



Best Practice:
Disease Management
Heart Failure

Nurse Track



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-HHQ07.467 App. 1/2008



Nurse Track – Heart Failure

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” – Heart failure is presented as the primary resource for this package. You or your agency management may elect to pursue the **COPD Track** located at www.homehealthquality.org as an Associated Resource.

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 **Heart Failure Track**:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read Disease Management and Home Health	Page 29	10 minutes
<input type="checkbox"/>	Read “Polish Your Practice: Heart Failure”	Page 31	20 minutes
<input type="checkbox"/>	View “Disease Management and Home Care: Heart Failure WebEx” by Lisa Gorski (podcast also available)	Page 37	50 minutes
<input type="checkbox"/>	Listen to “Disease Management and Reducing ACH” podcast featuring Dr. David Nash	Page 37	15 minutes
<input type="checkbox"/>	Read Examples of Excellence	Page 39	10 minutes
<input type="checkbox"/>	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:



Formal disease management programs were one of the top 15 strategies used for agencies who had the lowest acute care hospitalization rates of 19 percent or less (Briggs National Quality Improvement Reduction Study of 2006). **Heart failure** is the number one diagnosis for hospitalizations in people over the age of 65. This nurse track offers a refresher in management of heart failure.

Polish Your Practice: Heart Failure



This is a review of pathophysiology, symptoms, assessment parameters, treatment modalities, pharmacologic update and patient self-management and self-management support activities. This overview was prepared by **Sandy Sanderson, RN**, President/Consultant of the Sanderson Group, Inc.

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. He has been published in more than 100 articles featured in major journals.

Disease Management and Home Care: Heart Failure WebEx

This 50-minute WebEx reviews several tools to improve the management of heart failure. These include:

- Patient Selection Criteria
- Decision Support Tool (page 38)
- 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: Heart Failure



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Polish Your Practice: Heart Failure

Incidence

There are currently 5 million cases of heart failure (HF) in the United States with an additional 500,000 new cases diagnosed annually. Heart failure is the number one diagnosis, primary or secondary, for hospitalizations of people over the age of 65. The 5-year mortality rate for heart failure is 50 percent.

Pathophysiology

Heart failure can occur when there has been some type of damage done to the heart that prevents it from pumping blood adequately, such as hypertension, MI, renal failure, diabetic large and small vessel disease or coronary artery disease.

Heart Failure means that the heart is unable to pump sufficient blood to the tissues to meet metabolic needs. Blood carries oxygen and nutrients, so decreased blood flow deprives tissues of essential energy and nutrition. As a result, the body compensates by causing a cascade of chemical reactions that **1)** stimulate the sympathetic nervous system (fight or flight response) in an attempt to increase heart rate and blood pressure to deliver increased blood and oxygen, and **2)** cause vasoconstriction within the kidneys that raises blood pressure, and retention and re-absorption of sodium and fluid in the kidneys, increasing vascular volume, again, raising blood pressure. This is very effective in the short term, such as during an episode of cardiogenic shock, however in the long term, it can decompensate and worsen HF symptoms.



Types of HF: Systolic and Diastolic

Systolic HF typically is the inability of the **left** side of the heart to pump blood adequately and is defined primarily by Left Ventricular Ejection Fraction (LVEF) of 40 percent or less. An LVEF is measured using an echocardiogram, cardiac catheterization or trans-esophageal echo (TEE), and is a measurement of the amount of blood ejected from the left ventricle with each beat. A normal LVEF is 50-60 percent.

Diastolic HF typically occurs when there is obstruction or enlargement of the **right side** of the heart that does not allow blood to get into the heart adequately. Diastolic HF is most commonly seen in patients with hypertension, COPD or pulmonary hypertension. The LVEF may be normal, because there is nothing wrong with the heart's pumping ability, and these patients may actually exhibit a slightly higher LVEF of greater than 60 percent.



