing rehospitalizations (Paramanandam, et al., 2020, Roberts et al., 2021, WHO, 2018). Years of employee service, patient medical condition, and insurance regulations all play a role in nurse decision making at start of care (SOC) (Sokolow et al., 2021). Lack of clinical information at SOC is the most common barrier to completing a timely SOC (Sokolow et al., 2021; Topaz et al., 2018).

Data Collection: Data mining will be facilitated through the HomeCare and Hospice electronic medical record (Home Care Home Base) embedded analytics tools to compare pre/post intervention admissions and non-admissions. All referrals will be tracked via chart review in EPIC by this author for 30-day acute care readmission. Nurses will receive a brief survey pre and post education to evaluate staff comfort level/learning via MS Teams Forms.

Practice Change: Increase the conversion rate from referral to admissions.

Implementation Strategies: A standardized process will be created to share relevant clinical information (i.e: after visit summary from acute care admission) to nurses completing start of care visits for HBPC referrals. All nurses will receive education in the form of a Virtual MS Teams meeting with power point on qualifying home health admission criteria and the DVACO Palliative Conditions Waiver Program. This meeting will be recorded for staff reference.

Evaluation: Evaluation of nurses’ responses to 5-point Likert Scale questionnaire before/after education to determine the impact of the education. The impact of the intervention will be evaluated using HCHB analytic reports to review HBPC referral to admission conversion data for 8 weeks pre and post intervention. Trends related to readmission rates will be considered by monitoring for acute care admissions via EPIC.
Appendix E
Health Care Institution IRB Waiver

October 16, 2023

RE: Information Impact on Home-Based Palliative Care Admissions

Dear Ms. Rugh,

I have reviewed the Evidence Based Practice / Quality Improvement proposal submitted to the Nursing Research and Innovation Council. Based on the information you provided, the project as submitted, to be implemented between December 4, 2023 – February 23, 2024, is a Quality Improvement and Evidence Based project and does not require Office of Human Research Protections (ORP) approval.

As confirmation, this project has been reviewed in cooperation with the MLH ORP and confirms the project qualifies as quality improvement and that collection, use, and retention of data for support of this project is permitted.

In the future, if changes are made to the above referenced project, please notify me to determine if ORP review is necessary. Please contact me if you have questions or concerns regarding the proposal review.

Sincerely,

Amy Callahan, DNP, RN
System Director, Nursing Administration
Magnet & Professional Excellence
Nursing Research & Innovation Council, Facilitator
Main Line Health
240 N. Radnor Chester Road
Radnor, Pa 19087
Office: 484-337-4327
callahana@mlhs.org
Appendix F

West Chester

University IRB Approval

IRB FY2226-104 - Initial - Unint - Expedited

Nov 8, 2023 10:37 AM

To: Donna Hugh

Nursing

Re: Expedited Review - Initial - IRB FY2226-104 Information Impact on Nurse-based Palliative Care Administrators

Dear Donna Hugh:

Thank you for your submitted application to the West Chester University Institutional Review Board. Since it was deemed expedited, it was required that two reviewers evaluated the submission. We have had the opportunity to review your application and have rendered the decision below for information impact on nurse-based Palliative Care Administrators.

Decision:

Selected Category: Category 2.2: Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including oral or auditory recording) if at least one of the following criteria met:
The information obtained is recorded in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

Sincerely,
West Chester University Institutional Review Board

[Email signature with contact information]
Appendix G
Decreasing Non-Admissions in Home Based Palliative Care

Pre-Survey
Please take the short survey by scanning the QR code or following the link in the chat.

This survey will gather some demographic data and measure your knowledge, skill, and comfort level with Home Based Palliative Care admissions and services.

This survey is anonymous.

