



Best Practice: Disease Management

Leadership Track



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Leadership Section

Objectives

After completing the activities included in the Leadership Section of this **Best Practice Intervention Package – Disease Management**, the leader will be able to:

1. Verbalize that chronic illness knowledge and management understanding is essential to build a successful disease management program
2. Describe the potential impact a structured disease management program may have on an agency’s acute care hospitalization rate
3. Explain the business case for the development of a disease management program
4. Initiate the development of and/or enhancement of an established disease management program
5. Ensure that all clinical staff remain disease-specific clinically competent as defined by their scope of practice and associated clinical practice guidelines

How to Use This Package

- Read the Disease Management Leadership Section
- Review selected resources in the Disease Management Toolbox
- Complete the Disease Management Agency Assessment
- Identify Disease Management Program Agency Action Items
- Establish a Disease Management Program Action Plan
- Select the “Polish Your Practice” Nurse Track for **Heart Failure or Congestive Obstructive Pulmonary Disease** for clinician education
- Distribute discipline-specific care tracks
- Complete the Leadership and care track activities:

	Review PYP Package	View DM WebEx	View COPD WebEx	Read Business Case	Listen to Podcast	Complete Agency Self-Assessment	Read Examples of Excellence	Complete Post-test for certificate
Leadership	X	X	optional	X	X	X	X	optional
Nurse	X	X		optional	X		X	X
Therapist			X	X	X		X	X
MSW				optional	X		X	X
Aide					X			X

PYP – Polish Your Practice Package

DM – Disease Management

Disease Management

A Best Practice for Reducing Hospitalizations

Introduction:

This is the second of three best practice intervention packages included in the **Building Upon the Basics Series**. You may think that disease management (DM) is beyond your business/clinical capabilities, but you may be surprised to learn that you are currently utilizing best practices that serve as a foundation of a full disease management program. These include:

- Hospitalization Risk Assessment
- Emergency Care Planning
- Medication Management
- Telehealth
- Fall Prevention
- Immunization
- Patient Self-Management

Because most health care systems are designed to respond to acute illnesses, the prevalence of chronic disease in America raises the question of how to best provide effective care over a long-term period (Wagner et al., 1996). Many providers are currently using disease-specific interventions as a mechanism to move from the acute model for intervention to a holistic chronic illness approach via the development of DM programs. DM is also being used as an acute care hospitalization reduction strategy. Although it is included as a best practice in the Home Health Quality Improvement (HHQI) Campaign, it is being highlighted near the end because it **builds upon the basics** of previous HHQI best practices.

Disease management processes have been gaining momentum in home care agencies across the country as a mechanism for:

- Improving quality
- Increasing efficiencies in care delivery
- Improving patient safety
- Improving patient satisfaction
- Reducing costs
- Decreasing avoidable hospitalizations

Disease management definition:

The literature reveals many definitions for disease management. The definition selected for this package is the one used by the Disease Management Association of America (DMAA).

“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).

Key Point

Why Disease Management?

The 2006 Briggs National Quality Improvement/Hospitalization Reduction Study surveyed agencies that had acute care hospitalization (ACH) rates of 19 percent or less. These agencies listed disease management as one of their top 15 strategies for improving outcomes and reducing hospitalization rates.



Disease management objectives: Do they align with yours?

- Support the physician or practitioner/patient relationship and plan of care
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Evaluate clinical, psychosocial and economic outcomes on an on-going basis with the goal of improving overall health

Traditionally, DM has focused on the “big five” chronic diseases: ischemic heart disease, diabetes mellitus, COPD, asthma and heart failure. The core of DM programs has been the use of evidence-based treatment and management guidelines. Patients have been expected to play an active role in managing their chronic illnesses.

Whole person model

As a result of the presence of comorbidities or multiple conditions in most high-risk patients, this approach has become operationally difficult to execute, with patients being cared for by more than one program. Over time, the industry has begun to move toward a whole person model in which all the chronic illnesses a patient may have are managed by a single disease management program.

The current state of the DM industry: The industry is evolving

DMAA announces new name

The Disease Management Association of America announced it has changed its name to “**DMAA: the Care Continuum Alliance**” to reflect the broad scope of high-quality population health improvement services its members provide (September 2007).

