Best Practice Intervention Package

Cross Settings II

Improving Care Transitions for Chronic Care Patients

Through Disease Management, Self-Care Management and Telehealth

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Quick Start Guide

QUICK START GUIDE: A brief guide and introduction to the Best Practice Intervention Package (BPIP) contents.

INTRODUCTION: A brief introduction to the topic of the Cross Settings II BPIP*: Improving Care Transitions for Chronic Care Patients through Disease Management, Self-Care Management, and Telehealth

LEADERSHIP TRACK (PAGE 8): Designed for **agency leadership and the quality or implementation team**. Although this section is designed for leadership and the implementation team, it is divided in sections so that it can be printed and shared with other staff. Click on this link to the *BPIP Guide* if you are not familiar with the BPIPs. This is also available via a link from the HHQI home page.

Contents include:

- **Guidance for Leadership (includes link to Focus on Improving Care Transitions in Chronic Care Patients)**
- **Checklist for Agency Leadership (Select interventions)**
- **Organizational Culture**
- **Tools and Resources**
- **Links to Success Stories**
- **Physician Perspective**
- **Suggested Timeline for BPIP**

DISCIPLINE TRACKS: These 1-page guides are designed for the following disciplines:

- Skilled nurse (page 56)
- Therapist (page 57)
- Medical social worker (page 58)
- Home health aide (page 59)

The content is very similar between the discipline tracks since they are designed to be interdisciplinary. Each will include discipline specific best practice(s) and checklist. We suggest either giving a hard copy or sending electronically to staff.

My HHQI offers a collection of resources you can use to connect with campaign organizers, experts, other participants and supporters. Take advantage of these Social Networking opportunities. Review the discussion boards for General Comments, BPIP comments, Information Station, Data comments, Home Health Experience and Disparities Corner. For Quick Tips and Fun Facts to share with your staff, see the HHQI blog.

ASSOCIATED RESOURCES AND WEB LINKS include supportive resources for the topic of this BPIP. *For a complete listing of tools see pages 30-37.*

**There will be three Cross Settings BPIPs all with pertinent topics about transitions and more efficiently managing patients in all provider settings.*

INTRODUCTION

The goals of the Cross Settings II Best Practice Intervention Package (BPIP) are to provide:

- Home care leaders with guidance for selecting best practices for improving care transitions with chronic care patients through:
  - Disease Management
  - Self-care Management Support
  - Telehealth
- Clinicians with best practice tools and resources to assist them with improving care to patients with chronic diseases

> Health care reform must address changed health needs through
> - evidence-based community prevention
> - care coordination
> - support for patient self-management
>
> *Thorpe et al., 2010.*

DID YOU KNOW?

- The elderly (age 65 and over) made up around 13 percent of the U.S. population in 2002, but they consumed 36 percent of total U.S. personal health care expenses. Health care spending is higher with the elderly due to the prevalence of multiple chronic conditions in that population (AHRQ, 2006).

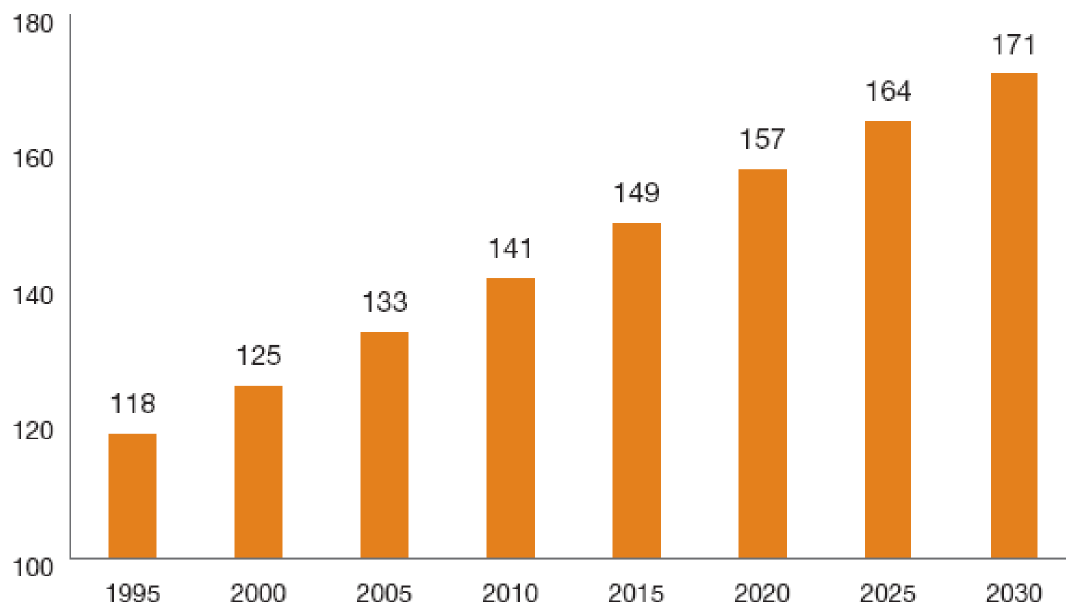
- "Virtually all of the growth in (health care) spending from 1987 to 2002 can be traced to the 20 percent increase in the share of Medicare patients receiving medical treatment **for five or more conditions during a year"** (Thorpe and Howard, 2006, p. 378).

- "In 2009, 145 million people—almost half of all Americans—lived with a chronic condition" (Robert Wood Johnson Foundation, 2010, p. 5).

- "Between 2000 and 2030 the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people" (Robert Wood Johnson Foundation, 2010, p. 7).

- Coleman (2003) states that the frequency of care transitions among the older population in the United States is determined from several national estimates. "In 2000, the population of adults aged 65 and older averaged: more than 400 ambulatory visits, 300 visits to the emergency department, 200 hospital admissions, 46 SNF admissions, and 106 home care admissions per 1,000 persons" (p. 550).

- (Patients with) "Complicated transitions were more likely to be older, receive Medicaid, and have a higher burden of chronic disease" (Coleman, 2007, p. 467).



Source: Wu, Shin-Yi and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation.* RAND Corporation, October 2000. Robert Wood Johnson Foundation, p. 9.

> "Regardless of age at onset, whether their etiology is known or whether their manifestations are primarily physical or psychosocial, essentially all chronic conditions present a common set of challenges to the sufferers and their families—dealing with symptoms, disability, emotional impacts, complex medication regimens, difficult lifestyle adjustments and obtaining helpful medical care."
> *Wagner et al., 2001, p. 65.*

The impact of chronic illness in our country is significant and necessitates health care provider collaboration **to improve care transitions and care delivery to the chronically ill**. Care transitions put those with multiple chronic conditions at great risk due to more opportunity for gaps in communication with each handover. When an organization decides to improve its care transitions' management processes and interventions, leadership must evaluate current Cross Settings processes to develop its improvement action plan to improve quality of care and promote patient safety.

Leadership

The Cross Settings II BPIP will provide direction to leaders initiating or enhancing care transition processes and practices for chronic care patients. Approaching chronic care management within the framework of a continuum of care provides **the leadership with the ability to view the problem from a community perspective.** Key practices/interventions that may assist leadership with this include: ***Disease Management, Self-care Management Support, and Home Telehealth.*** These practices are featured in BPIP. To further support these topics, the agency success stories focus on:

- Working in a care transition community to provide care across the continuum with multiple settings and multiple providers
- Improving the skills of the nursing clinical staff to maximize the effect of a disease management/telemonitoring program
- Using telemonitoring to improve chronic disease management and decrease rehospitalizations

> "Rehospitalization may be better viewed as a **health care system problem than a hospital problem, because care fragmentation is a property of the whole system.**"
> "Almost **every institution and individual involved in a patient's care can contribute to preventing rehospitalization.**" *Jencks, 2010, p. 757.*

Insights are also provided throughout the BPIP with practical ideas on applying selected best practices within an agency. Tools and resources are abundant in this BPIP, either through embedded links or as part of this BPIP. Leaders should use the BPIP as a guide to either adopt new tools and/or revise existing tools. Leaders must ensure all agency resources are evidence-based.

