HHQI
Home Health Quality Improvement

Best Practice:

Chronic Obstructive Pulmonary Disease

Nurse Track

Home Health
HHQIOSC
QUALITY INSIGHTS
Quality Improvement Organization Support Center

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ08.726 App. 1/2008

Nurse Track - COPD

This best practice intervention package track is designed to educate nurses in disease management and to provide an update on symptom management of high-risk diagnoses.

Polish Your Practice: COPD is presented as the primary resource for this track. You or your agency management may elect to pursue the Heart Failure Track located in the Nurse Track of the BPIP located at www.homehealthquality.org.

Objectives

After completing the activities included in the Nurse Track of this **Best Practice Intervention Package–Disease Management**, the learner will be able to:

1. Identify the role of home health in disease management and reducing avoidable acute care hospitalizations
2. Apply current assessment and symptom management modalities in daily practice
3. Describe two nursing actions that support an effective disease management program

Complete the following activities for the **COPD Track**:

	Activity	Location	Estimated Time
❑	Read Disease Management and Home Health	Page 3	10 minutes
❑	Read "Polish Your Practice: COPD"	Page 5	20 minutes
❑	View "Disease Management and Home Care: COPD WebEx" by Lisa Gorski (podcast also available)	Page 13	50 minutes
❑	Listen to "Disease Management and Reducing ACH" podcast featuring Dr. David Nash	Page 13	15 minutes
❑	Read Examples of Excellence	Page 15	10 minutes
❑	Complete the nursing evaluation and post-test online for free CNEs for RNs and certificate of participation for LPNs/LVNs	See link below	10 minutes
	Total time for completion		115 minutes

RNs: Apply for **free** 2.0 Continuing Nursing Education units for completing the nursing track activities. **Complete evaluation/post-test online at:** http://www.zoomerang.com/survey.zgi?p=WEB227AGTMLAMM

LPNs/LVNs: Apply for a certificate of attendance for completing the nursing track activities. **Complete evaluation/post-test online at:** http://www.zoomerang.com/survey.zgi?p=WEB227AGTMLAMM

Disease Management and Home Health

Definition:

Disease Management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant (DMAA, 2007).

Acute Care Hospitalization Connection:

A formal disease management program was one of the top 15 strategies used by agencies who had the lowest acute care hospitalization rates of 19 percent or less (Briggs National Quality Improvement Reduction Study of 2006). Patients who survive a severe exacerbation of chronic obstructive pulmonary disease (COPD) are at high risk of rehospitalization for COPD and death. The risk of rehospitalization for COPD was 25 percent at one year and 44 percent at 5 years, and was increased by age, male gender, prior hospitalizations and co-morbidities including asthma and pulmonary hypertension.

Polish Your Practice: COPD

This is a review of pathophysiology, symptoms, assessment parameters, treatment modalities, pharmacologic update and patient self-management and self-management support activities.

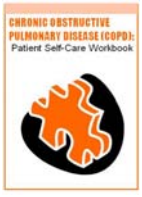
Disease Management and Reducing ACH

This 15-minute audio recording offers a brief overview of disease management. David Nash, MD, MBA, offers his expert perspective on the role of home health in reducing acute care hospitalizations. Dr. Nash is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement. His work has appeared in over 100 articles in major journals.

Disease Management and Home Care: COPD WebEx

This 50-minute WebEx reviews several tools for improving the management of COPD. These include:

- Patient Selection Criteria
- Decision Support Tool (next page)
- Patient Encounter Documentation Tool
- Patient Self-Care Workbook
- Staff Education Guide



This session is presented by Lisa Gorski, MS, APRN, BC, FAAN. Lisa is a Clinical Nurse Specialist at Covenant Home Health & Hospice in Milwaukee, Wisconsin. She has over 20 years of home care experience and has contributed over 50 articles and books to professional literature. Lisa is a Senior Associate Consultant with OASIS Answers, Inc.

All tools are available at www.homehealthquality.org.