Symptoms (Acute worsening occurs during exacerbations)

✓ Shortness of breath	✓ Increased weakness or fatigue
✓ Decreased urination	✓ Confusion, agitation or restlessness
✓ Chest pain or heaviness	
✓ Edema of the feet, ankles, hands, abdomen, sacrum or generalized (anasarca)	
✓ Increase in weight of 2-3 lbs. in 24 hours or 3 lbs. in one week	
✓ Dry, hacking cough or cough producing a white, foamy sputum	
✓ Orthopnea (the number of pillows needed prop up to breath comfortably)	
✓ Paroxysmal nocturnal dyspnea (feeling of smothering or fullness in chest when lying down, will resolve when sitting up)	



Assessment Parameters

<p>1. Obtain weight, abdominal girth, blood pressure, heart rate and oxygen saturation Note: Identify changes from baseline data. Early reporting of changes in symptoms can lead to early intervention and decreased ACH rates.</p>
<p>2. Assess activity level, perceived dyspnea and sleep patterns Note: Decreased activity tolerance, increased dyspnea and poor sleep patterns can be early signs of fluid retention.</p>
<p>3. Assess edema Note: Be sure to evaluate all areas of potential edema, including feet/ankles, hands, triceps area, sacrum, the back, scrotal area, abdomen and periorbital areas, edema may even be generalized (anasarca).</p>
<p>4. Assess heart sounds for additional sounds (S3 or S4), new or recurrent dysrhythmias or murmurs Note: Changes in heart rhythm can lead to poor cardiac output and worsening heart failure symptoms. Extra heart sounds can be a warning sign of impending heart failure exacerbation.</p>
<p>5. Assess lung sounds Note: Identify changes, including the presence of wheezes, crackles, rhonchi or diminished breath sounds.</p>
<p>6. Assess appetite Note: Poor appetite, feelings of abdominal fullness (in the absence of constipation) and early satiety (get full quickly) are all signs of potential fluid retention in the abdomen. Correlate patient complaints with abdominal girth measurement to validate.</p>
<p>7. Assess for increases in orthopnea or the presence of paroxysmal nocturnal dyspnea Note: Orthopnea can be determined by asking the patient how many pillows he/she needs to breath comfortably, when lying down. Paroxysmal nocturnal dyspnea is represented as a smothering feeling when lying down. These are intermediate signs of fluid retention, but intervention at this point could still prevent re-hospitalization.</p>
<p>8. Obtain thoracic impedance reading (ZO) if equipment is available Note: Changes in fluid status can be an early indicator of fluid retention, and can allow for early intervention.</p>



Assessment Parameters (cont.)

9. Assess psychosocial coping and the presence of depression

Note: Poor family or home support can lead to self-management adherence issues. Depression can be a major barrier to teaching self-management techniques. Depression may need to be treated before patient will be able to participate in a plan of care, eat properly, take medications as ordered and engage in meaningful learning about the disease process.

10. Assess mental status

Note: Changes in mental status, new onset confusion or restlessness may be indicators of poor cerebral perfusion from inadequate cardiac output, and may be a sign of worsening heart failure. Also may be due to electrolyte imbalance, which is common especially with increasing diuretic doses.

11. Assess urinary output

Note: Decreases in urinary output may indicate that patient is experiencing renal failure, or it may be an indication of heart failure decompensation, as the body retains fluid in an attempt to increase blood pressure and cardiac output.

Treatment

- Primary supportive treatment begins with **decreasing fluid overload**; this can be done with an increase in oral diuretics or by parenteral administration of diuretics (either IM or IV)
- Administer oxygen to maintain oxygen saturation above 90 percent. If identified early, changes in diuretic therapy may be adequate. In severe cases, hospitalization may be required for more aggressive diuresis and cardiac monitoring, and in worst case scenarios, BiPAP, CPAP or mechanical ventilation may be necessary
- After obtaining an order from a physician, get a portable chest x-ray to determine if patient is suffering from heart failure, COPD or pneumonia
- Elevate legs to decrease edema. If there has been an order to increase diuretic therapy, obtain type natriuretic peptide (BNP) level for baseline, and re-evaluate BNP and a basic metabolic profile (BMP) following the increase in diuretics to evaluate effectiveness of increased diuretic therapy and to evaluate for electrolyte imbalances that may occur following diuresis
- Consider institution of daily telemonitoring if the patient is not already being monitored daily
- Hospice or palliative care programs may be most appropriate level of care



Patient Education

- Instruct patient to limit sodium intake and adhere to any physician **prescribed** fluid restriction
- Instruct patient to adhere to prescribed medication regimen