Rehospitalizations and fragmentation of care delivery are two of the many ills and challenges that plague our health care system. Solutions to overcoming these challenges are presented in this BPIP. The BPIP and tools can be used by all health care providers in all provider settings based upon the results of their own needs' assessments. Often the smallest change can make a big difference.
For example:

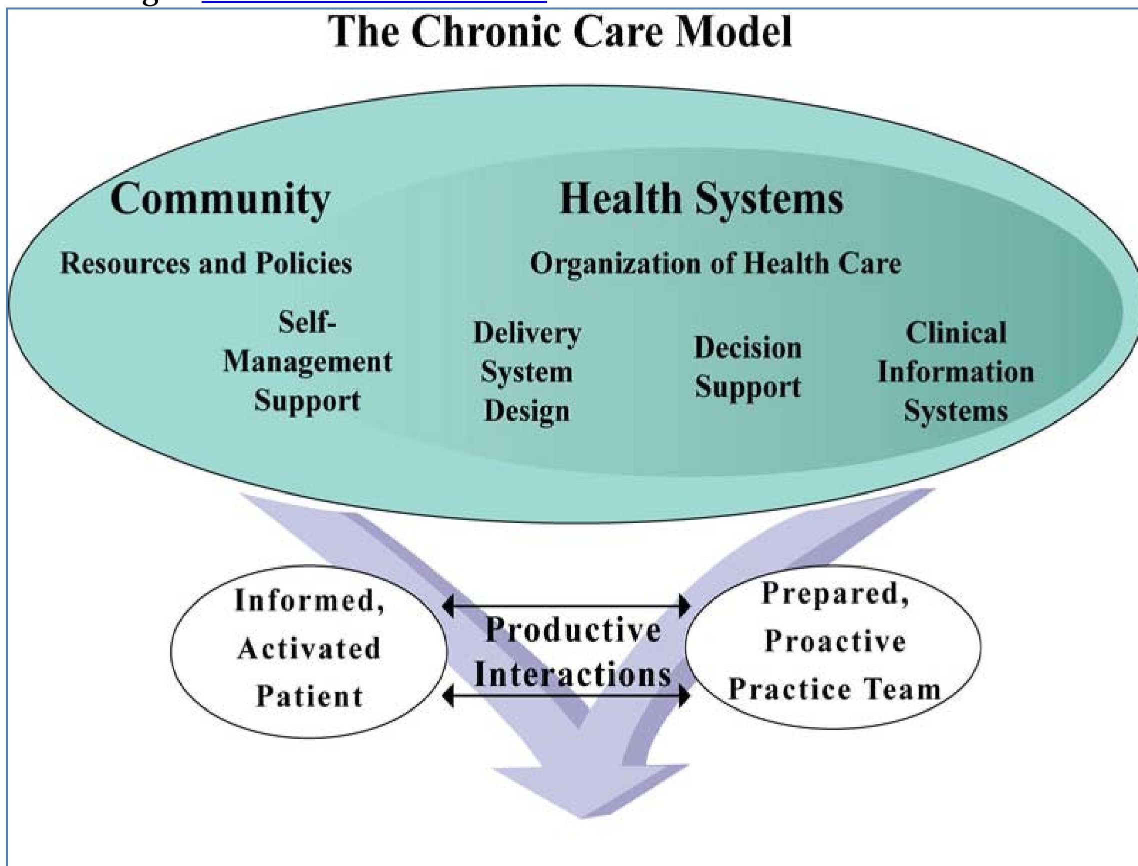
- Brief Action Planning Checklist (page 42)
- Partnering with Patients and Families to Accelerate Improvement: Readiness Assessment (page 43-44)
- Tools available through the Web Links (page 33-37)

> ***Using the BPIP across settings***:
> "We have reviewed the fall prevention (BPIP) content in a brief PI meeting held recently with the administrator in attendance. We did not go into great detail at the time; the committee was informed as to the nature of the content, some of the tools available to assist the staff, and how to involve the local PI and Case Management nurses at our local hospital (continuity of care/ transitions of care). **We plan to incorporate the Best Practices into a bi-partisan (Hospital-Home Health) program.** Their patients are ours and vice versa. We have already contacted the responsible person at the hospital and she is excited about working together." *Gail Batson, RN, MSN. QA/PI Coordinator, Harmony Home Health, Inc. Natchitoches, LA*

CHRONIC CARE

It may assist leadership to approach chronic care management across the continuum as a framework from which to view the problem from a community perspective. A close look at a model for chronic care may provide participants from all health care settings with a lens to better view the spectrum and understand the challenges and solutions for caring for the chronically ill.

"The **Chronic Care Model** (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care. **These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems.** Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings". [The Chronic Care Model]



"Copyright 1996-2010 The MacColl Institute. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Institute for Healthcare Innovation".

USING THE CHRONIC CARE MODEL TO IMPROVE CARE TRANSITIONS

The Chronic Care Model can be used as a framework within every health care community to define the community and produce a more effective community-based health team. The Cross Settings I BPIP reviewed concept of community—and why health care providers that collaborate can determine reasons for readmissions and intervene appropriately. Collectively, the *provider community* can deliver better care to this population through improving communication between providers and patient and using self-management support. Health care providers must recognize their role and responsibility in health system design and become part of the solution.

> "There are six fundamental areas identified by the Chronic Care Model making up a system that encourages high-quality chronic disease management. Organizations must focus on these six areas, as well as develop productive interactions between patients who take an active part in their care and providers backed up by resources and expertise."
>
> Institute for Healthcare Improvement

> A recorded presentation by Ed Wagner, M.D., M.P.H., Director of Improving Chronic Illness Care, provides information on The Chronic Care Model:
> *The Chronic Care Model Talk*

Health care system changes are occurring quickly. Home care agencies must *find their voice* and be a leader in improving care to the chronically ill patient. Home care's unique ability to provide ***skilled care*** in the home, for patients who meet eligibility requirements, is something that must be clearly communicated. To illustrate, telemonitoring can be provided without home care services. However, ***telemonitoring coupled with the provision of home care services*** **may provide the most effective treatment plan for many patients.**

> "In clinical practice, chronic conditions require continuous care and coordination across health care settings and providers."
>
> Robert Wood Johnson Foundation, *p. 39.*

Do your upstream and downstream providers know the components and outcomes of your disease management/self-care management/telehealth program? (See: *Use of Telehealth To Reinforce Health Coaching: From Hospital Transition To Home Health Discharge*)

> **Upstream Providers:** Provider you are *receiving* patients *FROM.*
> **Downstream Providers:** Provider you are *sending* patients *TO.*
> ***You are accountable to both!***

Disease management, self-management, and telehealth are designed to be integrated in practice.

These interventions are interrelated; and delivered together provide ***best practice for patients with chronic diseases***. Additionally, these interventions require planning by leaders to maximize effectiveness. For example, see page 20 to compare the differences of 'what works' and 'what does not work'. **Staff will need education to understand and apply more intensive targeted interventions.**

Staff clinical practice expertise needs to be at a level to provide the more intensive, general, and disease specific skill requirements. New clinical standards and guidelines have made it easier to provide the same level of care across settings and providers ***if*** clinicians are knowledgeable and skilled to meet the standard and deliver the best practice. New learning and new skills must become part of staff competencies. Show others that your staff provides care as defined by the standards.

"Home health is uniquely positioned to work with patients who have chronic diseases in the most comfortable of all environments—the patient's home."
Suter et al., 2008, p. 223.

Encourage staff to obtain certifications in their expertise (e.g., Heart Failure Nursing Certification on page 14). Jovicic, Holroyd-Leduc, and Straus (2006) completed a systematic review to determine the effects of self-management interventions on health outcomes and found that within individual studies the self-management interventions ***with more intensive education components*** had better benefits.

The Cross Settings II BPIP can be used in multiple settings. The guidance on improving care transitions in chronic care patients will work when all provider settings collaborate. Employing *The Chronic Care Model* across settings will have the greatest impact. A number of tools can be used in multiple settings. For example pages 33-36 lists numerous Web links that contain evidence-based information for many diseases. These can be used to provide staff education and develop patient education. Additionally, action planning is an intervention that can be employed at a home care visit, at hospital discharge, and/or at a physician appointment. The section on disease management (pages 14-16) gives guidance on educational opportunities for all clinical staff—hospital, homecare, nursing home, and/or physician office.

The table on the following page includes recommendations, solutions, and some specific ways this BPIP can help your agency plan intensive best practice interventions. The table lists only a few of the resources in this BPIP and on the BPIP web page. Other BPIP tools and resources may fit your agency needs—see pages 30-37 for a listing of all tools.

Home Health Quality Improvement

Cross Settings II BPIP Resource Table

Agency Goals	First Steps	BPIP Resources
To effectively educate clinicians to care for patients with advanced disease	Invest in educational resources for staff. Look to community experts to provide assistance and up-to-date information.	• BPIP offers success stories to show how agencies educated staff • BPIP recommends Agency for Healthcare Research and Quality Clinician Guides • BPIP recommends standards and guidelines from national disease-based organizations (e.g., AHA, ADA)
To effectively utilize telemonitoring and telephone support	Examine patterns of use and protocols for assigning services. Evaluate hospitalization rate for target population before and after telemonitor use. Drive home importance of assigning scarce resources with inspiring real life stories where technology made a difference.	• BPIP offers experts' telemonitoring advice • BPIP recommends Using Telephone Support to Manage Chronic Disease • BPIP offers Home Telehealth Disease Management Series featuring Patient Selection Criteria: Home Telehealth for Heart Failure
To encourage patients to begin self-management on day one of admission	Educate staff about the importance of patient self-management. Distribute resources to patients to foster self-management.	• BPIP recommends Partnering in Self-Management Support: A Toolkit for Clinicians • BPIP offers Self Hospitalization Risk Assessment
To work effectively with other health care providers	Take the lead to improve care transitions in your community.	• BPIP Focus section offers Palliative Care Track: Focus on Care Transitions • BPIP Focus section outlines advantages of working together in *What's In It For Me*?