Patient Education:

Disease management's success will lie within patient and caregiver education and patient self-management. The Institute for Healthcare Improvement (IHI) identified typical failures found in patient and caregiver education, which included the following:

- Assuming the patient is the key learner
- Poor discharge planning instructions
- Patient and caregiver confusion about patient self-care instructions and medications
- Non-adherent patients, resulting in unplanned readmissions

IHI's recommended changes included the following:

- Identify the key learner(s) on admission (e.g. patient, specific caregiver)
- Redesign patient education process to improve patient and family understanding of self-management
- Use **Teach Back** during visits and phone calls to assess patient's and caregivers' understanding of instructions and self-care

(Transforming Care at Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure. 2007)

Teach Back
After teaching has occurred, ask patient and/or caregiver to repeat it back or **teach back** the information to the clinician to evaluate that appropriate learning occurred.

Transitional Care Coordination:

Disease management is not an inclusive intervention for home care. Ideally disease management goes across the continuum from home to hospital to physician office, etc. Transitional Care has been defined as a set of actions designed to ensure the **coordination** and **continuity** of health care as patients transfer between different locations or different levels of care (Coleman and Berenson, 2004).

For more information see the next BPIP - **Transitional Care Coordination** available February 1, 2008.

Additional Resource:

Heart and Lung Sounds by 3M http://solutions.3m.com/wps/portal/3M/en_US/Littmann/stethoscope/education/heart-lung-sounds	Visit the Web site to listen to normal and abnormal heart and lung sounds

Polish Your Practice: COPD

Home Health
HHQIOSC
Quality Insights
Quality Improvement Organization Support Center

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number: 8SOW-PA-HHQ07.691. App. 11/07.

Polish Your Practice: COPD

Definition

Chronic obstructive pulmonary disease (COPD) is characterized by the progressive development of airflow limitation that is not reversible and it encompasses chronic obstructive bronchitis, emphysema and mucus plugging. Most patients with COPD have all three conditions. COPD affects 14-20 million Americans each year.

Pathophysiology

COPD is a disease state characterized by airflow limitation that is not fully reversible. The airflow limitation is usually both progressive and associated with an abnormal **inflammatory** response of the lungs to noxious particles or gases. It is likely that there are interactions between environmental factors and a genetic predisposition to COPD, which makes some people more prone to develop COPD than others.

There is a chronic inflammatory process in COPD that differs from that seen with asthma. Over time, those with COPD not only develop a chronic cough, but experience changes in lung capacity, purulent sputum and a decline in pulmonary function. Many develop weight loss and fatigue since they can't eat or sleep due to the dyspnea and possible respiratory distress.

The most important risk factor for COPD is cigarette smoking. A diagnosis of COPD should be considered in any individual with symptoms and a history of exposure to risk factors. The diagnosis should be confirmed by spirometry.

Symptoms (Acute worsening of these symptoms occurs during exacerbations)

✓ Dyspnea • Patient's subjective awareness of altered or uncomfortable breathing • Most common symptom characterizing pulmonary pathophysiology May assess using the modified Borg perceived level of dyspnea scale
✓ Cough • Can be debilitating associated with sleeplessness, fatigue and chest pain
✓ Sputum production
✓ Respiratory distress • Physical or emotional suffering that results from the experience of dyspnea can be observed and measured objectively in the absence of a patient self-report
✓ Sleeplessness

Symptom exacerbations are often associated with COPD. They may be caused by pulmonary infections or an increase in air pollution, but the cause of about 30 percent of severe exacerbations can't be identified. If the patient's risk for respiratory acidosis has been determined and stabilized, patients can typically be managed at home with success.

Determine disease **severity** for an individual with consideration of patient's symptoms, complications, general respiratory status, co-morbidities and general health status.

