

# Examples of Excellence

## Reducing Acute Care Hospitalization: The Impact of Chronic Illness Assessment Staff Education

### Aiming “LOW”

South Davis Home Health (SDHH) is a small, hospital-based agency in Bountiful, Utah. The staff is committed to reducing the number of patients who experience an avoidable acute care hospitalization and providing effective self-management support. As a voluntary participant in the national ReACH (Reducing Acute Care Hospitalizations) Collaborative, SDHH set its outcome goal at nine percent based upon OBQI data. As of the July 2007 OBQI data, the acute care hospitalization (ACH) rate for South Davis is 9.90 percent, which is 11 percent better than the Utah state average. “We aimed low, and have been amazed at our progress,” says Denise Cook, QI Director.

### Methods

How are they doing it? Leadership has incorporated quality improvement into the agency’s organizational culture. They have created a blame-free learning environment that has promoted teamwork. “We value staff involvement and input,” says Ms. Cook. “We want our clinicians to be involved in developing processes that will improve our patients’ care and support patient self management.”

SDHH conducted strategic process investigations to determine how to decrease avoidable hospitalizations. The investigation findings revealed that OASIS assessments were not always capturing patient acute care hospitalization risk factors. Consequently, South Davis decided to focus staff education efforts on comprehensive chronic illness assessment, which is the first step to ensure that patients remain safe in their homes, improve their level of functioning and develop effective self management skills.

The ability to identify risk factors that are associated with chronic illnesses requires clinicians to look beyond immediate acute conditions. SDHH realized that this level of knowledge and assessment skill required chronic illness expertise, so they sought the help of external chronic illness experts. Staff education emphasized that accurate assessments translate into patient-centered care plans that guide appropriate treatment, including determining the self-management support patients will need to manage their chronic conditions. They learned the characteristics of a comprehensive chronic illness assessment, how to gather patient information effectively and efficiently and how to evaluate patients’ conditions based on these data. This comprehensive assessment and evaluation then serves as the basis for the development of a patient-centered self-management plan.



*Reaching Goals at South Davis Home Health*

In order to strengthen patient assessments and determine a patient's ability to self-manage, clinicians are now administering the CLOX test to patients upon admission, at resumption of care and anytime a patient seems to have a cognitive decline. They also test caregivers when appropriate. The CLOX test is a clock-drawing activity used to detect early signs of cognitive impairment. The tool helps clinicians assess the patients' ability to initiate and sequence tasks or events. This information can lead to more effective care plans by helping clinicians determine what level of assistance each patient needs to safely self-manage his/her chronic conditions as independently as possible. This is important because even the most appropriate care plan will fail if clinicians and patients don't execute it correctly.

After patients are assessed appropriately, clinicians use personalized emergency care plans, which list early warning signs and symptoms, and standardized teaching tools to educate patients and their caregivers on chronic disease management. The teaching tools have been organized in a file cabinet drawer for easy access for clinicians and can be taken to the home as a handout if appropriate. Clinicians also use the tools as a guide for documentation of teaching and evidence of the patient's self-management skill development.

### **Outcomes**

Following the chronic illness assessment training, agency clinicians reported a positive shift in the way they assess patients with chronic diseases. Many sources of information are considered, starting with the H & P. Clinicians are now using their observational skills, and they're asking open-ended questions to gather objective and subjective evidence. They are looking at patient health status from physiological, functional, psychosocial and cognitive perspectives to create a whole picture. Their clinical skills have been enhanced and they are seeing the benefits in their patient care and their ability to provide individualized patient self-management support. Because fewer patients are requiring hospitalization, this means more are being cared for safely at home, while developing effective self-management skills. Data are collected regularly to determine if clinicians are performing these new best practices consistently and accurately. As noted, they are definitely seeing a reduction in the number of avoidable hospitalizations.

### **Staff Engagement**

To promote staff involvement, the agency is ensuring the outcomes data is visible to everyone in very creative ways. A picture of a bed, representing hospitalization, is hanging on a wall in the agency office. If a patient experiences an acute care hospitalization, a cutout figure is added to the bed.

To learn more about what South Davis Home Health is doing to reduce avoidable hospitalizations, contact Denise Cook at [denisecook@sdch.com](mailto:denisecook@sdch.com) or 801.299.4866.

*Denise Cook, RN, QI Coordinator, South Davis Home Health  
Cher Edmonds, MS, CHES, SSW, Project Coordinator, HealthInsight*

*\* Content and data provided by Denise Cook, South Davis Home Health*

# Identification of Self-Management Support Strategies: The Role of Technology



## **The ACH Reduction Directive**

For HMO Group Health in Seattle, Wash., reducing acute care hospitalization rates was a directive from leadership, expedited by a confluence of outside influences and the manipulation of existing company technology.