The Bottom Line

Leaders must create an operational environment that ensures availablity of **evidence-based practice standards.** Review current evidence through literature reviews and organization sites devoted to specific diseases (e.g., American Diabetes Association). Refer to the Tools/Resources available through Web links (page 33-36) for quick links to several web sites that offer evidence-based resources and guidelines.

"Health care is changing and chronic diseases are among the biggest threats to health worldwide and account for over 75% of health care spending. In this new health care environment a **broader application of evidence-based care standards** is the best hope for promoting consumer health, independence and resource management." Health Sciences Institute

Suggestions on ways to incorporate and apply evidence-based practice include:

- Revise agency education guidelines and protocols to make certain they are current with the most recently published treatment guidelines
- Integrate the standards into orientation/annual competencies
- Reach out to community providers to share/gain knowledge and establish cross settings/provider protocols for the handover of patients living with chronic disease
- Ensure that equipment is available *and being used* to support evidence-based practice (e.g., telemonitors)

Disease management, patient self-management, and telehealth are essential interventions to reduce readmissions and improve quality of life for chronic care patients. Some specific recommendations on each of these interventions are on the next few pages—but remember-- effective quality improvement programs will merge facets from all three interventions.

- Disease Management (page 14-16)
- Self-Management (page 17-20)
- Telehealth (page 21-22)

"Chronic diseases, such as heart disease, cancer and diabetes, are responsible for seven out of every 10 deaths among Americans each year and account for 75 percent of the nation's health spending. Many of the risk factors that contribute to the development of these diseases are preventable."

Healthy People 2020 News Release

U.S. Department of Health and Human Services

DISEASE MANAGEMENT

Disease Management

Disease management is a system of ***coordinated health care interventions and communications*** for populations with conditions ***in which patient self-care efforts are significant.***
http://www.carecontinuum.org/dm_definition.asp

The chronic disease list is long, but cardiovascular disease, diabetes, and COPD figure significantly in home care admissions.

CARDIOVASCULAR DISEASE

What can an agency do to ensure the best possible is provided to their patients? First, make certain you have received all necessary patient-centered information from the upstream provider/setting. Additionally, the use of evidence-based practices and guidelines which are delivered by competent staff supports an agency of excellence. Here are three foci for evidence-based practice standardization and improvement for easy access and potential implementation related to the management of those patients with **cardiovascular disease**:

- American Heart Association / American Stroke Association provides a "Learning Library" with current evidence-based standards / guidelines and webinars as well as electronic patient education tools for the more technology-savvy patient / caregiver.

- Heart Failure Nursing Certification will be offered for the first time in June, 2011 by the American Association of Heart Failure Nurses (AAHFN). This certification is for those wishing to remain competitive in the market place by demonstrating responsibility for providing the best possible heart failure care. "The purpose of this certification is to promote the highest standards of practice within the specialty, to validate attainment of a common knowledge base required for practice, and to encourage and promote continued educational growth"(AAHFN Media Release).

- Hospital to Home (H2H) is organized by the American College of Cardiology (ACC) and the Institute for Healthcare Improvement (IHI) and seeks to improve patient care during transitions from inpatient to outpatient setting for patients with cardiovascular disease. The overall goal is to reduce rehospitalizations. H2H provides resource toolkits, best practices, and shares tactics from experts and other health care providers all free of charge. H2H incorporates the viewpoints of patients and family caregivers, clinicians across the continuum of care, integrated health systems, communities, policy-makers and payers.

DIABETES

Centers for Disease Control and Prevention (CDC) recently announced that nearly 26 million Americans have diabetes and an estimated 79 million U.S. adults have prediabetes. Dr. Albright, director of CDC's Division of Diabetes Translation, states that "these distressing numbers show how important it is to prevent type 2 diabetes **and to help those who have diabetes manage the disease to prevent serious complications such as kidney failure and blindness**". The information below describes strategies for promoting better management of diabetes.

The AADE7™ Self-Care Behaviors for diabetes are:
- Healthy eating
- Being active
- Monitoring
- Taking medication
- Problem solving
- Healthy coping
- Reducing risks

More information on the AADE7™ self-care behaviors click here.

"Diabetes education, also known as diabetes self-management training (DSMT) or diabetes self-management education (DSME), is defined as a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions. DSMT/DSME is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator(s). The intervention aims to achieve optimal health status, better quality of life and reduce the need for costly health care" (American Association of Diabetes Educators --AADE).The ADE7™ self-care behaviors are listed in the box above. Patient resources, which include a self-management plan for each behavior, are available for each of the behaviors at this link.

Franz, et al., (2010) reviews the evidence and nutrition practice recommendations presented in the American Dietetic Association Nutrition Practice Guidelines for Type 1 and Type 2 Diabetics in Adults. The article shares 29 key nutrition practice guidelines to support diabetics. This includes the recommendations on assessing patient needs, selecting interventions, and monitoring and evaluating outcomes. The evidence supports medical nutrition therapy provided by a registered dietitian (RD). Some of the key recommendations include:

- Consistency in day-to-day carbohydrate intake for persons with type 2 diabetes
- Adjusting insulin dose to match carbohydrate intake for persons with type 1 diabetes
- Focusing on total carbohydrate intake rather than the type of carbohydrate
- Cardio protective nutrition interventions
- Weight management strategies
- Regular physical activity
- Use of self glucose monitoring data to determine if goals are being met

A publication from the American Diabetes Association (ADA), *Standards of Medical Care in Diabetes--2010*, gives guidance including diabetes care, prevention and management of diabetes complications, diabetes care in specific populations, diabetes care in specific situations, and strategies for improving diabetes care.

COPD

COPD self-care management poses significant challenges for the patient and caregiver. In addition to managing oral medications, patients often must manage oxygen delivery systems and various inhalers. These inhalers vary not only in ingredients; but in technique for self administration. Self-care management support is critical for these patients not only from a quality of life perspective, but also from a hospital readmission perspective. Ineffective medication administration can cause a hospitalization. Without careful instruction at discharge and return demonstration, one can NOT assume patient/caregiver is prepared to self administer at home. Home care nurses are in the perfect position to ensure patients are using the device as designed. The status of patient understanding and demonstration of appropriate use should be part of the information shared between providers during a handover in care. Many resources are available from disease-based organizations. The American Lung Association has the COPD management tool that can be used by home care nurses for patient education and to promote patient self-management.

> The Global Initiative for Chronic Obstructive Lung Disease (GOLD) works with health care professionals and public health officials to raise awareness of Chronic Obstructive Pulmonary Disease (COPD) and to improve prevention and treatment of this lung disease for patients around the world. Guidelines and resources for professionals and patients can be found here: http://www.goldcopd.com/

Palliative Care

Clinicians need to have an understanding of palliative and hospice care for patients with advanced disease and recognize when to enlist the help of palliative and hospice providers. Palliative and hospice care can be a part of disease management—and unfortunately many people with advanced disease do not receive this type of care. "Improving care for people with advanced illness means ensuring **that they get the appropriate care**, at the right time, in the right place, in a way they can rely on. This often requires a shift in focus from cure and prevention to alleviating symptoms, making thoughtful decisions, supporting families, and providing ongoing care in the appropriate setting" IHI. Several resources can be found at the National Hospice and Palliative Care Organization.

Self-Management: Empowering the Patient and Their Caregiver

"Good self-management support involves collaboration between patient and their care provider, one in which the provider is a coach as well as clinician and the patient and family are managers of daily care. Through collaboration patients, family, and providers share information, understand a patient's goals, and create a plan that all can use to guide care at home and in the clinical setting" IHI.

Healthy People 2020

On December 2, 2010, the U.S. Department of Health and Human Services unveiled Healthy People 2020. The Healthy People objective is to "improve the quality of our Nation's health by producing a framework for public health prevention priorities and actions." The impact of chronic diseases is addressed and the goal for measureable improvement is stated.

> "Ultimately, patients are the largest health care work force available. Investing in patients to give them the knowledge, confidence, and tools that enable them to become an effective and reliable workforce will be essential to maintain, and hopefully improve, the quality of care for most long-term illnesses."
> *Cleland and Eckman, 2010, p. 1383.*

Self-management is integrated in some of the objectives for Healthy People 2020. Here are two of the objectives for older adults (the complete list of **Older Adult** –OA-objectives can be found here: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=31)

- **OA-3** Increase the proportion of older adults with one or more chronic health conditions who report confidence in managing their conditions
- **OA-4** Increase the proportion of older adults who receive Diabetes Self-Management Benefits

Health care providers must actively understand the effective interventions that promote self-management: self-management, self-management support, self-management education, patient activation, and action planning.