DMAA states that its members offer so much more than can be fully captured by “disease management”—a term that is now being seen as perhaps, limiting to its scope of work. It is recognized that disease management remains a valuable tool in the fight against chronic disease, but it has been identified that **all points along the care continuum** have to be recognized (www.dmaa.org).



Improved Chronic Care

Chronic illness home care challenges—do you face these at your agency?

- Inconsistencies in care delivery
- Various levels of staff clinical knowledge in relation to disease process, interventions and evaluation

The DM connection

Disease management cannot be discussed without addressing chronic care and the cost of that care.

Chronic care definition

A chronic condition is one that requires **ongoing adjustments by the affected person and interactions with the health care system.** People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery for those with chronic conditions is complex, confusing, fragmented, costly and less effective than it might be otherwise.

<http://www.improvingchroniccare.org>

Significance

Almost half of those with a chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting deficiencies in current management of diseases such as diabetes, heart failure, asthma and others. Overcoming these deficiencies requires that care providers move from being reactive—responding mainly when someone is ill—to being proactive and focused on keeping a person as healthy as possible throughout the continuum of care and across care settings.

<http://www.improvingchroniccare.org>

Key Points

- Almost 50 percent of all Americans (approximately 133 million) live with chronic condition.
- That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million.
- Chronic care accounts for 75 percent of all health care spending.
- Only 50 percent of care recommended for the chronically ill actually takes place.
- Improving care for the chronically ill requires a transformation of our health care system.

<http://www.improvingchroniccare.org>

Chronic care: The goal







The goal of chronic disease care is to improve clinical outcomes and quality of life for those living with chronic illnesses.

Hospice and palliative care may be the most appropriate level of care for some chronically ill patients.



The Design Components of a Disease Management Program Home Health Considerations

There is no single “magic bullet” for disease management (DM). The best DM strategies consist of multiple components—some you may already have in place, and others may need to be added—based on appropriateness. According to the DMAA, a **full service disease management program must include each of the following six design components**. Programs that do not contain all six-design components are considered to be disease management **support** services.

	<p>#1 Population identification processes</p> <ul style="list-style-type: none"> • High risk for hospitalization • General focus on chronic conditions • High risk for disease exacerbation/complications • High risk for self-care adherence problems
	<p>#2 Evidence-based practice guidelines implementation</p> <ul style="list-style-type: none"> • Move away from clinical practices based on tradition • Encourage the use of current best practice to guide decision making
	<p>#3 Collaborative practice models to include physician and support services provided</p> <ul style="list-style-type: none"> • Promote coordination during care transitions across settings • Include processes to promote communication between all providers
	<p>#4 Patient self-management (SM) education</p> <ul style="list-style-type: none"> • Self-management is key to an effective disease management program • Self-management empowers the patient living with chronic illness • Increased confidence in ability to change + knowledge = <i>change</i>
	<p>#5 Process and outcomes measurement, evaluation and management</p> <ul style="list-style-type: none"> • Consider utilization measures such as acute care hospitalization and any emergent care • Explore reasons for hospitalization • Evaluate effectiveness of specific interventions
	<p>#6 Routine reporting/feedback loop</p> <ul style="list-style-type: none"> • Include processes for communication with physicians and health plans • The patient and caregiver must be included in the feedback-loop.

Patient Education

Disease management's success lies 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 include 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 and caregiver understanding of instructions and self-care

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.

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

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



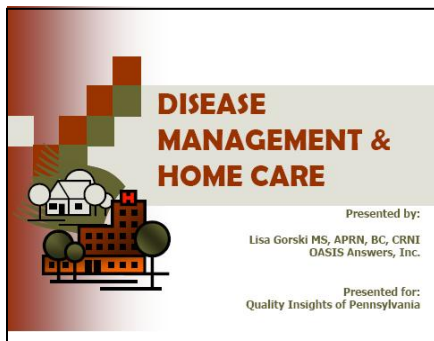
"The home care industry needs to become the leader in geriatric health care by taking on the responsibility of disease management for patients with chronic medical conditions. The future will see a shift from acute care and hospitals, towards care management and home health."