The home health and hospice segment of Group Health covers all of western Washington, an area encompassing an urban, suburban and rural customer base of about 500,000. The home health segment has an average daily census of 500 patients.

Paul Ehrlich, RN, Performance Improvement and Quality Specialist, has been with Group Health for 25 years. Ehrlich says the home health group began addressing ACH rates through the ReACH project, introduced by Washington state's QIO, Qualis Health, several years ago. The program contained similar elements to the current national Home Health Quality Improvement Campaign.

## **High-Risk Identification Strategies: The Role of Technology**

Through the work of the ReACH project, a pilot program through the New York Visiting Nurses Association addressing acute care hospitalizations, the HMO developed methods to identify patients that were at high-risk, and then incorporated these risk factors into the electronic OASIS start of care (SOC) assessment. Company technology was then employed to calculate a numerical score to flag high-risk patients. Clinicians need not complete additional paperwork to assess those at high-risk for ACH.

"Other agencies have an additional form," said Ehrlich. "Our clinicians only had to do what they normally do, and the score is calculated and available right there in front of them. As soon as they pull up the patient's name they see 'high-risk' flagged in the non-clinical note."

According to Ehrlich, technology was an important piece of the puzzle. Since the HMO's system was partially in place, IT staff had time to devote to this project. However, he emphasizes that even though "we are a little ahead of the curve, it's not by leaps and bounds."

## **Patient Emergency Planning: A Self-Management Support Strategy**

After the assessment, Group Health created a single, simplified emergency planning form for high-risk patients called "Steps to Health," which includes

a lot of space to fill in the blanks. The form is completed on the first visit and then placed on the patient's refrigerator so it is visible to everyone. "Everyone knows how to call 911," said Ehrlich. "Almost every form we've seen has 911 printed prominently on the form, so we specifically left it off ours. We think it's redundant, and without it, patients are prompted to call our home health nurses first." \*\*

### Leadership's Role: ACH Risk Identification and Self-Management Support

Group Health's leadership was attuned to national efforts that were underway, including a discussion of the HHQI Campaign. They also were moving along a parallel path because patients want to stay at home, and because reducing ACH is good for the bottom line. Everything began to come together simultaneously for Ehrlich and Group Health—ReACH, HHQI in the national pipeline and a leadership directive.

"We've had support and encouragement from leadership, but it is a lot of work," said Ehrlich. "Teaching the staff and getting buy-in at the staff level means that a lot of ongoing effort is involved, but the results show what can be done."

Group Health's ACH rates have dramatically improved. Prior to the program, Group Health's ACH percentage was consistently in the low 20s—for years it was tracking between 20-22 percent (OBQI reports). Since implementing the program two years ago, their ACH rate has gradually declined each month. "The last two months, rates have been down to 17.6 percent using this program," said Ehrlich. "This is the lowest it has ever been and we're still on a downward trend."

According to Ehrlich, technology, management support, national programs and the efforts of the QI staff and clinicians have led to measurable improvements.

\* Content and data provided with permission by Group Health Home Health & Hospice  
 \*\* The "Steps to Health" form is available for download at [www.homehealthquality.org](http://www.homehealthquality.org).

**Group Health** **STEPS TO HEALTH CENTRAL**  
**BEFORE 8 AM TO 4 PM** CALL YOUR VISITING NURSE OR THERAPIST AT 1-800-793-0890  
**AFTER 4 PM TO 8 AM** CALL GROUP HEALTH CONSULTING NURSE AT 1-800-297-6877  
 Diagnosis: \_\_\_\_\_  
 Special Instructions: \_\_\_\_\_

PLEASE CALL IF YOU HAVE:

<b>Heart/Lung Problems</b> <input type="checkbox"/> A productive or fruity cough <input type="checkbox"/> A dry hacking cough <input type="checkbox"/> New congestion/cold symptoms <input type="checkbox"/> Increased shortness of breath <input type="checkbox"/> More swelling in your legs or feet <input type="checkbox"/> Weight gain of _____ in 24 hours <b>Signs of Infection</b> <input type="checkbox"/> Increased redness <input type="checkbox"/> More or different drainage <input type="checkbox"/> Wound gets bigger <input type="checkbox"/> Temperature of 100 degrees F. or more <input type="checkbox"/> Change or new odor from wound <b>Diabetic Problems</b> <input type="checkbox"/> Sudden weakness <input type="checkbox"/> Increased urination <input type="checkbox"/> Sweating spells <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Drowsiness <input type="checkbox"/> Blood sugar level greater than _____ or less than _____	<b>Urinary Problems</b> <input type="checkbox"/> Foul odor to urine <input type="checkbox"/> Catheter not draining <input type="checkbox"/> Back or flank pain <input type="checkbox"/> Unable to urinate <input type="checkbox"/> Increased weakness <input type="checkbox"/> Bloody, cloudy, or change in urine color <input type="checkbox"/> Body aches <b>Other Problems</b> <input type="checkbox"/> No bowel movement in 3 days <input type="checkbox"/> New skin problems <input type="checkbox"/> Change in balance, coordination, strength <input type="checkbox"/> Fall with small or no injury <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
--	--

PLEASE POST ON REFRIGERATOR

# Collaborative Interdisciplinary Self-Management Support: Patient Case Study

## Situation

Rosa is a 68-year-old woman who has type 2 diabetes mellitus. Rosa was referred to home health care after she sustained a mild stroke. She had received inpatient rehabilitation and was discharged to her home with orders for nursing and physical therapy.