> "Patients are more likely to succeed with a health behavior change when the change can be related to a matter that is important to them and when they are confident that they can achieve the change."
> *Simmons, Baker, Schaefer, Miller, and Anders, 2009, p. 18.*

Self-management is the "individual's ability to manage the symptoms, treatment, physical, and psychosocial consequences and lifestyle changes inherent in living with a chronic condition. Efficacious self-management encompasses ability to monitor one's condition and affect cognitive behavioral and emotional responses necessary to maintain a satisfactory quality of life" (Barlow, Wright, Sheasby, Turner, and Hainsworth, 2002, p. 178).

Patients with a chronic illness will learn to manage the illness---perhaps effectively or not so effectively. Lorig and Holman (2003) states that "unless one is totally ignorant of healthful behaviors it is impossible not to manage one's health. The only question is ***how*** one manages" (p. 1). As health care providers we can support the patient in self-management. This is **self-management support (SMS)**. Contrary to popular belief, **patient education is NOT the same as SMS.** The term *patient education* implies a passive patient participation—in contrast, SMS implies an active relationship between the provider and patient. How does education fit in to self-management? It does—through ***self-management education***. "Patients and families need clear information to understand the signs and symptoms of the disease(s) and treatments, and training to build the skills to monitor clinical indicators such as glycemic control or peak flow volume. This clinical content distinguishes self-management **education** from self-management **support**, which helps people make behavior changes and sustain them over time. Physicians, nurses, or other clinicians with appropriate training can provide self-management education" (Schaefer, Miller, Goldstein, Simmons, 2009).

Self-management *support* is the care and encouragement provided to people with chronic conditions to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors (IHI).

"Focus on the learning *more* than the teaching."

Deborah Perian, RN, MHA, CPHQ, Manager of Clinical Leadership, Skilled Visit Services, Bayada Nurses

Bodenheimer, Lorig, Holman, and Grumbach (2002) compare traditional patient education and self-management education.

What is taught?
Traditional Patient Education: Information and technical skills about the disease
Self-management Education: Skills on how to act on problems

Relation of education to the disease
Traditional Patient Education: Education is disease-specific and teaches information and technical skills related to the disease
Self-management Education: Education provides problem-solving skills that are relevant to the consequences of chronic conditions in general

What is the goal?
Traditional Patient Education: Compliance with the behavior changes taught to the patient to improve clinical outcomes
Self-management Education: Increased self-efficacy to improve clinical outcomes

What is Patient Activation? How Does this Relate to Self-care Management?

Additionally, understanding the importance of **patient activation** is critical to successful self-care management. Patient activation is defined as "increased feelings of personal control over the contingencies surrounding the management of medical regimens" (Morisky, Bowler, and Finlay, 1982, p. 171). Increased activation leads to improved, sustained self-care management behaviors.

Action planning is a way the patient demonstrates ***ownership*** of his/her health management. The goals and adherence to the action plan can be an indicator of a patient's level of activation. Action Planning tools are included in this BPIP on pages 39-40 and in the Associated Resources.

Lorig states that "action planning is a tool or technique that helps people change their behavior over a short period of time".

HHQI BPIP, 2007

The table on the following page, ***Patient-Clinician Interaction Level Tips***, gives guidance on how to provide self-management support and promote patient activation.

Patient-Clinician Interaction Level Tips	
What Works	**What Does Not Work**
Philosophy	
▪ Patient-centered, acknowledging patients expertise in their own lives ▪ Responsibility to patients ▪ Self-directed, iterative, and ongoing support	▪ Clinician knows best, care based on clinician needs ▪ Responsible for patients ▪ One-time educational sessions
Strategies and Techniques	
▪ Evidence-based programs that patients can choose to participate in ▪ Group interactions following tested models ▪ Various SMS methods (group, individual, electronic, telephonic, in person)	▪ One-time referral ▪ No clear clinical care or behavior change support ▪ Only one program or approach
Assess	
▪ Brief standardized assessments with feedback to both patient and team on progress/status ▪ Assessment of patient's view of progress and how behaviors relate to risk/benefits, goal attainment, and values	▪ Trying to do behavior change work without any assessment or baseline information ▪ Assuming patient shares same goals, values, and understanding of condition as the professional
Advise	
▪ Personalized feedback on lab values, exam findings, or functional status related to risk/benefits and ways behaviors can affect outcomes ▪ Participatory decisions making with patient-determined level of involvement ▪ Learner directed, tailored to person and environment ▪ Problem-based learning ▪ Listening to patients	▪ Rushed or overly complicated feedback that patient cannot understand or that does not appear to be relevant to patient ▪ Clinician-imposed interaction style ▪ Imposed regimen or didactic curriculum ▪ Didactic, standardized recommendations ▪ Lecturing to patients
Agree	
▪ Collaborative goal setting based on patient priorities and data review ▪ Action planning for specific behavior changes	▪ Clinician-imposed goals; taking on too many goals at once ▪ Vague recommendations (e.g., lose weight, exercise more)
Assist	
▪ Problem solving-based approach; linked to patient social environment and identified barriers	▪ Telling patient what to do; lack of awareness of personal, cultural, and community context
Arrange	
▪ Follow up (in person, by phone, or by e-mail)	▪ Failure to follow up

(Glasgow, Davis, Funnell, and Beck). Table used with permission from the Joint Commission Journal on Quality and Safety, November 2003, Volume 29, Number 11. Figure 1 – Table 1. (p.563-574).

TELEHEALTH

Telehealth encompasses a broad definition of remote healthcare activities http://www.americantelemed.org/. The use of telehealth has greatly expanded over the last decade. What was initially seen as an innovative way to support home health visits has become a fairly common, but an important intervention in home care. The use of telehealth with disease management provides a way to closely watch the patients who are at risk of hospitalization. Self-management support is used by encouraging the patient to participate in the monitoring process and begin taking responsibility for his/her actions. This includes many patients with chronic illnesses.

Phone Monitoring:
Scheduled remote care delivery or monitoring in which scheduled patient encounters via the telephone occur between a health care provider and a patient and/or caregiver.
Home Telehealth Reference, 2005

Telehealth includes both phone monitoring and telemonitoring. The success stories in this BPIP share lessons learned by agencies providing telemonitoring. Methods and processes for delivery vary across the country.

Phone monitoring is often used on days when no visit is planned. This is a low technology way to provide an assessment—but can be very effective. Often scripts are used to guide the interaction between the clinician and patient. The *Phone Monitoring Assessment Guides* found in the Cross Settings I BPIP—Associated Resources are an example of phone scripts the clinician could use.

Telemonitoring:
The collection of clinical data and the transmission of such data between a patient at a distant location and a health care provider through electronic information processing technologies.
HHQI Telemonitoring BPIP, 2007

Telehealth can enhance care transition management by providing more intensive monitoring for chronically ill patients. If you currently have a telehealth program or plan to begin one, **inform other referral sources/providers (*senders*) that your agency can provide telehealth services**. Share your ACH rate—before and after telehealth. Additionally, has your agency readmission rate on targeted populations/specific chronic diseases improved with telemonitoring? Share this with other providers.

Applying Technology

Agencies looking for more tools and guidance on Telehealth can refer to the **Home Telehealth Reference 2005** and / or **Home Telehealth Reference 2006/2007**

Findings reported in a recent *New England Journal of Medicine* article titled T*elemonitoring in Patients with Heart Failure (Chaudhry, 2010)* remind us that technology is simply an enabler of reengineered teams, processes, and business models. The way technology is *applied* determines its value. Given that the study intervention was

placement of an automated telehealth system within the current, acute care-focused delivery model, their results teach us valuable lessons. Did the culture of physician practice change to permit teams to proactively act on data? It must. Was the importance of human interaction realized in fostering behavior change? It is critical. We know that physician-led empowered teams, proficient with complex chronic care delivery, including behavior change facilitation, net positive outcomes.[1,2] In this paradigm telehealth should be utilized to *augment* care connections between patients and healthcare teams. Methods to match resource-allocation with need and partnering with other teams in the healthcare sector, namely home health professionals, can begin to address professional resource allocation issues.

Paula Suter, RN, MA, Director of Clinical Care Management, Sutter VNA & Hospice

1. Boult C, Karm L, Groves C. (2008). Improving chronic care: the guided care model. *Permanente Journal, 12*(1), 50–54.
2. Gilfillan, R.J., Tomcavage, J., Rosenthal, M.B., Davis, D.E., Graham, J., Roy, J.A., Pierdon, S.B., Bloom, F.J., Graf, T.R., Goldman, R., Weikel, K.M., Hamory, B.H., Paulus, R.A., & Steele, G.D. (2010). Value and the Medical Home: effects of transformed primary care. *The American Journal of Managed Care, 16* (8), 607-614.

Would you like to know more about Telehealth Nursing?

The **ATA Telehealth Nursing Special Interest Group** collaborates with nurses to provide collective input, guidance and information about telenursing and its various emerging roles and settings, policy, educational preparation, competencies, clinical orientation and the use Telehealth, eHealth and mHealth technologies for patient care.