Lanyard K. Dial, MD
President/CEO and
Medical Director
Livingston Memorial
Visiting Nurse Association

For More Information

If you would like to know more about the disease management program design, you may access the [Disease Management and Home Care](http://www.medqic.org) WebEx or podcast located on www.medqic.org. This session provides an overview of the six components that comprise a disease management program as defined by the Disease Management Association of America (DMAA). Strategies for implementation and clinical examples are provided to assist the home care agency in decision-making and program development.

The presentation is given by **Lisa Gorski**, MS, APRN, BC, FAAN, a Clinical Nurse Specialist and Senior Associate Consultant with OASIS Answers, Inc. She has 20 years of home care experience and has contributed over 50 articles and books to the professional literature.



Located on www.medqic.org, under *Home Health, Disease Management*

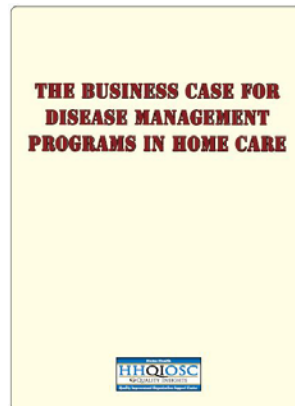
The Business Case: Potential Returns and Results

(Located on next page)

Best practice DM strategies can increase staff productivity and reduce health costs, achieved through the proper mix of the six DM components that:

- Improve the quality of health care for specific diseases/conditions
- Improve patient safety and recovery and other clinical outcomes
- Reduce the incidence of avoidable hospitalization and emergent care

Lisa Remington, Health Care Business Strategist and Publisher of *The Remington Report*, offers insights to the business case for disease management programs in home care.



The Business Case for Disease Management Programs in Home Care

By Lisa Remington, Healthcare Business Strategist and Publisher of *The Remington Report*

The annual economic impact on the U.S. economy from the most common chronic diseases is more than \$1 trillion, which could balloon to nearly \$6 trillion by the middle of the century, according to a study by the Milken Institute. Much of this cost is avoidable, the study found. “An Unhealthy America: The Economic Burden of Chronic Disease” attempts to quantify the economic loss associated with preventable illness and the cost to the nation’s Gross Domestic Product (GDP) and American businesses in lost growth.

The study found that:

- Seven chronic diseases — cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness — have a total impact on the economy of \$1.3 trillion annually.
- Of the total economic impact, \$1.1 trillion represents the cost of lost productivity.
- In ranking all 50 states by the reported number of these diseases per capita, researchers found that West Virginia, Tennessee, Arkansas, Kentucky and Mississippi have the highest rates of chronic disease, while Utah, Alaska, Colorado, New Mexico and Arizona have the lowest rates.
- Assuming modest improvements in preventing and treating diseases, by 2023 the nation could avoid 40 million cases of chronic disease and reduce the economic impact of chronic disease by 27 percent, or \$1.1 trillion annually.
- A decline in obesity rates could lead to \$60 billion less in treatment costs and \$254 billion in increased productivity.

Staggering statistics alone support reasons for the home care industry to have business and clinical disease management models. However, there are more compelling issues that impact the future of the health care delivery system when it comes to disease management...it is the shift in market share of who is overseeing the chronically ill population.

There are the four big trends in disease management that directly impact home care.

1. **Moving to a Pay for Performance Model Across the Health Care Delivery System** – The entire health care delivery system is redefining health care business around medical conditions and specialization. Hospitals, physicians and home care payments are changing to reflect accuracy of payments and outcomes. More data-rich information is being collected from providers in an effort to better understand the complications of the chronically ill population. For home care, a pay for performance model will rally around an agency having

the ability to be a partner in the coordination of patients across the health care delivery system and triaging patients to the best place of care based upon their illness.