Assessment Parameters

1) Vital signs including blood pressure, heart rate, temperature, oxygen saturation and weight ***Note:*** Obtaining this information allows the clinician to identify changes in condition.
2) Level of dyspnea at rest with activity should be assessed with each visit. ***Note:*** Increasing dyspnea is the main symptom associated with COPD exacerbation.
3) Abdominal girth should be obtained at least weekly, more often if there are changes identified ***Note:*** This allows the clinician early identification of fluid retention that may indicate early diastolic heart failure development. Abdominal girth and weight also allow for evaluation of nutritional status.
4) Lung sounds should be obtained to identify worsening of condition or the presence of fluid or pneumonia ***Note:*** Lung sounds will often be diminished, so subtle changes will be immensely important.
5) Sleeping patterns should be assessed ***Note:*** Helps to determine if patient is having increased orthopnea (need to sleep propped up to breath comfortably), and to determine if patient is getting enough restorative sleep to prevent deterioration of condition.
6) If patient complains of increased shortness of breath at night or in the morning, obtain an **overnight pulse oximetry** ***Note:*** Helps to determine if patient has lower oxygen saturations, possibly due to breathing through the mouth at night, or there may be a presence of obstructive sleep apnea and patient may require a sleep study to determine if CPAP or BiPAP is indicated.
7) Evaluate nutritional status ***Note:*** Helps to determine if patient is eating adequate amounts of calories and protein to meet the body's metabolic needs and to prevent muscle breakdown which can lead to increasing immobility due to weakness and increased fall risk.
8) Evaluate psychosocial status ***Note:*** Depression and coping are common in this patient population and may need to be addressed.

9) Assess for the **presence of compensatory breathing techniques**, including the use of pursed-lip breathing, diaphragmatic breathing, use of the tripod position or use of accessory muscles ***Note:*** Changes in breathing technique may be a signal of worsening condition.
10) Sputum color and amount ***Note:*** May indicate a worsening of the condition or the development of pneumonia.
11) Medication reconciliation is essential. ***Note:*** Process of identifying the most accurate list possible of all medications a patient is taking and comparing that list against the physician and/or hospital discharge orders, with the goal of providing correct medications.

"If we are not picking up on early and often subtle changes in SOB, we are missing an opportunity for early intervention."

Lisa Gorski, MS, APRN, BC, FAAN, Clinical Nurse Specialist
Covenant Home Health & Hospice

Treatment of COPD

The quality of life for a person suffering from COPD diminishes as the disease progresses. None of the existing medications for COPD has been shown to improve the long-term decline in lung function, therefore the:

- The **goal of treatment** is to provide relief of symptoms and prevent complications and/or progression of the disease with minimum side effects.

Pharmacological

Primary treatment for COPD is pharmacological, using a combination of bronchodilators, both short-acting and long-acting, systemic corticosteroids and antibiotics as needed for exacerbations of bronchitis or pneumonia.

Immunization

Further treatment includes ensuring patients receive flu and pneumonia vaccines if they have no allergies or contraindications.

Oxygen

Oxygen therapy may eventually be needed to help ensure adequate supply to the tissues of the body to prevent stimulation of the sympathetic nervous system and renal cascade that can lead to the development of heart failure and increase oxygen demand.

Low-level oxygen should be used to ensure that the breathing drive is not suppressed.

Pulmonary Rehabilitation

Pulmonary rehabilitation consisting of exercise training is beneficial to help patients prevent further deterioration of lung function, and help patient cope physically, psychologically and socially with COPD.

Lung transplantation and lung volume reduction surgery is increasing in acceptance for people who suffer from severe emphysema.

AAT Replacement Therapy

For patients with Alpha-1 Antitrypsin Deficiency related emphysema, treatment includes life-long AAT replacement therapy.

Smoking Cessation

Smoking cessation classes, medications and alternative methods can assist patients to stop smoking.

