

Assessing Your Home Care Practice
Microsystem Approach

Aim: Use an assessment of your home care practice to focus your improvement work on achieving better clinical, functional, satisfaction, and financial results.		
Team Name and Number:	Clinical Director:	Date:

1. Know Your Patients: Build knowledge of **the patient population** that this team serves: Who are they? What do they need / receive for services? How long are they under your care on average?

Demographics: (Oasis Discharged Cases n=)		Received Services (%)	
Active Patients (#)		PT	
New Admissions (#)		SW	
Re – Certs (# follow-up)		OT	
Average Age		HHA	
Gender (% female)			
Race	Asian Black Hispanic white		
Medicare FFS Managed Care		Referral Sources (top 3)	Hospital Physician Health Care Facility
Medicaid FFS Managed Care		LOS ≤ 30 days 30-60 90-120 >120	
Dually Eligible			
Private HMO/managed care			
Lives Alone			
Diagnoses (top 3 primary)			

Wounds and Diabetes (Start of Care n=)		
Any Type Wound		
Wound Types		
Pressure		
Stasis		
Surgical		
Diabetes		

Functional Limitations (Start of Care n=)		
Bathing		
Toileting		
Ambulation		
Cognitive Impairment		

2. Know Your People: Who are the **people in the care team**, what are their roles and skills, when are they available ?

Team Names	FTE, Availability	Yrs Exper	Expertise	Avg Visits per Day (Range)	Case Load Range
Coord. Of Care (RN)					
Physical Therapist					
Wound /Diabetic Resource Nurse					
SW					
Advance Practice Nurses (CNS, NP)					
Per Diem					
Occupational Therapist					

Office Team Names	Yrs Exper	Expertise	Avail
Manager			
Facilitators			
Team Assistants			

<p>Hours of Operation <i>Region:</i> Days_____Hours_____</p> <p><i>After Hours</i> Weekday Hours _____ Weekend Hours _____ Evening Hour Services _____</p>

Home Health Aide Services		
# Licensed Agencies		
# HHAs per team		
% cases accepted by Primary Licensed Agency		
HHA hours/visit (avg, range)		
% changes HHA		

3. Know Your Processes

- Implementation Evidence Based Protocols
- HHA service monitoring
- Physician Communication
- Clinical Specialist Consultations
- Interdisciplinary Coordination of Services
- Self Management Support

Process Measures (monthly)	% yes
MD Communication : inadequate progress, ineffective treatments, status changes	
Follow through on physician changes in plan of care	
Interdisciplinary coordination	
HHA supervision, review, monitoring	
Evidence based protocols used	
Adherence self –management activities	
Consult initiation <i>Wounds</i> <i>Diabetes</i>	

4. Know Your Patterns: What clinical outcomes are you achieving? What are staff, patients and providers saying about this team? Are you cost effective in your delivery of services?

Emergent Care	
Overall Population Emergent Care	
Wound Patient Emergent Care	
Diabetic Patient Emergent Care	

Functional Improvements at Discharge	
Management Oral Medications	
Bathing	
Transferring	
Ambulation	

Patient Satisfaction	(%very satisfied, satisfied)
Prepared for decreased or stopped services	
Handling of Problems	
Overall Quality of services <input type="checkbox"/> Nurses <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Home Health Aides	

Staff Satisfaction	% excellent
Morale	
Initiative	
Teamwork	

Utilization	
RN visits per week	
HHA hours per visit	