2. **Payors** – Payors are systematically developing disease management programs based on specialization. Trends in disease management are changing the initial face of managed care. For example, many managed care organizations have carved out Medicare Advantage Plans. Today, these plans are already shifting agency's revenues. In some markets, Medicare Advantage plans comprise 38 percent of Medicare revenues. Home care should expect to see more contracts under these plans.
3. **Disease Management Companies** – American Healthways, the largest disease management company, and others are developing disease management programs to oversee the chronically ill populations. Models under these programs include health coaching, patient education, phone calls to patients and medication compliance. Special Needs Plans and Chronic Care Improvement Plus programs designed for the chronically ill, and Medicaid dual eligibility are capitated programs that accept full risk from Medicare for all of the health expenses of enrollees. These programs are rolling-out statewide. Some programs are contracting with home care...others are not.
4. **Government Moving Patients Out of Nursing Homes Into Community-Based Care** – Billions of dollars have been allocated to move patients out of nursing homes into community-based programs. The transition of these patients will equate to longer stays in home care supporting the case for disease management programs and the need to develop long-term care management programs beyond 60-day episodes of care.

These trends are indicators of the shift in the health care delivery system's business and clinical models, also the key roles that companies are establishing as major players in disease management. It is important for home care agencies to make sure they are developing disease management programs to be able to partner across the health care delivery system, and position their agencies to partner with payors and disease management companies. However, clearly the underlying factor of these new trends is for home care to figure out how they will show these major players the value and role of home care in disease management. Of greater concern, is the new competition entering home care's market share. The question is does this shift mean your agency will strategically align with these new players...or will they be your direct competition?





Clinician education

Is your nursing staff clinically competent to support disease management?

This best practice intervention package provides a refresher and update on the management of heart failure for nurses. Heart failure is the number one diagnosis for hospitalizations in people over the age of 65. A similar track for COPD is located in the Associated Resources for this package. Both are chronic illnesses that account for significant numbers of hospitalizations.

Care Tracks Clinician audio



The Care Tracks for clinicians include a brief podcast that gives a high-level overview of disease management. It includes comments from **David Nash, MD, MBA**, on reducing acute care hospitalizations through home care and disease management. Dr. Nash is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement.

Therapy Track

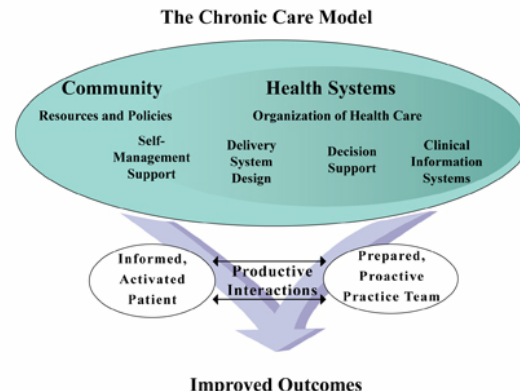


Patients who survive a severe exacerbation of chronic obstructive pulmonary disease (COPD) are at high-risk of re-hospitalization. **Managing the Patient with Dyspnea** is a 30-minute WebEx or podcast from the perspective of a physical therapist.

Nurse Track

“Polish Your Practice” resources for heart failure and Chronic Obstructive Pulmonary Disease review pathophysiology, symptoms, assessment parameters, treatment modalities, provide a pharmacologic update and patient/family self-management education points.

The [Home Telehealth Disease Management Series](#) offers WebEx/audio presentations that further support clinician disease management competency. Both telemonitoring and phone monitoring are addressed in these 50-minute presentations. The tools that are reviewed are based on current evidence-based practice guidelines and incorporate concepts of the Chronic Care Model. By understanding the origin and intent of these tools, the home care agency will be able to effectively educate staff and utilize the tools in day-to-day practices to enhance patient outcomes. This series includes disease management tools for heart failure, COPD, cancer and diabetes. The heart failure segment is highlighted in the Nurse Track of this package.



Wagner, E.H. (1998) Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*.