Pharmacologic Management for COPD

Medication	Action	Observation Parameters
Bronchodilators Inhaled preferred to oral (Long and short acting) - Beta 2 agonists - Anticholinergics - Methylxanthines	• Short-acting bronchodilators last about 4-6 hours and are used only prn • Long-acting b bronchodilators last about 12 hours and are used every day when indicated • Relaxes smooth muscle of bronchi and open constricted airway passages • Prescribed for maintenance treatment of bronchospasm	• Observe patient use of metered-dose inhalers and re-instruct in technique as appropriate • Observe for methylxanthines for potential side effects and adverse drug interactions
Glucocorticosteroids (Inhaled/ingested)	• Inhaled corticosteroids reduce the frequency of COPD exacerbations, but they are not useful for symptom control • High dose oral corticosteroids may improve lung function, but they have no clinically significant benefits for patient-oriented outcomes; inhaled corticosteroids should be used instead. • Relieves inflammation and swelling of tissues of the lung • Reduces fluid build-up and bronchospasm	• Observe patient use of inhalers and re-instruct in technique as appropriate • Monitor weight, blood pressure, s/s infections/gastric distress, skin condition • Monitor glucose levels and renal function
Immunization - Influenza - Pneumococcal	• Influenza vaccination minimizes severity of influenza symptoms • Pneumococcal vaccination provides protection for the prevention of pneumonia	• Encourage influenza immunization annually, if not contraindicated • Encourage pneumococcal immunization per protocols (including non-flu season)
Antibiotics	• Use to treat *infectious* exacerbations *only* • If the exacerbation is associated with changes in sputum (quality, volume, or color) and increased dyspnea, cough, or fever, treatment with antibiotics is reasonable	• Observe closely for response to treatment
Psychotropics - Anti-anxiety - Antidepressants	• Reduces anxiety and aid in relaxation	• Observe response, signs of drowsiness, balance deficits, suicidal ideation • Assess for orthostatic hypotension

Pharmacologic Management for COPD – cont.

Medication	Action	Observation Parameters
Diuretics	• Eliminates excess fluid thereby reducing fluid build-up in lungs	• Monitor daily weight • Monitor lab values for BNP, electrolytes and renal function
Oxygen therapy	• Helps prevent hypoxemia • Improves sleep, cognition, activity tolerance and reduces breathlessness • Long term O2 therapy (> 15 hours/day) may increase survival & exercise capacity	• Monitor pulse oximetry; keep daily log; maintain SaO2 of at least 90 percent • Teach proper use of equipment: concentrator, compressed O2 cylinders, liquid O2; review use of flow meters and regulators

Frazier, SC (2005) Implications of the GOLD report for chronic obstructive lung disease for the home care clinician. Home Healthcare Nurse 23 (2) 109-114.

Grimes, G., Manning, J., Patel, P., & Via, R. (2007). Medications for COPD: A review of effectiveness. *American Family Physician, 76*, 1141-1148.

National Heart, Lung, and Blood Institute (NHLBI) World Health Organization (WHO) Workshop (2004) Global strategy for the diagnosis, management and prevention of chronic obstructive pulmonary disease: Executive summary.

www.gold.org Accessed 12/13/2007

www.guideline.gov Accessed 12/13/2007

ACH
Acute Care Hospitalization

Exacerbation Indicators for Possible Hospitalization	
Marked increase in symptom intensity, such as sudden development of resting dyspnea	Newly occurring dysrhythmias
Onset of new physical signs such as cyanosis and peripheral edema	Insufficient home support
Failure of exacerbation to respond to initial medical management	Instruct patient on keeping a written log of weights and taking it to every doctor visit
Malnutrition, exhaustion, depression or sleep deprivation	Inability to manage self in absence of caregiver

Self-Management

Self -Management	Self -Management Support
SMOKING CESSATION!!!	• Assist patient in obtaining assistance with smoking cessation if indicated
Participate in a home exercise program that helps strengthen muscles, increase lung elasticity and includes energy conservation techniques.	• Consult physical and/or occupational therapy to help patient develop a home exercise program • Teach patient effective breathing techniques, such as pursed lip breathing or diaphragmatic breathing • Teach patient pacing strategies for activities to assist with energy conservation
Eat small, frequent, high protein meals that are easy to chew. Drink plenty of fluids to thin secretions and aid in their elimination.	• Assist patient with meal planning; many COPD patients are protein malnourished as nutrition is poor • Help patients choose foods that have high protein content to help prevent muscle breakdown
Take all medications as prescribed.	• Instruct patient on actions, benefits and side effects of medications; greater understanding of the reason for taking medications increases compliance • Observe patient's ability to use inhalant medications to obtain full benefit from inhalant • Many long-acting bronchodilators and inhaled steroids will yield no benefit if not taken regularly and allowed to build-up to a therapeutic level in the body
Weigh daily at the same time each morning, wearing the same amount of clothing, after emptying bladder and before eating or drinking.	• Instruct patient on proper technique for daily weights; instruct patient on importance of obtaining a scale if he/she does not already own one • Instruct patient to report a weight gain of 2-3 lbs. in 24 hours or 5 lbs. in one week