Pharmacologic Management of Heart Failure

Medication	Action	Observation Parameters
ACE Inhibitors (ACE-I) or Angiotensin Receptor Blockers (ARB's)	<ul style="list-style-type: none"> • Causes vasodilation within the kidneys • Lowers blood pressure 	<ul style="list-style-type: none"> • Monitor blood pressure • Monitor electrolytes, as ACE-I and ARBs can cause hyperkalemia (contraindicated in renal failure)
Diuretics (loop or thiazide-type)	<ul style="list-style-type: none"> • Causes removal of excess fluid from the blood stream and body tissues 	<ul style="list-style-type: none"> • Monitor daily weights • Monitor lab values for BNP, electrolytes and renal function
Beta Blockers	<ul style="list-style-type: none"> • Slows heart rate down, allowing for greater filling time of the heart, improving cardiac output • Lowers blood pressure 	<ul style="list-style-type: none"> • Monitor heart rate • Notify physician of a heart rate less than 60 • Monitor blood pressure • Monitor blood glucose if patient has diabetes; beta blockers can block sympathetic nervous system response to hypoglycemia and patient may have asymptomatic hypoglycemic episodes
Nitrates (short-acting, long acting or nitroglycerine patches/ointment)	<ul style="list-style-type: none"> • Causes vasodilation, which increases oxygen-rich blood to the tissues • Decreases blood pressure and treats angina pain 	<ul style="list-style-type: none"> • Monitor blood pressure as vasodilation can cause a hypotension • Assess for orthostatic hypotension, which increases risk for falls
Digoxin (positive inotropic agent)	<ul style="list-style-type: none"> • Helps regulate irregular heart rhythm, especially related to atrial fibrillation • Increases the squeeze of the myocardium, resulting in improved cardiac output 	<ul style="list-style-type: none"> • Monitor heart rate and rhythm, notify physician of heart rate less than 60 • Teach patient to check heart rate daily prior to taking digoxin • Monitor lab values to prevent digoxin toxicity

Self-Management Activities

Patient Self -Management	Provider Self -Management Support
<p>1. Obtain daily weights at approximately the same time each day:</p> <ul style="list-style-type: none"> • After emptying bladder • Before eating or drinking • Obtain weight while wearing approximately the same amount of clothing each day 	<ul style="list-style-type: none"> • Instruct patient to obtain a scale if they do not have one. If the patient is indigent, consider providing patient with a scale • Instruct patient to report a weight gain of 2-3 lbs. in 24 hours or 3 lbs. in 1 week (or as defined by physician for each particular patient) • Utilize telemonitoring, if available, to help establish a daily routine
<p>2. Adhere to physician prescribed sodium restriction (typically 2 gram sodium diet)</p>	<ul style="list-style-type: none"> • Demonstrate to patient how to read a food label to identify sources of sodium and actual sodium content • Provide patient with a list of foods to avoid • Provide patient with a list of seasoning alternatives (Do NOT instruct to use salt substitute unless approved by physician due to high potassium content)
<p>3. Take all medications as prescribed by the doctor</p>	<ul style="list-style-type: none"> • Provide patient with appropriate information about the actions, benefits and side effects of medications, while discerning patient's ability to manage the regimen • Complete medication reconciliation (increased knowledge leads to improved medication adherence)
<p>4. Identify changes in condition early and report them to the nurse or physician</p>	<ul style="list-style-type: none"> • Provide patient with disease-specific education by developing an emergency care plan that is reinforced at every visit • Provide patient with a disease-specific zone tool to help him/her identify which symptoms should be reported and the appropriate action to take
<p>5. Obtain abdominal girth daily</p>	<ul style="list-style-type: none"> • Provide patients with a measuring tape to enable them to measure abdominal girth for early identification of fluid retention in the abdomen for diastolic (right-sided) heart failure patients

Polish Your Practice: Heart Failure resource developed by **Sandy Sanderson, RN**, The Sanderson, Group, Inc.; Educational & Consulting Services, Thompson's Station, TN



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 more than 100 articles featured in major journals.	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.