Nursing Tools

Tools in the Home Telehealth Disease Management Series

- **Patient Selection Criteria** – A checklist home care clinicians can utilize to identify patients who meet the criteria for disease specific telehealth options
- **Decision Support Tool** – A flowchart that guides the clinician through the critical decision-making process
- **Patient Encounter Documentation Tool** – A disease-specific tool formatted to facilitate the documentation of the decisions made during the related patient encounter
- **Patient Self-Care Workbook** – Patient-centered workbook used to educate the patient regarding disease process and risk factors, as well as associated medication, dietary and treatment considerations; offers the patient an opportunity to become involved in their disease management by setting goals and documenting progress
- **Staff Education Guide** – Includes tools that can be utilized to help make the patient assessment and care planning processes more comprehensive and standardized; includes topics for patient education and assessment, as well as patient teaching support material, additional assessment tools, phone monitoring assessment guide and telehealth system guide


The tools for heart failure, COPD, cancer and diabetes are all included in the Home Telehealth Disease Management Series Manual at www.medqic.org.

“None of us chose the health profession because we thought we were going to be millionaires. We chose the health profession because we want to deliver quality care and help our patients improve their outcomes. Using chronic disease management processes based on evidence-based practice standards helps us to do just that.”

Laurie Salmons, RN, BSN
Disease Management Specialist, Outcome Strategies, LLC

Disease Management needs the ‘Feet-on-the Street’ advantage that home care provides.

Disease Management Toolbox

Category		Resources
 <p>Clinician Education</p>	<ul style="list-style-type: none"> ◆ Helping Patients Manage Their Chronic Conditions www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf ◆ Home Telehealth Disease Management Series http://www.medqic.org/ ◆ National Guideline Clearinghouse www.guideline.gov ◆ ACC/AHA Guidelines for the Evaluation and Management of Heart Failure in the Adult http://circ.ahajournals.org/cgi/content/full/112/12/1825 	
 <p>Building Collaborative Relationships</p>	<ul style="list-style-type: none"> ◆ Organizational Self-Assessment Tool: Elements of Patient- and Family-Centered Care www.ihl.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/EmergingContent/PFCCOrgSelfAssess.htm ◆ Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System www.familycenteredcare.org/tools/downloads.html ◆ Patients and Families as Advisors: A Checklist for Attitudes www.familycenteredcare.org/tools/downloads.html 	
 <p>Engaging & Motivating Patients</p>	<ul style="list-style-type: none"> ◆ My Shared Care Plan www.sharedcareplan.org ◆ Motivate Healthy Habits http://www.ihl.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/Tools/DecisionBalanceWorksheet.htm 	
 <p>Self-Management Support</p>	<ul style="list-style-type: none"> ◆ New Health Partnerships Web site www.newhealthpartnerships.org ◆ Symptom Log www.newhealthpartnerships.org/TopicTool.aspx ◆ Doc Talk Form www.newhealthpartnerships.org/TopicTool.aspx ◆ Patient Self-Management Best Practice Intervention Package http://www.homehealthquality.org/ 	
 <p>Optimizing Remote Care/ Telehealth</p>	<ul style="list-style-type: none"> ◆ Using Telephone Support to Manage Chronic Disease www.chcf.org/topics/chronicdisease/index.cfm?itemID=111784 ◆ Front Loading /Phone Monitoring and Telehealth Best Practice Intervention Packages www.homehealthquality.org 	

Disease Management Program: Agency Self Assessment

This agency self-assessment provides parameters to assess your agency's current status with disease management in relation to the DMAA: The Care Continuum Alliance's six components described on page 10.

<i>#1 Develop patient population identification processes</i>	Yes	No
Have you defined the patient population for a disease management program? (e.g., patients with diabetes, heart failure etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Have you determined how you would select the patient population?	<input type="checkbox"/>	<input type="checkbox"/>
Have you determined which evidence-based best practices are applicable to your selected patient population?	<input type="checkbox"/>	<input type="checkbox"/>
<i>#2 Utilize evidence-based practice guidelines</i>	Yes	No
Have you designated a person to ensure that best practice interventions are evidence supported as applicable and possible?	<input type="checkbox"/>	<input type="checkbox"/>
Have you sent your clinical experts to training outside your organization to keep them current with practice guidelines?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reviewed clinical practices to determine if they are based upon tradition and ritual versus evidence-based?	<input type="checkbox"/>	<input type="checkbox"/>
Do clinicians demonstrate knowledge of current symptom management of high-risk diagnoses? (e.g., heart failure, COPD)	<input type="checkbox"/>	<input type="checkbox"/>
<i>#3 Establish a collaborative practice model</i>	Yes	No
Are your referral sources aware of your disease management (DM) program?	<input type="checkbox"/>	<input type="checkbox"/>
Have you included community physicians in development and review of your DM program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you educate and update payers on your DM program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you inform other settings (e.g., skilled facilities, physician offices) about agency disease management programs?	<input type="checkbox"/>	<input type="checkbox"/>
<i>#4 Provide collaborative self-management education</i>	Yes	No
Does patient education include processes that develop patient problem-solving skills?	<input type="checkbox"/>	<input type="checkbox"/>
Are clinicians performing action planning with patients selected for your DM program?	<input type="checkbox"/>	<input type="checkbox"/>
Have clinicians been educated in action planning techniques?	<input type="checkbox"/>	<input type="checkbox"/>