Disease Management
Multi-Media Activities

Podcast*

Disease Management Clinician Podcast Instructions:

Title	Description	Link
Disease Management and Reducing Acute Care Hospitalization	This 15-minute audio recording offers a brief overview of disease management. **David Nash, MD, MBA,** offers his expert perspective on the role of home health in reducing acute care hospitalizations. Dr. Nash is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement. His work has appeared in over 100 articles in major journals.	The podcast link is located at: http://www.homehealthquality.org/hh/hha/interventionpackages/dm.aspx

There are several ways to listen to the podcast:

- Visit the link above and listen directly through the Web site
- Download the podcast by right clicking on the audio file and selecting "Save Target As …" This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can save the audio file to a CD or MP3 player

*A podcast is a digital media file, for use on a home computer or personal digital recording device for convenience.

Disease Management WebEx or Podcast Instructions

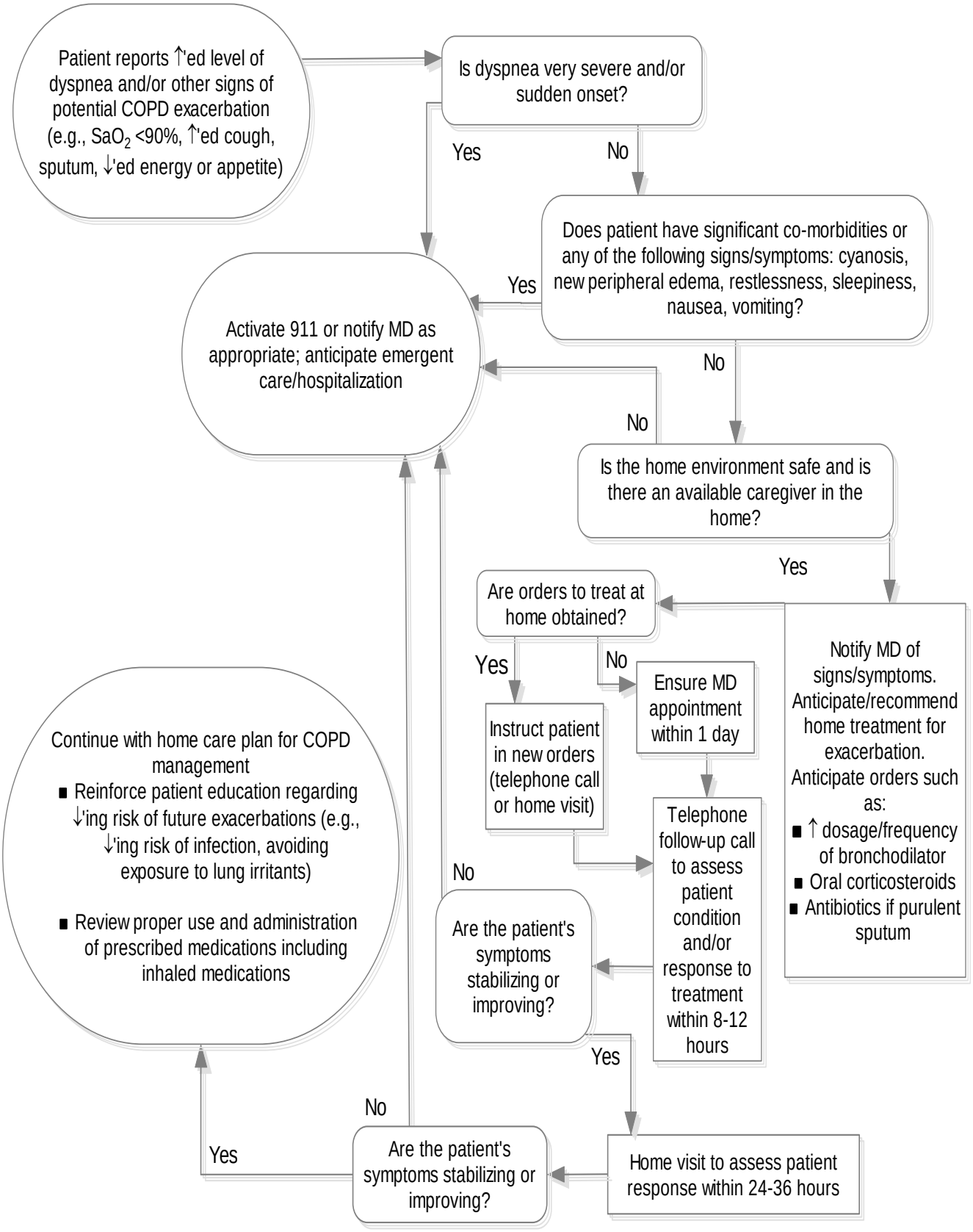
View the WebEx or listen to the podcast: **Disease Management and Home Care: COPD** at www.medqic.org, under Home Health