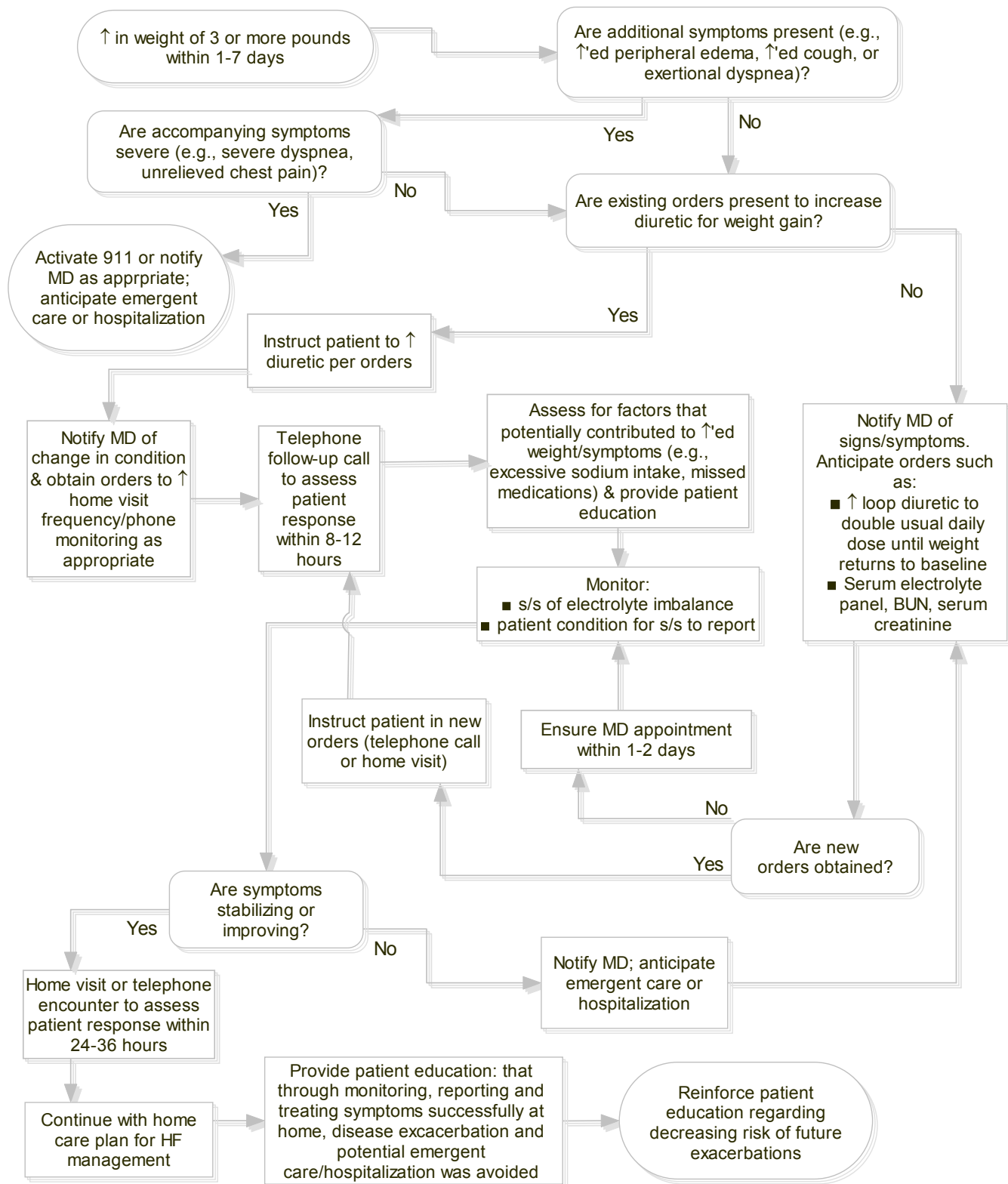


Disease Management WebEx or Podcast Instructions

View the WebEx or listen to the podcast: [Disease Management and Home Care: Heart Failure](#) at www.medqic.org, under Best Practice Intervention Package - Disease Management

- 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

Decision Support Tool: Heart Failure



This material was developed by OASIS Answers, Inc. and distributed 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-HH05.187. References listed on document on Associated Resources.

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.





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 28.

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 Leadership Section page 24.