Disease Management Program: Agency Self Assessment (cont.)

#5 <i>Routinely complete program evaluation</i>	Yes	No
Have you clearly defined desired outcomes for your DM program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a process to evaluate your DM program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you monitor quality outcomes, such as acute care hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>
Do you monitor specific OASIS M0 codes associated with specific disease for improvement?	<input type="checkbox"/>	<input type="checkbox"/>
#6 <i>Create a reporting/feedback loop</i>	Yes	No
Do you communicate outcome information to community, physicians, staff, payers and ancillary providers?	<input type="checkbox"/>	<input type="checkbox"/>
Do you evaluate and report specific interventions for effectiveness to stakeholders?	<input type="checkbox"/>	<input type="checkbox"/>

Disease Management Program: Action Items

***Bold red designates tools/resources**

#1 Develop patient population identification processes

- Develop a team to define patient population for disease management (DM)
- Evaluate OBQI and OBQM data to assist with defining appropriate population
- Review disease management resources
 - **Disease Management Toolbox** (see page 17)

#2 Utilize evidence-based practice guidelines

- Designate an agency champion to ensure that best practice interventions are evidence supported
- Plan and budget to send clinical experts to training outside your organization to keep them current with practice guidelines
- Select clinician and management team members to review clinical practices to determine if they are based upon tradition and ritual versus evidence-based
- Provide opportunities for clinicians to receive current symptom management education on high-risk diagnoses
 - **Polish Your Practice for Heart Failure** (see Nurse Track page 31)
 - **Polish Your Practice for COPD** (Associated Resource)
 - **Disease Management & Home Care/Heart Failure WebEx/audio**
 - **Disease Management & Home Care/COPD WebEx/audio**
 - **Managing the Patient with Dyspnea WebEx/audio**
- Encourage clinicians to use a teach back approach to evaluate patient/caregiver learning

#3 Establish a collaborative practice model

- Develop promotional materials to educate referral sources and payers about your DM program
- Identify physician champion(s) to develop, review and promote your DM program
- Designate specialty home health clinicians to work closely with specified physicians
- Review and modify all transitions of care processes and forms (e.g., transfer sheets) to include agency's disease management program or protocols

#4 Provide collaborative self-management education

- Refer to patient and staff education resources from Patient Self-Management Best Practice Intervention Package (www.homehealthquality.org)

#5 Routinely complete program evaluation

- Define desired outcomes for your DM program
 - **Business Case for Disease Management** (see page 13)
- Identify process to evaluate DM program including monitoring of clinical outcomes and targeted OASIS M0 codes for targeted population

#6 Create a reporting/feedback loop

- Develop bulletin board to share evaluation findings with staff
- Include evaluation findings in board and Professional Advisory Committee meetings
- Include information about your DM program in newsletters, newspaper articles and marketing brochures