View presentation from individual computer
  - Click on the WebEx link to the file
- View presentation using the WebEx file with projector for in-service
  - Download the WebEx file onto your laptop computer or save the WebEx file on a CD
  - Open file and test your audio volume (may need to use a microphone to project the audio in your room)
- Click play

Home Telehealth Disease Management Series

Quality Insights of Pennsylvania

Decision Support Tool: COPD



This material was developed by OASIS Answers, Inc. and distributed by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support C
Home Health under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of
Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HH05.177.
References listed on document on Associated Resources.

Examples of Excellence

Pennsylvania Home Nursing Agency Improves Publicly Reported Outcomes through Disease Management

HOME NURSING AGENCY

In response to the focus on acute care hospitalization by the Centers for Medicare & Medicaid Services (CMS), Home Nursing Agency in Altoona, Pa. implemented a disease management program as one of its principle strategies to reduce the acute care hospitalization rate among its patients. The CMS focus, coupled with the pay-for-performance era, was the impetus to move forward with implementation of a specific disease management program.

Staff identified through internal clinical and benchmarking data generated from Outcome Concept Systems, Inc. (OCS) the top four chronic diseases affecting the agency's population base: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes mellitus, and pneumonia. With the most prevalent disease being CHF, Home Nursing Agency chose to design a disease management program utilizing the Brigg's National Quality Improvement and Hospitalization Reduction Project Report (January 2006), which identified the top ten strategies to reduce acute care hospitalization.

One key strategy identified was the value of a disease management approach. Home Nursing Agency extrapolated the disease management concept and then incorporated the remaining eight strategies as the framework for the CHF disease management program. These strategies are:

- Fall prevention
- Frontloading
- Medication management
- 24-hour response
- Patient/caregiver education
- Case management
- Special support services
- Data driven services

The Brigg's study also discussed the incorporation of telehealth as a strategy. The advancement of technology has been a strategic initiative of Home Nursing Agency. Therefore, it was incorporated into the agency's disease management model.

Home Nursing Agency developed tools for several of the acute care hospitalization strategies including a fall risk assessment, standardized care guidelines, and medication management assessment tools. Also developed was a patient/caregiver teaching tool, which aids the patient in identifying acuity of symptoms and determining the level of health care services necessary for treatment. This was coupled with the expansion of the Central Intake Department, which has been in existence for over 20 years, to a 24-hour-per-day

staffed department to meet the needs of patients experiencing complications after normal business hours. This seamless system assured that each patient call was clinically triaged with the appropriate night nurse contacted.