Objectives
- Identify the importance of Home-Based Palliative Care (BPC) aka “PBridge”
- Discuss the impact of non-admission to PBridge services
- Review Home Health (HH) Admission Criteria/Medicare Conditions of Participation
- Learn a new non-admission process for PSOC from MLH Hospitals
The World Health Organization (WHO) (2018, preface) states “Palliative Care is an ethical responsibility of health care organizations” and “it is imperative that palliative care be provided in the community”.

**Importance**

1. Prompt admission to home care services from an acute care stay is proven to reduce 30-day hospital readmissions by 66% (Smith, et al., 2021).

2. Patients ordered but not admitted to home health services from an acute care stay have a 19% higher mortality rate (Demiralp et al., 2021).

3. HBPC is proven to decrease healthcare spending, increase quality of life for patients, and increase hospice enrollment while decreasing rehospitalizations (Paramanandam, et al., 2020, Roberts et al., 2021, WHO, 2018).
## Non-Admit Reasons

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Skilled Need</td>
<td>12.6%</td>
</tr>
<tr>
<td>Not Home Bound</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

### Non-Admission Mortality and Readmission Data

<table>
<thead>
<tr>
<th>Event</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Urgent Care</td>
<td>9.7%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>20.2%</td>
</tr>
<tr>
<td>Death</td>
<td>21%</td>
</tr>
</tbody>
</table>

MLH Patients Deceased within 60 days if Non-Admission: 25%
### What does the Literature tell Us?
#### Why do Non-Admissions Occur?

| Regulatory differences between home health and hospice admission criteria may cause confusion... are they eligible? |
| Lack of clinical data at the time of admission impacts the nurse’s opinion related to appropriateness of admission and other important decisions... what information do we share with our nurses? |
| Some patients may not be home bound but have a skilled need making them non eligible for traditional HH services... how can we help? |

### Are they Eligible?

### Home Health & Palliative Care Eligibility
Learning Objectives

- Demonstrate understanding of the Medicare definition of Homebound
- Demonstrate understanding of the Medicare definition of Skilled Need
- Demonstrate understanding of the Medicare definition of Part Time & Intermittent

Do these rules apply to just Medicare Patients?

- No
- Most insurance companies follow these definitions
- Unsure if the patient’s situation meets the definition of all three?
  - Call the office

If all 3 are not met, are there other options?

- Yes!
- Some insurance companies may waive homebound status.
- Some insurance companies may waive skilled need.
- An insurance company should never waive the Part Time & Intermittent requirement.
- Palliative Care Waiver option
Homebound Definition per CMS
“Chapter 7”

- Criterion One: The patient must either because of illness or injury:
  - need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
  - OR - Have a condition such that leaving his or her home is medically contraindicated.

- Criterion Two: There must exist a normal inability to leave home; AND - Leaving home must require a considerable and taxing effort.

Homebound Status:
When can a patient leave the home?

The client is confined to home except for infrequent periods of relatively short duration for non-medical purposes, or for the need to receive medical treatments such as:
- Adult day care where medical treatment is given
- Kidney dialysis
- Chemotherapy
- Radiation therapy

What does homebound mean to a patient?

- You can generally leave home as often as you need for medical treatment that cannot be provided in the home and still be considered homebound.
- These trips must be infrequent and require considerable and taxing effort.
What does homebound mean to a patient?

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn’t recommended because of your condition.
- You’re normally unable to leave your home because it’s a major effort.

Homebound Status

- If my patient is not homebound, should I tell them they should stay at home to qualify for our services?
  - No
12 Components of Skilled Nursing

- Observation and Assessment
- Teaching and Training Activities requires the skills of the nurse to teach
- Wound Care (3 components)
  - hands on care
  - observation and assessment
  - teaching and training activities
- Catheters
- Tube Feedings
- Nasopharyngeal and Tracheostomy Aspiration
- Ostomy Care
- Heat Treatments
- Medical Gases (initial phases of regimen)
- Administration of Medication (other than oral meds, eye drops and topical ointments)
- Rehabilitation/Restorative Nursing
- Management and Evaluation of the Care Plan

