



Best Practice: Disease Management

Therapist Track



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Therapy Track

This best practice intervention package track is designed to familiarize therapists with disease management and to provide the therapist perspective on managing a high-risk diagnosis (COPD).

Objectives

After completing the activities included in the Therapy 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. Demonstrate improvement in management of dyspnea in clinical practice
3. Describe the therapist’s role in a disease management program

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read Disease Management and Home Health	Page 47	10 minutes
<input type="checkbox"/>	Read “The Business Case for Disease Management Programs in Home Care” by Lisa Remington	Page 50	10 minutes
<input type="checkbox"/>	Listen to “Disease Management and Reducing ACH” podcast featuring Dr. David Nash	Page 52	15 minutes
<input type="checkbox"/>	View “Managing the Patient with Dyspnea” for therapists featuring Jay Cigna (podcast also available)	MedQIC link	30 minutes
<input type="checkbox"/>	Read Examples of Excellence	Page 53	10 minutes
<input type="checkbox"/>	Complete the therapy post-test online for free certificate of participation	See link below	10 minutes
	Total time for completion		85 minutes



Therapists (PT, PTA, OT, COTA, & SLP): Apply for a certificate of attendance for completing the therapist track activities. **Complete evaluation/post-test online at:**

<http://www.zoomerang.com/survey.zgi?p=WEB227AGTPLANU>



Therapist

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).



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.

Understanding the Business Case

How will a disease management program at your organization affect you as a therapist? Consider the business case for program development. Read **The Business Case for Disease Management in Home Care** by **Lisa Remington**, Health Care Business Strategist and Publisher of *The Remington Report*.



Managing the Patient with Dyspnea

Patients who survive a severe exacerbation of chronic obstructive pulmonary disease (COPD) are at high risk of rehospitalization for COPD and death. The risk of rehospitalization for COPD is 25 percent at one year, and 44 percent at five years. **Jay Cigna, PhD, MSPT** and contributor to *Home Healthcare Nursing*, provides recommendations for managing COPD patients in the home setting with an emphasis on the role of physical therapists in pulmonary rehabilitation. View the WebEx or listen to the audio on www.medqic.org.

Intervention:

Disease Management:

Hospitalization Risk Assessment	↔	Be alert for risks for hospitalization
Emergency Care Planning	↔	Reinforce when to call the agency
Medication Management	↔	Observe for non-adherence issues
Telehealth	↔	Assist with identifying patients that will benefit from telemonitoring
Immunizations	↔	Be a role model. Get your flu shot!
Communication	↔	Help patient communicate with all healthcare providers
Patient Self-Management	↔	Collaboratively set functional goals with the patient/caregiver

Some key areas of disease management require therapy involvement to facilitate patient/caregiver self-management, these areas include:

- Nutritious meal prep
- Medication administration
- Weight measurement
- Task reduction and energy conservation

Therapists need to be knowledgeable about high-risk chronic diseases including COPD, heart failure, diabetes, cancer, etc. For more resources see:

Additional Resources	Description
Disease Management Nurse Track – Heart Failure COPD www.homehealthquality.org	Two separate tracks with Your Practice that include current pathophysiology, treatments, etc.
Disease Management and Home Care – 5 part series	<ul style="list-style-type: none"> • Introduction to Disease Management • Heart Failure • COPD • Cancer • Diabetes
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

Patient Education:

Disease management's success will lie with 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 the patient and/or caregiver to repeat it back or **teach back** the information to the clinician to evaluate if 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.

"I think having therapists involved as members of the team in the management of disease is very appropriate. Many of the conditions we treat result in a loss of functional ability because of one or more chronic diseases. As with any chronic disease, intervention and client education is focused on management rather than cure. This is especially true for the client during times of exertion and this is where the therapist is best suited to provide instruction. Each discipline needs to address the particular disability and provide interventions to optimize the client's level of function, whether it be medically (nursing), physically (PT, OT), or psychologically (OT, MSW)."

Paul Schleich, PT, Director of Therapy Services
Columbia Montour Home Health Services/VNA

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?





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 Audio Instructions

View the WebEx or listen to audio: [Managing the Patient with Dyspnea](#) presented by Jay Cigna, PhD, MSPT at www.medqic.org, under Home Health.

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

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.





Therapy Post-test Disease Management



Clinician Name _____

Date _____

All therapists, including OTAs and PTAs, can apply for a certificate of attendance to use towards continuing education for 1.4 continuing education hours by following the directions on page 46.

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 Jay Cigna's WebEx (or podcast) "Managing the Patient with Dyspnea", the following tools or activities are appropriate ways to objectively assess dyspnea **except:**

- A. Dyspnea scale
- B. Pulse oximetry
- C. Functional assessment
- D. Auscultation and comparison of bilateral lung field sounds

Your answer:

3. Three specific areas that therapists can address with pulmonary rehabilitation were identified in "Managing the Patient with Dyspnea" WebEx. They include the following **except:**

- A. Endurance exercises
- B. Pulmonary function studies
- C. Strengthening exercises
- D. Postural drainage education

Your answer:

4. Appropriate patient education for therapists should provide includes:

- A. Smoking cessation and effects of secondhand smoke
- B. Danger of open flame sources
- C. Disease information, treatment options and coping strategies
- D. Healthy behaviors – nutrition, exercise
- E. Energy conservation
- F. All of the above

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.