The agency's visionary approach of having full-time night nurses (Night Team) instead of on-call nurses has been key to keeping patients out of the hospital. This has had a great impact on the overall goal to reduce avoidable hospitalizations. "It has clearly made a difference to have a dedicated staff person after hours, rather than depending on someone who has worked a full shift or has been awakened to take a patient call," shared Celeste Twardon, Vice President for Quality and Customer Service at Home Nursing Agency.

The impact of implementing this program was successful, resulting in improved staff morale and publicly reported outcomes data. The team then expanded the disease management model to include respiratory and diabetic patients. Through implementing the disease management program with their initial target population, Home Nursing Agency reduced their readmission rate of CHF patients by 50 percent, according to OCS. Other markers of success include improved results for the Home Health Compare scores as of the December 2007 report:

- Patients who had an admission to an acute care hospital is at 14 percent; the national average is 28 percent.
- Emergent care visits are at 14 percent; the national average is 21 percent.
- Patients who have stayed home after receiving home health care is at 82 percent; the national average is 68 percent.
- Medication management is at 50 percent; the national average is 43 percent.

In addition, the agency is among the top 25 percent in the nation for outcome-based measures. Home Nursing Agency was ranked within the top 500 home care providers in the nation in 2007, as compiled by OCS and Decision Health.

Besides the marked improvement in publicly reported data, staff morale has also improved significantly. Home Nursing Agency strongly believes in rewarding its team for successes. There are incentives and celebrations, including an annual recognition breakfast each December for its nearly 1,000 employees. Staff are recognized and awarded for special achievements including years of service and perfect attendance. Home Nursing Agency created the STAR (Staff Together Achieve Results) Award Program, which is a way to share the agency's success with those responsible for the success – its employees. When established goals related to the agency's core principles – Quality, Customer Satisfaction, Employee Satisfaction and Profitable Growth – are achieved, all employees receive a monetary reward, including part-time and part-time casual (PRN).

"The sense of pride associated with the fact that we consistently maintain and improve our rates has greatly improved staff morale and turnover," shares Janie Christner, Director of Home Health. "Even larger is our team pride in providing quality care."

Data in this article was provided by Celeste Twardon, VP for Quality and Customer Service, and Janie Christner, Director of Home Health for Home Nursing Agency, Altoona, Pa.

Dominion Care Home Health's Focus on Disease Management Contributes to Reduced ACH Rates

Dominion Care Home Health in San Antonio, Tx., working in a collaborative program with Texas Medical Foundation (TMF), the Medicare Quality Improvement Organization (QIO) for Texas, chose to focus on disease management as a contributing means to reducing acute care hospitalization (ACH) rates among its patients.

"A lot of our patients are cardiac/respiratory patients, categorized as high risk for hospitalization," says Elcee Cortez, BSN, RN, and Executive Vice President of Operations at Dominion. "We implemented a disease management care path, focusing on CHF, hypertension, COPD, asthma and diabetes."

The agency, which services a mostly urban, Hispanic community, has an average monthly census of 175–185. Cortez and her colleague, Rose Goodwin, LVN, QA Manager and OBQI Clinical Champion, say they also see chronic diseases, such as diabetes, in addition to cardio-respiratory conditions in the population they serve.

The disease management care path includes a thorough assessment of key indicators at the start of care and at each visit:

- respiratory status – lung sounds
- oxygen saturation readings
- medication management and compliance
- weight
- skin color
- edema

The agency also created two levels of foundation for high-risk patients. When a patient is admitted, each receives an assessment for high risk for ACH by the nurse in the field. The admission nurses call the case managers in the office and keep them updated on all aspects of the patient's condition and care plan.

Dominion's evidence-based hospitalization risk assessment tool was adapted from a form provided by TMF. A high-risk protocol is implemented for patients receiving a numerical score of five or above on the hospitalization risk assessment. This includes an emergency care plan and phone monitoring via an active list of patients at high risk. The agency believes that phone monitoring will support and reinforce patient self-management of their disease process, teach them the signs and symptoms of a worsening condition and tell them what to do if they experience changes in their condition.