Focus Section: Improving Care Transitions for the Chronic Care Patient

- ***Do you want to expand your knowledge regarding the role of patient activation with self-care management support and disease management?***
- ***Are you actively referring your patients for palliative care services in a timely fashion?***
- ***Do you want to learn how to utilize telehealth to enhance health coaching interventions?***
- ***Are you curious about what is happening in the 14 states participating in the CMS sponsored Care Transitions Theme?***

If you answered "yes" to any of the above questions, you will want to go to the Focus Section. Click here to open up the Focus Section.

For this BPIP issue, ***Focus on Improving Care Transitions in Chronic Care Patients can be accessed by clicking here.*** The Focus section provides health care ***leaders*** with perspectives and experiences from experts on cross setting topics:

- **Patient Activation**: Tapping into the Power of the Patient: Judith H. Hibbard, Dr PH, Professor of Health Policy at the University of Oregon
- **Patient Activation Research in Home Care:** VNSNY study results related to the use of the Patient Activation Measure (PAM)
- **Palliative Care Track:** Donna Hyatt, RN, BSN, CHPN, MBA
- **The role of home health agency administration in doing telehealth "right":** Lynda Laff, RN, BSN, COS-C
- **The role of telehealth in reinforcing health coaching during care transitions:** Paula Suter, RN, MA
- **CMS sponsored care transitions' state project experiences related to:**
    - Georgia Medicare Care Foundation (GMCF). Mari Lou Keberly, Quality Advisor at GMCF, discusses the role of ***intrinsic motivation*** in driving health care change.
    - The New Jersey Care Transitions Experience, Healthcare Quality Strategies, Inc. (HQSI). Judith L. Miller, Quality Improvement Specialist at HQSI, shares their successful interventions with providers and beneficiaries.

Organizational Culture

As technology advances and migrates into the home setting, patient safety becomes an increased concern for home health agencies. It is imperative that home health leaders assess the *human factor* in their settings "focusing on the variables that affect the performance of individuals using equipment" (Sawyer, 2006). Each clinician in a home health agency has varying degrees of sensory and physical abilities as well as different levels of knowledge and comfort with the technology being utilized by a home health agency. The success of integrating technology such as telehealth into the patient's home is greatly dependant on the human factor of clinicians and patients.

The diversity of the clinicians, patients, illnesses, and technology is what makes an agency unique. If this diverse human factor is not considered when making organizational decisions about technology, it can negatively impact the outcomes of the agency and create an organizational culture of negativity. Taking into account the strengths and limitations of the caregivers and clinicians in an individual agency will greatly impact the outcome of implementing new technology in a healthcare setting. What are the attitudes of the clinicians and patients about the new technology? Do they believe it will positively impact the care delivery? Has enough time been allotted during the visit for proper patient education if the device is to be left in the home and used when the clinician is not there? What, if any, cultural / religious factors influence the use of the new technology (Olson, 2010)?

Technology will never replace the human factor in the home; only improve the quality of care delivered. Here are a few tips for highly functioning agencies using the enhancement of technology:

Tips for a highly robust organization:

- Understand who will be using the equipment – clinician or patient / family.
- Assign tasks of setting-up the equipment in the home to those most familiar with the technology.
- Implement standardized patient teaching tools for each form of technology to be left in the home. Allow for modification for each patient.
- As new technology is being interfaced in the agency, ensure the clinicians have enough time at each visit to set-up and review use of equipment with the patient / family; review the on-call schedule to ensure enough coverage.
- Assess the caregivers' knowledge and comfort level of the technology. Recognize the variations of patient's homes and the individual hazards in each.

Checklist for Agency Leadership

How to use:

1. Review this checklist and **select a few interventions** that are appropriate for your agency after identifying areas for improvement. Remember, these activities are designed for agencies with **varied degrees of best practice implementation**. These activities are best practices and are included to guide and direct you with improving quality of care.
   - Identify who will champion the process from senior leadership. Who will steward resource allocation?
   - The improvement team should make intervention selection with **staff**
   - Select 1-4 interventions to begin
   - ***Cross Settings*** chart reviews and staff input can help identify areas that need improvement (for example, the area of focus may be to improve patient education, medication reconciliation and/or resources for staff)
2. Refer to the BPIP timeline (pg. 55) to plan implementation of the selected interventions.
   - **Plan small tests of change** during short intervals of time with new tools and processes, evaluate effectiveness (what works and what doesn't) and then move to total agency implementation
   - Add additional interventions as team/staff recognizes other areas for improvement
3. Utilize the 'assigned to' and 'notes' on the checklist to make it a *working checklist.*
   - Revisit your timeline frequently to ensure timelines are met and as interventions are discontinued or added.

The checklist begins on the following page; the checklist can be printed independent of the additional leadership information.

Checklist for Agency Leadership **Suggested Activities:**	**Assigned** **to:**	**Notes**	**Date** **Complete:**
☐ Commit to provide new and valuable education opportunities. Although this will require resources—both financial and time, this is imperative to continue to provide highly skilled services.			
☐ Meet with your staff to discuss the importance of patient self-management and assess their skills in self-management support. Provide information on the terms ***patient activation*** and ***action planning***. Plan educational sessions and ways to evaluate if staff is incorporating self-management principles. ☐ Evaluate tools and resources for patient self-management (e.g., Action Plan and Conviction/Confidence Ruler) ☐ Distribute electronic or hard copies of ***Partnering in Self-Management Support: A Toolkit for Clinicians*** to staff. This toolkit is an easy-read—with valuable information on self-management, ideas on how to use an Action Plan and Conviction/Confidence Ruler.			
☐ Evaluate current patient education and staff protocols for disease management. Assess if these are current and supported by evidence. ☐ Select resources (e.g., Home Telehealth Disease Management Series, Tools/Resources available through Web links (pp. 33-37) to develop/improve both areas.			

Checklist for Agency Leadership **Suggested Activities:**	**Assigned to:**	**Notes**	**Date Complete:**
☐ Survey clinicians to assess their impressions of disease management, self-care management and telehealth. Evaluate both their understanding and their perspective of agency programs.			
☐ Review an expanded **Home-Based Chronic Care Model** (HBCCM) (Suter et al., 2008) in *Home Healthcare Nurse Journal*. This builds on **The Chronic Care Model** and provides a foundation for home health's integral role in chronic disease management (HHCNJ, April 2008). Share this article with staff (along with a copy of **The Chronic Care Model** and conduct a discussion session to see if clinicians understand these models and how they are applied. Plan follow-up sessions as needed.			
☐ Review SunCrest HealthCare Insights/success story (page 49) for their approach to education and/or Virtua Home Care Insights/success story (page 49) on how they used intensive education to initiate Care Transitions. Share these with staff and plan ways to implement these ideas at your agency.			
☐ Identify your upstream and downstream community providers. Reach out to these providers to share educational resources and dialogue how you might collaborate to provide improved cross setting collaborative care. For example: Hospitals have staff that can provide pharmacological and clinical expertise; home care can provide expertise on medication reconciliation and communication between providers; nursing homes can provide expertise on			

CHECKLIST FOR AGENCY LEADERSHIP **SUGGESTED ACTIVITIES:**	**ASSIGNED** **TO:**	**NOTES**	**DATE** **COMPLETE:**
preventing pressure ulcers and chronic disease maintenance.			
☐ Confirm how your patients are made aware of their risk for hospitalization and how staff is documenting this. ☐ Incorporate the Self HRA for patient use to promote understanding of their risk. ☐ Use the ***Personal Health Record*** for patients to take ownership of their health record—and provide a communication tool that can be used between all settings			
☐ Include a caregiver or patient representation to your agency's teams (board, quality team, etc.). ☐ Use the ***Partnering with Patients and Families to Accelerate Improvement Readiness Assessment*** *(page 43-44)* to assess organizational readiness.			
☐ Incorporate / expand your agency's telehealth program (telephonic support and / or telemonitors). • Evaluate if protocols current. • Evaluate if all monitors are in use—if not set goals to increase monitor usage until 100% are utilized. • Confirm your patients at high risk for hospitalization receive a monitor or phone support. (see Patient Selection Criteria: Home Telehealth for Heart Failure, page 48; Flow Chart for High-Risk Patient - Associated Resources)			
☐ Explore patient care alternatives for when you may not have the staff to implement telehealth or if a patient continues to require care but is no longer homebound. This could include coordinating vendor service providing telehealth to			

CHECKLIST FOR AGENCY LEADERSHIP **SUGGESTED ACTIVITIES:**	**ASSIGNED TO:**	**NOTES**	**DATE COMPLETE:**
the patient with or without agency input.			
☐ Read and share journal articles and BPIP success stories with staff and use as an example to develop/enhance your agency chronic disease management and telemonitoring program. Hall and Morris (2010) share their agency's story to develop an evidence-based disease management and telemonitoring program. This is in the November/December 2010 issue of Home Healthcare Nurse.			
☐ Post mini-posters from some pages in this BPIP • Page 9—***The Chronic Care Model*** • Page 20- ***Patient-Clinician Interaction Level Tips***			
☐ Use the parts of this BPIP (e.g., Focus Section--individual or all excerpts) to share with board of directors, owners, other care settings.			

