Examples of Excellence

Pennsylvania Home Nursing Agency Improves Publicly Reported Outcomes through Disease Management

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.

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.