"Once we identify high-risk patients, we frontload visits, visiting as often as daily for the first two to three weeks," says Goodwin. "We also do a patient-specific and disease-specific emergency care plan, identifying signs and symptoms of the disease and when a patient or caregiver should call 911 versus calling our agency."

The agency closely monitors all high-risk patients behind the scenes, conducting weekly case conferences and monthly meetings where staff members debrief if a re-hospitalization occurs.

"At weekly and monthly meetings, we ask how we could have prevented a re-hospitalization. We discuss what went wrong, how we coordinated the care, what we could have done better, and if we used the protocol religiously. We also do a lot of retraining at the monthly meeting," says Cortez. "We came to realize that we couldn't hold an in-service on something once and expect the staff to understand. So we hold three or four in-services on the same subject and, if necessary, re-introduce the tools that we use. We also conduct one-on-one training for the clinician that has a little trouble catching on."

Dominion began the acute care hospitalization (ACH) collaborative program in August 2005, but initiated cultural changes, like a care team model, before that. At the agency, field nurses update the case managers regularly and work in close coordination. Case managers conduct phone monitoring, while the field nurses frontload visits.

"It [the care team model] is costly, but the quality is higher, and financial success will follow. That's the philosophy we follow – after all...quality is about doing the right things every time, and outcomes only tell us after the fact if we did the right things," says Cortez.

All the effort is working! Dominion's ACH rate was 41 percent before the TMF collaborative program, and is down to 28 percent on Home Health Compare, as of December 1, 2007.

"We received the Award of Excellence from TMF on December 6, 2007," says Cortez. "Only twelve of over 400 Texas agencies who have joined received the gold award." Dominion Care Home Health is the only agency in San Antonio to receive the Home Health Collaborative Award of Excellence.

Other factors that Cortez and Goodwin say contribute to the agency's success:

- Close coordination and communication
- Training and retraining
- Leadership support
- In-house therapists that also receive training
- Technological tracking of interventions
- Regular financial reporting to track successes
- Providing patients with tools to self-care disease management
- Employee rewards and recognition

Cortez sums up Dominion's success this way: "It's not just about the business and reimbursement. The top management group are all very involved in the clinical operations as well."

Data in this article was provided by Elcee Cortez and Rose Goodwin, Dominion Care Home Health, San Antonio, Tx.

Home Health
HHQIOSC
Quality Insights
Quality Improvement Organization Support Center

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ08.724 App. 12/07.

Nursing Post-test
Disease Management

Clinician_____ Date_____

RNs – May apply for 2.0 FREE CNEs and LPN/LVNs may apply for certificate of participation by following directions on page 2.

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.
   A. True
   B. False

   Your answer:

2. In Lisa Gorski's WebEx (or podcast), "Disease Management and Home Care …" (heart failure and COPD) she addressed essential clinical components of disease management. They included all of the following **except:**
   A. Utilize clinical specialists in the specific disease area (e.g., heart failure or COPD)
   B. Optimize medication therapy and assess for appropriateness
   C. Provide intensive comprehensive patient education
   D. Use specialized outpatient clinics for disease management instead of home care
   E. Provide early attention to signs and symptoms of exacerbation
   F. Address barriers

   Your answer:

3. "Polish Your Practice" (heart failure and COPD) encourages brushing up on the following areas to improve disease management**:**
   A. Pathophysiology and symptom management
   B. Assessment parameters
   C. Current and appropriate treatment
   D. Self-management and self-management support
   E. All of the above

   Your answer:

4. A decision support tool can assist a clinician in determining how to respond to abnormal signs and symptoms.
   A. True
   B. False

   Your answer:

5. In Dr. David Nash's "Disease Management and Reducing ACH" podcast, he talks about three significant ways to improve chronic disease management. The improvements include all the following **except**:
   A. Provider coordination across the continuum
   B. Communication with patient and all providers
   C. Patient empowerment
   D. Using specialized outpatient clinics for disease management instead of home care

Your answer:

Answers to the post-test are located in the Disease Management BPIP Leadership Track page 24.