Selected Tools and Resources

The tools in this package are contributed by home health agencies and/or recommended from other organizations concerned with care of chronic care patients. They are

- available in the BPIP or on the HHQI BPIP Web page (must be logged in to access)
- available through links to other organization Web sites

Additionally, look for links to the numerous tools and resources throughout the package. Due to the number of tools and resources, it is easy to select too many resources. It is suggested that you **choose carefully** which tools you would like to use and **select a few** that are best suited for your prioritized interventions. So please examine the tools in this BPIP, the tools available through Web links, or tools under Associated Resources on the Cross Settings II BPIP Web page--then pick and choose what you would like to use!

The tools are organized by :

- Tools included as part of this package (listed below *and begin* on page 39)
- Tools through other Web links (page 33-37) and also on the HHQI BPIP Web page
- Associated Resources (page 38) and also on the HHQI BPIP Web page

Tools may include specific criteria and may need to be modified for your agency use. Some resources may need to be adapted to the home care population. The example of the action plan (page 39-40) lists 'walking around the block'. This may not be a good example for a homebound patient, but does give the clinician and patient ideas on how to use the form.

WVMI & Quality Insights does not advocate any one particular tool. We simply provide tools associated with a best practice(s) that is in the public domain or given to us to share by other organizations or home health agencies.

The tools included as part of this package (pages 39-48) are:	
Tool/Contributor	**Designed for:**
Action Plan *New Health Partnerships (NHP)*	Patients **Partnering in Self-Management Support: A Toolkit for Clinicians (NHP)** is found under Associated Resources and provides guidance on the Action Plan.
Conviction-Confidence Ruler *NHP*	Patients **Partnering in Self-Management Support: A Toolkit for Clinicians (NHP)** is found under Associated Resources and provides guidance on the Conviction – Confidence Ruler.
Brief Action Planning (B.A.P.)™ Checklist *B.A.P.™ is a registered trademark of Steven Cole, MD* *The B.A.P. Checklist is the core self-management support tool of Comprehensive*	Clinicians and patients The background of the **Brief Action Planning Checklist** can be found under Associated Resources: *Comprehensive Motivational Interventions (CMI)™: A Pragmatic, Stepped--Care Application of Motivational*

Motivational Interventions (CMI) ™	*Interviewing Using Brief Action Planning (B.A.P.)™*
Partnering with Patients and Families to Accelerate Improvement: Readiness Assessment *NHP*	Organizations and Teams The Readiness Assessment is an organizational assessment preparing to include patients and families on teams
Self-HRA --developed to increase patient engagement in self care management behaviors **Clinician's Worksheet and Helpful Guidelines to Consider from the Completed Patient Self- HRA** **Call Me First Because I Care** *Girling Health Care*	Some ideas to maximize use of these documents: • Use NCR paper so original can be left with the patient and the copy for the medical record. • Include helpful information on the back of the top (original) page that is left for the patient. For example (three questions to ask your physician at every visit --see Ask Me 3, agency information, etc.) • Include OASIS –C measures that correlate with the risk items on one of the back copies. (e.g., "I started home health care right after leaving the hospital" --M1032)
Patient Selection Criteria: Home Telehealth for Heart Failure *One of the Home Telehealth Disease Management Series tools*	Clinicians These tools are often requested by home health agencies. Many of these tools have been revised for this BPIP. A complete list of all the Home Telehealth Disease Management Series is under *Associated Resources.*

INSIGHTS

What resources can help the patient transition from home health services to independent living? How do you address both patient safety, provide disease management monitoring, and promote patient self-management at the same time?

Medi Home Health & Hospice in Pittsburgh PA uses small emergency call devices.
Disease Management/Self-management:

- Units provide cordial reminders to assist with disease management process. For example: a HF patient can have reminders set to take medications or obtain his/her weight.
- Units are provided when the patient is on service as a part of the disease management education and support for self-management. At discharge the patient is given the option to rent the unit through a monthly rental fee.
- Promotes transition from home health to independence at home by providing the contact to the agency when on home care and to patient identified contact (family or neighbor) upon discharge from home care

Patient Safety:

- Units are easy to use with color coded buttons that plugs into the wall and can be worn as a pennant or velcroed to a wrist band. They are water safe and can be used in the shower—where many falls occur!
- Unit can become a speaker phone (to regular phone) so patient doesn't have to come to the phone to answer an incoming call or to call for help.
- Alert goes to first point of contact if patient doesn't respond to cordial reminders within 20 minutes.

Carol Gevaudan RN, BSN, Director of Coordinated Services
Medi Home Health & Hospice
Pittsburgh PA

Tools/Resources available through Web links	
Web site:	**Examples/Descriptions:**
Agency for Healthcare Research and Quality Guides for Patients and Consumers: Short, plain-language guides — tailored to clinicians, consumers, or policymakers — summarize research reviews' findings on the benefits and harms of different treatment options. Consumer guides provide useful background on health conditions. Several consumer guides are also available in Spanish. Clinician Guides summarize research review findings on the benefits and potential harm for different treatment options and rate the strength of evidence of the review's conclusions. Direct links to some of the guides are in the next column.	**Patient Guides:** Comparing Two Kinds of Blood Pressure Pills: ACEIs and ARBs ACE Inhibitors and ARBs to Protect Your Heart? Pills for Type 2 Diabetes: A Guide for Adults **Clinician Guides:** Comparing Oral Medications for Adults With Type 2 Diabetes ACEIs or ARBs for Adults with Hypertension
Agency for Healthcare Research and Quality Integrating Chronic Care and Business Strategies in the Safety Net: A Toolkit for Primary Care Practices and Clinics Improving care for chronically ill is one of the most pressing health needs of our time. **To help more safety net organizations implement the Chronic Care Model** effectively and sustainably, the Agency for Healthcare Research and Quality (AHRQ) contracted with the Group Health's MacColl Institute, RAND Health, and the California Health Care Safety Net Institute (SNI) to develop a toolkit. The toolkit informs safety net providers on how to develop a toolkit. The toolkit informs safety net providers on how to redesign their systems of care along the lines of the Chronic Care Model while attending to their financial realities. A practice coaching manual is available as a companion piece to this toolkit.	Integrating Chronic Care and Business Strategies in the Safety Net (Toolkit --PDF version) Integrating Chronic Care and Business Strategies in the Safety Net: A Practice Coaching Manual (Toolkit—PDF)
American College of Cardiology (ACC)	Full text articles focusing on Practice Guidelines & Quality Standards
American Association of Diabetes Educators	Includes the AADE7™ Self-Care Behaviors for diabetes. Patient resources are available for each of the self-care behaviors.

	(Available in English, Spanish, and audio for the hearing impaired.)
American Diabetes Association	Includes resources for health professionals: clinical practice guidelines and research
American Heart Association	Provides resources for health care professionals: statements, guidelines and clinical updates.
American Lung Association	Provides evidence-based clinical information/resources for COPD. Patient resource includes COPD Management Tool
American Telemedicine Association Organization that is a resource and advocate promoting the use of advanced remote medical technologies.	Provides current news /information and standards/ guidance for telemedicine.
American Thoracic Society Association dedicated to advance clinical and scientific understanding of pulmonary diseases, critical illnesses and sleep-related breathing disorders.	Provides guidance on treatment of pulmonary diseases and breathing disorders.
Ask Me 3 Ask Me 3 is a patient education program designed to promote communication between health care providers and patients in order to improve health outcomes.	Encourages patients to understand the answers to three questions: **1. What is my main problem?** **2. What do I need to do?** **3. Why is it important for me to do this?** Patients should be encouraged to ask their providers (doctors, nurses, pharmacists, therapists) these three simple but essential questions in every health care interaction. Likewise, providers should always encourage their patients to understand the answers to these three questions.
Care Continuum Alliance Promotes and aligns population health improvement through a patient centric focus on care continuum and disease management.	Resources and guidance for health care professionals.
Care Transitions SM Web site for the Care Transitions Intervention.	Resources include: • Personal Health Record • Patient Activation Assessment • Link to the Four Pillars

	The four conceptual areas (referred to as The Four Pillars™): • Medication Self-Management • Use of a Dynamic Patient-Centered Record • Primary Care and Specialist Follow-Up • Knowledge of Red Flags
Centers for Disease Control and Prevention	Provides two easy ways to find out about diseases and conditions through an A-Z Index or thorough the Top Requested Diseases & Conditions. Information is available on chronic and acute diseases.
The CHAMP program The first national initiative to improve home care quality for older persons.	Provides programs & learning designed specifically for home health managers and staff, and free evidence-based resources (including tools) for transitions, care coordination, rehospitalization, and other topics to assist in managing home care patients with chronic diseases.
Chronic Care: Making the Case for Ongoing Care	A 2010 update of the Robert Wood Johnson Foundation's 2002 chartbook, examines the impact of chronic conditions on individuals and their caregivers, as well as the inadequacies of the U.S. health care system to meet their needs.
Global Initiative for Chronic Obstructive Lung Disease(GOLD) The GOLD works with health care professionals and public health officials to raise awareness COPD and to improve prevention and treatment for patients around the world.	GOLD 2010 Pocket Guide (for health care professionals) Patient Guide
HealthSciences Institute The HealthSciences Institute is a multidisciplinary collaborative and health care certification, development, and resource organization founded in 2003.	HealthSciences prepares health care organizations and professionals for a new health care environment in which chronic, not episodic, conditions are the biggest threats to health. HealthSciences developed the Chronic Care Professional Certification Program—review their Web site for current chronic care information.