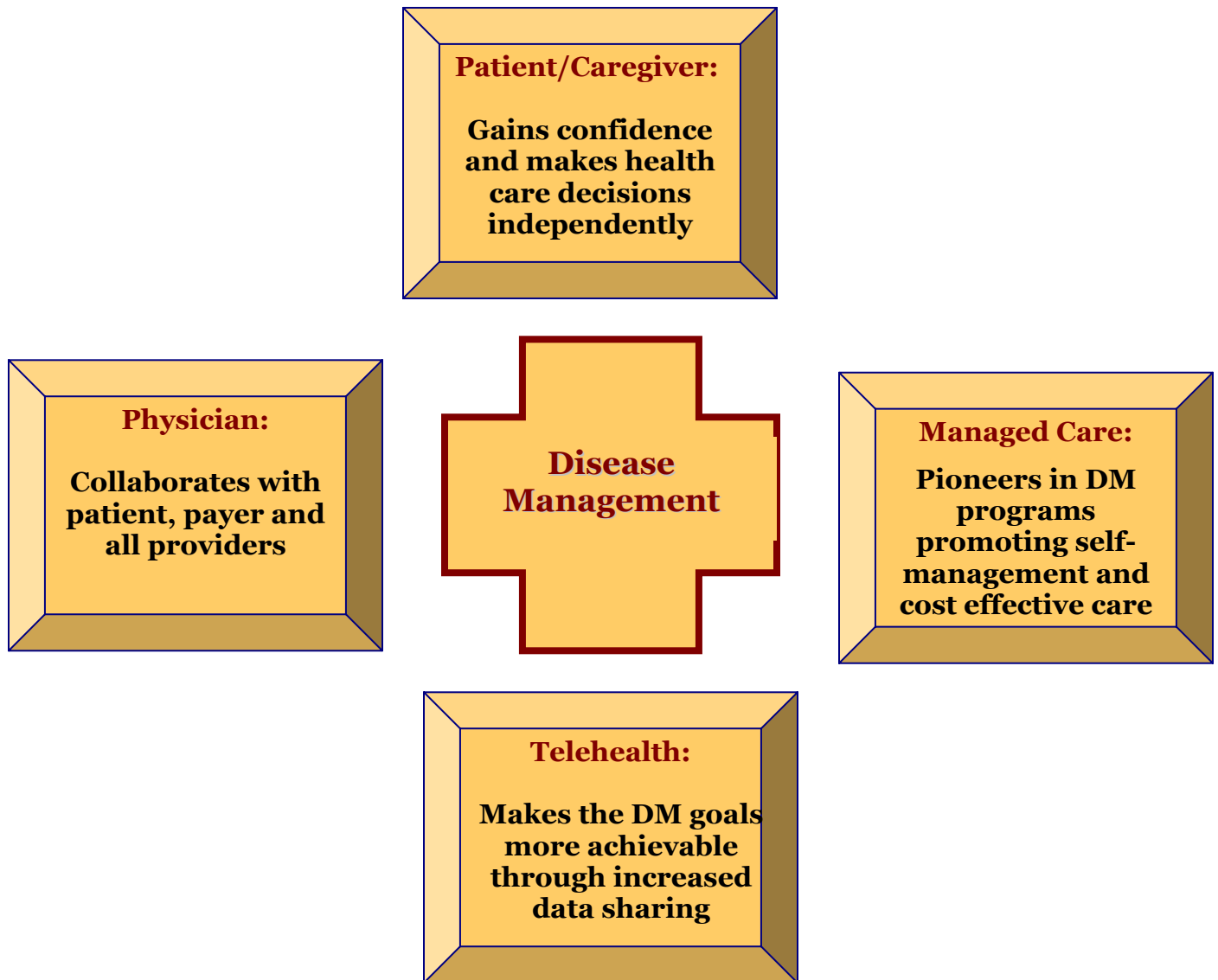


Disease Management Program Development: Action Plan

Using the Leadership Action Items, select and prioritize items to be implemented or modified. The development of a Disease Management program may be a year-long effort.

Date	Action	By Whom	Status
	Establish a timeline for development/enhancement of your disease management program		
	Review Care Tracks to determine what portions of this Best Practice Intervention Package – Disease Management you choose to use and how you want to utilize them		
	Decide which Nurse Track to pursue – Heart Failure or COPD		