## Assessment Findings – Objective:

*During the initial assessment, Rosa demonstrated the following skills:*

- Unassisted toilet transfer
- Unassisted shower transfer

*Rosa was able to:*

- Remove shoes, socks and sweater
- Check and record blood sugar using her own glucometer
- Be supervised while ambulating with walker, but had difficulty at doorways and on carpet
- Know the name of a new medication—a circulating anticoagulant—but was not sure why it was prescribed and seemed confused by an alternating dose schedule

## Assessment Findings – Subjective:

*Rosa reported that she was able to:*

- Shower and dress using equipment by the time she left the rehabilitation unit
- Identify the names and doses of medications she had been taking prior to her stroke, and stated that she was used to taking these medications

## Care Plan

The care plan included skilled nursing visits to focus on medication education and physical therapy to address gait training and functional mobility.

## New Findings

One week after admission, Rosa complained that she felt weak and shaky after performing her self-care. As a result, PT added strengthening exercises to Rosa's home program as well as activities to increase her endurance. The nurse verified that Rosa was taking her medications as directed, but obtained an OT referral to evaluate Rosa's self-care performance.

The OT assessment revealed that Rosa's usual routine was to take her Glucotrol upon waking, then shower and dress. She would then return to the kitchen to prepare her breakfast. She typically started eating about 30 minutes after taking the Glucotrol. The care team recognized that Rosa was able to perform the activities without assistance, but the additional 20 minutes and effort required for morning self-care tasks meant that her Glucotrol was administered too early, resulting in low blood sugar levels while Rosa was heading to the kitchen. Her blood sugar levels were continuing to drop as she prepared her meal, and the meal preparation also took longer than it had before the stroke. It was noted that as her blood sugar levels dropped, Rosa could sustain a fall while walking to the kitchen or sustain other injuries while preparing her breakfast.

## ***Collaborative Care Planning***

### **Morning**

The team collaboratively formulated a plan with Rosa to adjust her medication administration tasks to integrate with her existing daily routines. Initially, this included carrying her glucometer and her Glucotrol to her bedside table at night, so that she could check her blood sugar and take her Glucotrol without having to walk to and from the kitchen. She also kept some crackers available on her nightstand so she could ingest a few crackers as soon as she got out of the shower. When she entered the kitchen to prepare her breakfast, she immediately poured some juice to drink while she prepared the rest of her breakfast. With these modifications, Rosa was able to maintain her overall morning routine but avoid the risk of her blood sugar bottoming out.

### **Monitoring**

The care team also collaboratively worked with Rosa to develop a plan to monitor the duration of her activities so that as her mobility improved and activities required less effort, and her medication administration schedule was adjusted.

This plan also included more frequent blood sugar monitoring—three times a day instead of twice a day—so that Rosa could consider her activity and her blood sugar reading when she timed her medications and meals.

### **Interdisciplinary Collaboration (Nursing, PT and OT)**

All three disciplines tapered visits as Rosa became more proficient at managing these tasks. As her balance improved, PT worked with her to transition from a walker to a cane, which also reduced the time and effort of routine mobility. OT worked with Rosa to adjust her meal preparation routines to reduce activity demands. OT also worked with her to incorporate new tools and techniques during self-care and meal preparation to modify her use of sharp objects. Nursing monitored Rosa's blood sugar diary and coached her with implementing the anticoagulant dosing schedule. Nursing also collaborated with Rosa, Rosa's physician and Rosa's daughter to develop a plan for venipuncture completion to occur post discharge from home care.

### **Pre-Discharge Outcomes**

At the time of discharge, Rosa was:

- (1) Continuing to check her blood sugar three times daily
- (2) Managing her medications independently
- (3) Working to improve her mobility skills
- (4) Resuming additional home management activities

It had been arranged for venipunctures to be done on a pre-determined schedule at Rosa's physician's office with Rosa's daughter accompanying her. Rosa had agreed to take her blood sugar diary with her to the physician's office for the nurse to review.

*\*Content submitted by:*

*Carol Siebert, MS, OTR/L, FAOTA, Representative, American Occupational Therapy Association*  
*Karen Vance, OTR/L, Representative, American Occupational Therapy Association*