Heart Failure Society of America The Heart Failure Society of America (HFSA) represents the first organized effort by heart failure experts from the Americas to provide a forum for all those interested in heart function, heart failure, and congestive heart failure (CHF) research and patient care.	Provides clinician and patient educational resources and guidelines for heart failure. 2010 Heart Failure Practice Guidelines can be found here.
Improving Chronic Illness Care (ICC)	Brings research and strategies to improve care delivery to chronic illnesses. Provides many free resources under Critical Tools.
Institute for Healthcare Improvement (IHI)	IHI has many resources for health care providers –including chronic care and patient-centered care resources.
National Institutes of Health	Resources for clinicians and patients on many health conditions. Includes many resources in Spanish. Example: National Diabetes Education Program
New Health Partnerships The New Health Partnerships community is a project built and supported by individuals and organizations that believe that patients and families, in partnership with health care providers, can transform care for long-term conditions.	Numerous tools for patients, clinicians and organizations are available on the New Health Partnerships web site. Partnering in Self-Management Support: A Toolkit for Clinicians is also located under Associated Resources.
Home-Based Chronic Care Model™ Penta Health Institute	An integrated Chronic Care Certificate Program endorsed by the National Association for Homecare and Hospice. A turn-key *Train the Trainer Program* to enable broad-scale chronic disease self-management support competency acquisition at the agency level.
Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned This report provides a summary of lessons learned from an initiative by *California HealthCare Foundation* to promote patient self-management. The report includes successful strategies for self-management support, system design and patient flow, training, and measurement. Also available for download, in English and Spanish, is the "My Diabetes Plan" tool, which providers can use to structure their conversations with patients about goals	Promoting Effective Self-Management to Improve Chronic Disease Care: Lessons Learned My Diabetes Plan in English My Diabetes Plan in Spanish

and steps toward them.	
Self-Efficacy for Managing Chronic Disease 6-Item Scale	Shows level of confidence for health related goals/actions
Using Telephone Support to Manage Chronic Disease This report from the *California Healthcare Foundation* is aimed at clinicians and health care managers and describes the benefits and challenges of telephone care programs. Such programs can monitor patients' status between visits; deliver patient education or other counseling; send appointment reminders; and facilitate peer support and referrals for coping with illness.	Using Telephone Support to Manage Chronic Disease

The listing of other Web links (pages 33-37) provides you with a quick way to access many other organizations' tools and resources. The HHQI team suggests looking at the Cross Settings II BPIP online and clicking on the web links. Excellent resources for staff education and patient education are available. Listed below are just a few of the many resources you can find through the Web links.

- Would you like to provide your staff with a pharmacology update on ACEIs and ARBs?
  - AHRQ clinician guides
- Do you need a diabetic self-management plan to use with your patients?
  - Look in AADE7™ Self-Care Behaviors *or* the California Healthcare Foundation
- Looking for evidence-based resources for home care?
  - CHAMP has many resources designed for home care clinicians/patients
- Do you need to review and update protocols and guidelines for HF patients?
  - Look at the Heart Failure Society --2010 Heart Failure Practice Guidelines
- Do you need patient tools in Spanish?
  - Look in the National Institutes of Health *or* California Healthcare Foundation
- Do you want to provide staff in-services on patient self-management?
  - Look under New Health Partnerships

Tools included on the BPIP Web page under Associated Resources	
Tool:	**Designed for:**
Action Planning	Clinician Education
My Action Plan Action Plans that include pictures to help with limited health literacy.	Patients Available in Spanish and Chinese
Comprehensive Motivational Interventions (CMI)™: A Pragmatic, Stepped--Care Application of Motivational Interviewing Using Brief Action Planning (B.A.P.)™ *Steven Cole, MD*	Clinician Education—Resource Explains the history of the Brief Action Planning (B.A.P.™) tool—included in the BPIP on page 42.
Diabetes Tool *Marshall University Center for Rural Health*	Patients
Flow Chart for High Risk Patient *Home Health & Hospice Care* *Nashua, NH*	Clinicians
Home Telehealth Disease Management Series □ Patient Selection Criteria □ Heart Failure: Staff Education Tools □ Patient Encounter Documentation Tool □ Patient Self-care Workbook □ Decision Support Tool	Clinicians and Patients Available for: • HF • COPD • Diabetes • Cancer This series has been updated for this BPIP. Use all 5 tools together—or use separately.
Partnering in Self-Management Support: A Toolkit for Clinicians *New Health Partnerships*	Clinician Education This document provides examples and guidance on the Action Plan and Conviction/Confidence Ruler *(page 41)*
Personal Health Record *GMCF*—link from the Focus Section	Patients Also available in Spanish
Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned *California Healthcare Foundation*	Clinicians and Patients Several resources to promote self-management. Also includes: • Using Telephone Support to Manage Chronic Disease • My Diabetes Plan (*English and Spanish)*
Staff Application Activities	Clinician Education
Top Ten Posters for: • Physician Follow-up • Personal Health Record	Clinicians

1. Goals: *Something you WANT to do:*

____

____

____

____

2. Describe

How: ______________________________

Where: ____________________________

What: _________ **Frequency:** _______

When: _____________________________

3. Barriers: ________________________

4. Plans to overcome barriers: ____________

5. Conviction ___ & Confidence ___ratings (0 - 10)

6. Follow-Up:____________________________

(Example)

1. **Goals:** *Something you WANT to do:*
   Begin exercising

2. **Describe:**
   How: Walking
   Where: Around the block
   What: 2 times **Frequency:** 4 x/wk
   When: after dinner

3. **Barriers:** have to clean up; bad weather

4. **Plans to overcome barriers:**
   ask kids to help; get rain gear

5. **Conviction** 8 **& Confidence** 7 **ratings (0 - 10)**

6. **Follow-Up:** next visit – 2 months

Conviction Ruler

0	1	2	3	4	5	6	7	8	9	10

Totally Unconvinced | **Unsure** | **Somewhat Convinced** | **Very Convinced** | **Extremely Convinced**

Confidence Ruler

0	1	2	3	4	5	6	7	8	9	10

Totally Unconfident | **A Little Confident** | **Somewhat Confident** | **Very Confident** | **Extremely Confident**

Adapted from rulers developed by the Rhode Island Chronic Care Collaborative 2003

Brief Action Planning (B.A.P.)
A Self-Management Support Tool for Chronic Illness Care, Health and Wellness Coaching

The B.A.P. Checklist©

B.A.P. ™ is structured around 3 core questions:

1. ___ Elicit person's preferences/desires for behavior change

"Is there anything you would like to do for your health in the next week or two?"*
___ What?
___ Where?
___ When?
___ How often?
___ Elicit commitment statement
"Just to make sure we understand each other, would you please tell me back what you've decided to do?"

___*Some persons need or request ideas for change. Clinicians can offer a behavioral menu:
"If you would like, I can share some ideas that might help you feel better…"

2. ___ Evaluate confidence

"I wonder how confident you feel about carrying out your plan. Considering a scale of 0 to 10, where "0" means you are not at all confident and '10' means you are very confident, about how confident do you feel?"

___ If the confidence level is <7, problem solve overcoming barriers or adjusting plan:
"5 is great. A lot higher than 0. I wonder if there is any way we might modify the plan to get you to a level of 7 or more? Maybe we could make the goal a little easier, or you could ask for help from a friend or family member, or even think of something else that might help you feel more confident?"

3. ___ Arrange follow-up (or accountability)

"Sounds like a plan that's going to work for you. When would you like to check in with me to review how you're doing with your plan?"

The Nine Core Principles of B.A.P.

1. Action planning is individual-centered, i.e. what the person wants, not what he/she is told to do.[1]
2. Action planning is collaborative.[2]
3. Action planning respects the right of the individual to change or not to change.[3]
4. The most effective Action Plans are 'SMART' (specific, measurable, achievable, relevant, and timed).
5. After the plan has been formulated, the clinician/coach elicits a final "commitment statement."
6. Offer a behavioral menu when needed or requested.
7. Confidence levels are elicited and problem-solving utilized for confidence levels less than 7.
8. Action planning includes arranging follow-up or other accountability.
9. Question one is routinely integrated into chronic care, preventive, coaching and therapeutic visits.