Disease Management Connections



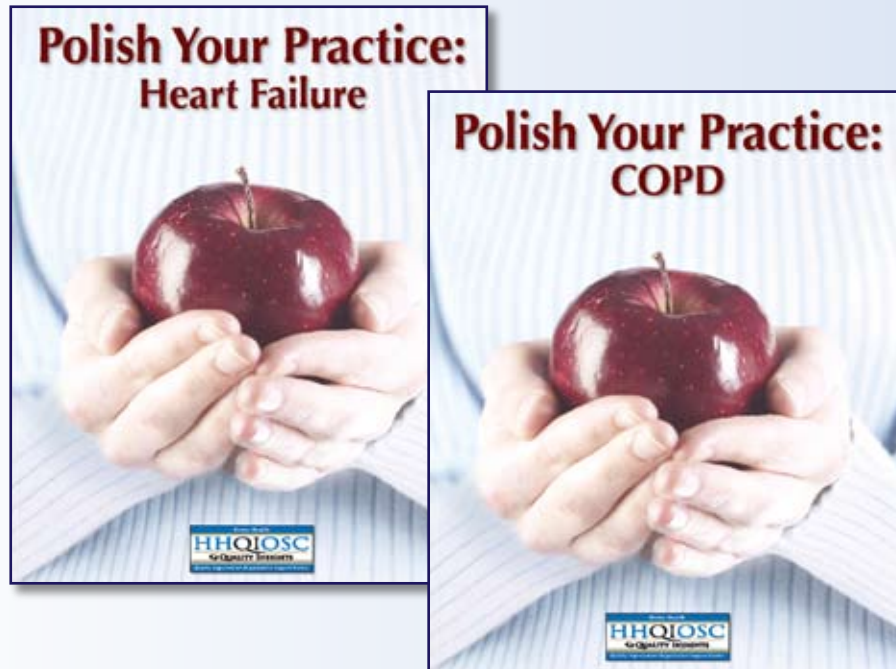
"We employed a home health specific disease management model of care that was designed to use specialty home health clinicians, physician collaboration and telehealth monitors. We identified that the largest patient population contributing to our ACH and Emergent Care rates were patients with a diagnosis of diabetes or cardiac disease. Patient diagnosis at admission, rather than geography, was the priority when assigning patients. Increased physician collaboration and utilization of telehealth contributed to the success of our program. This disease management model reduced hospitalizations for diabetes by 51 percent and emergency room visits for cardiac patients by 50 percent."

Kathleen Peterson-Sgro, DNP, MBA, RN,
Administrator/President, Alterna-Care Home Health

Disease Management

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

Support Effective Disease Management



Go to the Disease Management Best Practice Intervention Package at www.homehealthquality.org

Nurses: “Polish Your Practice” educational offerings on:

- **Heart Failure**
- **COPD**

Therapists: “Managing the Patient with Dyspnea” – a therapy perspective





Patient Disease Management Post-Test Answer Keys

Each track of the Best Practice Intervention Package has a post-test that providers may choose to complete after reviewing the track and completing the activities.

For the Disease Management package, the post-tests are found on the following pages:

Nurse Track – page 27

Therapist Track – page 45

Medical Social Work Track – page 59

Home Health Aide Track – page 67

Use the answer keys below to score the post-tests included with the **Best Practice Intervention Package – Disease Management**.

Nurse post-test answers:

1. A
2. D
3. E
4. A
5. D

Therapist post-test answers:

1. A
2. D
3. B
4. F
5. D

Medical Social Worker post-test answers:

1. A
2. H
3. F
4. D
5. D

Home Health Aide post-test answers:

1. A
2. H
3. F
4. E
5. D

Disease Management References

General

2006 Briggs National Quality Improvement/Hospitalization Reduction Study® (2006)

Coleman, M., & Newton, K. (2005). Supporting self-management in patients with chronic illness. *American Family Physician*, 77, 1503-1510.

Improving Chronic Illness Care (supported by the Robert Wood Johnson Foundation):

<http://www.improvingchroniccare.org>

Partnership to Fight Chronic Disease: <http://www.fightchronicdisease.org>

The Care Continuum Alliance: www.dmaa.org

The Design Components of a Disease Management Program: <http://www.hpn.com/diseasemgmt.htm>

Home Telehealth Disease Management Series/Heart Failure:

Hunt, S., Baker D., Chin, H., et al. (2001). ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *American Journal of Cardiology*. Available online: www.acc.org/clinical/guidelines/failure/hf_index.htm

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Polish-Your-Practice: COPD

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