Part-Time & Intermittent Requirement

The recipient’s care must require less than 28 hours per week of combined:
- Skilled Nursing and
- Home Health Aide Services

Case Studies

Are they eligible?
Mr. B
Referral for Palliative care

- Discharged yesterday from Lankenau Hospital with New Dx Lymphoma.
- New medications
- New balance and weakness challenges
- Pain
- Lives with daughter

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Mr. Z
Referral for Palliative care

- Discharged yesterday from Paoli Hospital with new onset seizures.
- His spouse tells you he has been so forgetful since he finished his radiation treatments last month for glioblastoma.
- Chemotherapy will start tomorrow.
- His BIMS score is 9.
- She also shares that when she finished her work call last night, he was gone.
- She tracked him with his iPhone and saw he was at his local bar.
Ms. Z
Referral for Palliative care

- Skilled Need
  - Observation & Assessment – recent hospital stay
  - Medication Teaching
  - Instruct Seizure Management
- Homebound
  - Cognitive Impairment (BIMS=9)
- Part time & Intermittent
  - Has a caregiver
  - RN and HHA Needs: 3 RN W1; 2 HHA W1

Ms. C
Referral for Palliative care

- Discharged yesterday from Riddle Hospital with Dx of Heart Failure (Stage 4)
- She informed the hospital case manager that her spouse will help her when she gets home.
- Provider requests Telemonitoring to keep her out of the hospital.
- New & adjusted medications
- Ambulance transported to home and to hospital bed
- Balance and weakness challenges
- Spouse died 2 years ago.
- BIMS 7

Ms. C
Referral for Palliative care

- Skilled Need
  - Observation & Assessment – recent hospital stay
  - Medication Teaching
- Homebound
  - Weakness with Balance issues
- Part time & Intermittent
  - Can her level of care be safely addressed for less than 28 hours per week?
  - Can her level of care be safely addressed by us intermittently?
Mr. W
Referral for Palliative care

- Referred by his oncologist with Dx of Lung cancer
- Starting a new oral chemotherapeutic medication.
- During the visit, he runs up the stairs easily to get the new medication he picked up yesterday.
- No oxygen
- He tells you he is driving to the grocery store tomorrow.

Mr. W
Referral for Palliative care

- Observation & Assessment – new medication
- Medication Teaching

Mr. F
Referral for Palliative care

- Dx last year with stage 4 Melanoma with metastasis
- Lives with his daughter
- Unsteady gait and uses a walker.
- His daughter will be driving him to his Margate, NJ home next week for a family vacation.
- Mr. F saw his PCP yesterday and received:
  - a new Rx for valsartan
  - Guidance to reduce Eliquis down to 2.5 mg a day due to worsening kidney disease.
Ms. F
Referral for Palliative care

- Skilled Need
  - Observation & Assessment – recent medication change
  - Medication Teaching

- Homebound
  - Does leaving the home require considerable & taxing effort?
  - Does leaving the home require assistance of another person or an assistive device

- Part time & Intermittent
  - RN and HHA Needs: 3 RN W1; 2 HHA W1

Ms. D
Referral for Palliative care

Diagnosis:
- Stage 4 ovarian cancer
- Balance concerns - uses a cane
- On Oxygen 2 L via NC
- New Rx for constipation: Miralax
- She tells you she drove to the grocery store yesterday.
- Lives alone
- No supportive family
- BIMS score 15

Ms. D
Referral for Palliative care

- Skilled Need
  - Observation & Assessment – recent medication change
  - Medication Teaching

- Homebound
  - Does leaving the home require considerable & taxing effort?
  - Does leaving the home require assistance of another person or an assistive device

- Part time & Intermittent
  - RN and HHA Needs: 3 RN W1; 3 HHA W1
What Clinical Information do we Share with our Nurses prior to SOC?

The Importance of Available Clinical Information at SOC

- According to Sokolow et al (2021) the Home Health RN’s critical clinical decision of admitting or not admitting a patient to an episode of care under the HH benefit is significantly impacted by “information deficits”
- The literature suggests utilizing a standard clinical care document

After Visit Summary (AVS)

- All patients d/c from a MLH hospital receive an After Visit Summary
- The AVS is available in EPIC and can be viewed; however, can be cumbersome from tablet
- The After Visit Summary will be provided via email to the nurse completing all PSOC and ROC patients coming from MLH Hospitals
AVS is reviewed with the patient by the discharging RN and sent home with the patient via email for all PSOC.

The CTC will email the AVS to for all PSOC patients discharged from a MLH Hospital as our standard clinical care document.

How can we Help Impact Patient Outcomes?
Delaware County Accountable Care Organization (DVACO)

The DVACO:

- Is an accountable care organization participating in the Center for Medicare and Medicaid Services (CMS) Shared Savings Program (MSP) who holds performance-based contracts with private payors.
- Focuses on quality and population health projects and programs with these providers (MLH is a preferred provider of the DVACO).
- Designed the Palliative Conditions Waiver to provide four to five skilled home care visits to beneficiaries who have a skilled need but are not homebound.

What does this mean?

Some patients may be eligible for admission to services under the “Palliative Conditions Waiver”. This care is not charged to the patient’s insurance.

- MUST have a skilled need but do NOT need to be Home Bound.
- This applies to all referrals, not just care from MLH Hospitals.
- Eligible for up to 4-5 skilled visits over 6 weeks, then discharge.
- Skilled: RN, PT/OT.

Psychosocial team should continue to be notified the usual way, visits do not count toward the total waiver visits.

Waiver patients cannot receive HHA, SLP services. Use this as a consult care instead.

Change in Clinical Condition?

If there is a change in the patient’s clinical condition during while on the Palliative Conditions Waiver Program as identified by the RNCM or CURE...

The patient will be discharged from Waiver and a FULL Admission will need to be completed under the traditional HH benefit.
Waiver Admission Process

1. RN completing SOC identifies a patient with skilled need, but not homebound
2. RN calls CTO/Manager to learn if patient is eligible for a waiver admission
3. If eligible for waiver, will proceed with admission
4. If NOT eligible for waiver, will non-admit
5. RNCM sends email as per usual re: admission/non-admission. OR (new) Waiver admission

Mr. R

Mr. R is a patient with Stage 4 heart failure who continues to work in the office 3 days a week. Recently discharged from BMH with increased dosage of Lasix and new O2 and ambulatory assistance with a cane.

On admission he tells you he plans to continue to go to work and “keep going as long as I can with a normal life!”

Traditional HH eligible? NO (not homebound)

The RNCM calls the office and learns the patient is eligible for an admission to the Palliative Waiver Program and proceeds with admitting the patient.

EXAMPLE

Mr. R

The RNCM admits the patient under the waiver program

Plans 2 visits for observation/assessment, medication teaching, O2 teaching, Requests PT/OT for eva and treat in visit each 2 visits

Notifies SW/CH of new patient in the usual way

Plan to d/c at skilled visit 5 within 6 weeks
Mr. R has a clinical change...

- Mr. R goes to the office late in the week and returns home before the end of the usual work day feeling exhausted.
- Mr. R’s partner connects with the RNCM.
- Mr. R realizes he can no longer go into the office and now meets traditional HH “Home Bound” criteria.

The RNCM contacts the office, the waiver episode is discharged, and a traditional HH episode is created and an admission is performed by the RNCM.

Pilot Phase December-February

- Begins Monday, December 11
- Goal is to increase PBridge admissions by 10%
- Patient outcome data will be evaluated (readmissions, ER/Med Urgent Care, deaths)

Updates will be provided on outcomes when available.

Questions?

ANY QUESTIONS?
Post Survey

Please take the short survey by scanning the QR code or following the link in the chat.

This survey reviews your knowledge, skill, and comfort level with Home Based Palliative Care admissions and services.

This survey is anonymous.