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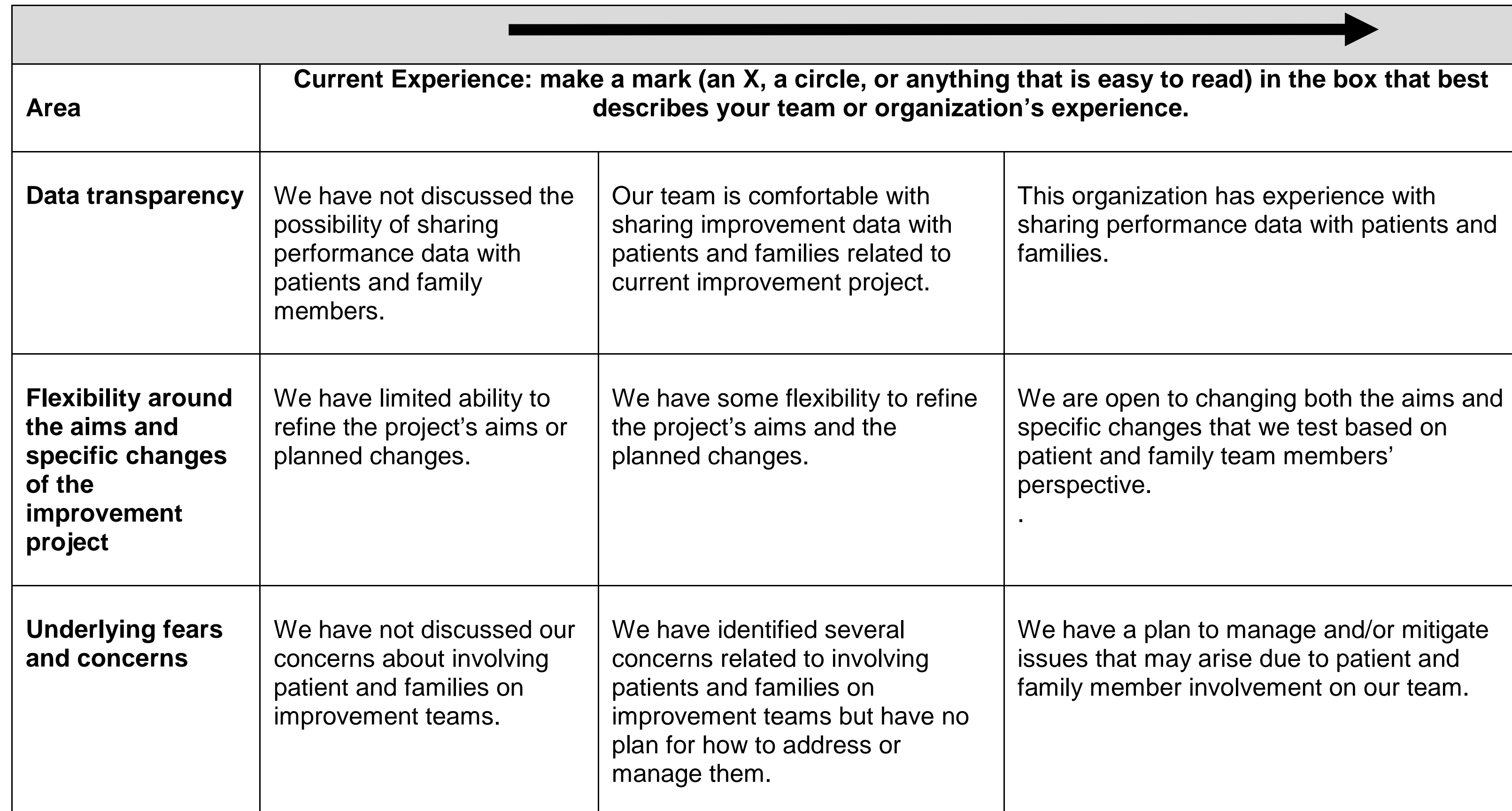
[1] This principle demonstrates alignment of B.A.P. with the "Spirit" of Motivational Interviewing: Evocation
Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*, NY, Guilford Press, 2002.
[2] Spirit of Motivational Interviewing: Collaboration
[3] Spirit of Motivational Interviewing: Support Autonomy
An earlier version of the BAP Checklist was published in Schwartzberg J et al, Physician resource guide to patient self-management support. American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/433/phys-resource-guide.pdf
© Steven Cole, 2002, 2009,2010 B.A.P.™ is a registered trademark of Steven Cole, MD
The B.A.P. Checklist is the core self-management support tool of Comprehensive Motivational Interventions (CMI) ™

www.ComprehensiveMI.com

Partnering with Patients and Families to Accelerate Improvement
Readiness Assessment

Instructions: In preparation for <complete as needed>

Name of Organization/Team_____________________________



Area	Current Experience: make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.		
Data transparency	We have not discussed the possibility of sharing performance data with patients and family members.	Our team is comfortable with sharing improvement data with patients and families related to current improvement project.	This organization has experience with sharing performance data with patients and families.
Flexibility around the aims and specific changes of the improvement project	We have limited ability to refine the project's aims or planned changes.	We have some flexibility to refine the project's aims and the planned changes.	We are open to changing both the aims and specific changes that we test based on patient and family team members' perspective. .
Underlying fears and concerns	We have not discussed our concerns about involving patient and families on improvement teams.	We have identified several concerns related to involving patients and families on improvement teams but have no plan for how to address or manage them.	We have a plan to manage and/or mitigate issues that may arise due to patient and family member involvement on our team.

© 2007 Cincinnati Children's Hospital Medical Center and Institute for Healthcare Improvement. Others may use and adapt this tool freely as long as credit is given to CCHMC and IHI

Perceived value and purpose of patient/family involvement	There is no clear agreement that patient and family involvement on improvement teams is necessary to achieve our current improvement aim.	A few of us believe patient and family involvement would be beneficial to our improvement work, but there is not universal consensus.	There is clear recognition that patient and family involvement is critical to achieving our current improvement aim.
Senior leadership support for patient and family involvement	Senior leadership do not consider pf involvement a top priority.	Senior leaders are aware of and communicate support for pf involvement in our team.	Senior leaders consider our participation in this Web & Action as a pilot for organizational spread.
Experience with patient and family involvement	Beyond patient satisfaction surveys or focus groups our organization does not have a formal method for patient/family feedback.	We have an active patient/family advisory panel.	Patient and families are members of standing committees and make decisions at the program and policy level.
Collaboration and teamwork	Staff in this organization occasionally works in multidisciplinary teams to provide care.	Staff in this organization work effectively across disciplines to provide care to patients.	Patients and family are included as valued members of the care team in this organization.

1. What supports moving in this direction?

2. What are your current challenges?

3. How confident are you on successfully involving patients and families on your team (1-10 scale)?

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Are You at Risk for Going to the Hospital?

Name: ____________________ **Date:** ____________

My Top Health Wish or Goal: ______________________________

Check all Boxes that are True for you:	
❑ I started home health care right after leaving the hospital	❑ I have very poor health
❑ I have been in the hospital or emergency room in the past year	❑ I need help taking my pills
❑ I have heart problems/weak heart	❑ I need help using my inhalers
❑ I have Diabetes	❑ I have three health problems They are: ______________________ ______________________
❑ I feel short of breath often	❑ I fell down in the last year
Check all that apply: I need some help every day to: ❑ dress ❑ take a bath ❑cook	❑ I live alone
❑ I often feel down, hopeless, or depressed	I have a: ❑ skin sore; ❑ skin ulcer; ❑ pressure sore on my ❑ body; ❑ legs; ❑ feet ❑ *I may need help to heal the sore or wound*
❑ I sometimes get mixed up or confused	

If recommended, I agree to an evaluation for:	***If recommended, I would agree to visit from a:***	***If recommended, I would agree to***	***If recommended, I would agree to a***
❑ Physical Therapy **❑ Occupational Therapy** **❑ Speech Therapy**	**❑ Social Worker**	**❑ Learn more about Hospice care**	**❑ nurse visiting me**

My total number of checked boxes above is _________.
(5) *or more checked boxes could mean a higher chance of having hospital trips.*
You can learn more to help stay safe at home. Call the Nurse when you want to learn more.

Patient Signature: ______________________________**Date:** _________

Home Health Signature: ___________________________**Date:** _________

❑ I know how to call for help and have a "Call Me First" home poster.

Completed by: **❑ Patient, ❑Caregiver, ❑ Physician, ❑CM, ❑SN, ❑PT, ❑OT, ❑ST, ❑SW, ❑HHA**

Page 2: Clinician's Worksheet and Helpful Guidelines to Consider from the Completed Patient Self- HRA

Purpose: Use this Worksheet and Based on the Patient's Information on Front of this Form: Identify Possible Interventions Appropriate or Ordered for Your At Risk for Hospitalization Patient:

Checklist of possible patient specific interventions that may be appropriate for this patient or may possibly be ordered by the physician for this patient at risk for hospitalization: **See front of form:(Coordinate with OASIS M2250)**		
Referrals: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ HHA ❑ Dietary Consultant ❑ Other:	❑ Medication Management ❑ Meds Reconciliation • Assessment of patient's: knowledge, ability, resources and adherence • Education	❑ Patient/family education ❑ Enrollment into a wellness or disease management program (DMP) e.g. CHF, AMI, COPD, Diabetes, HTN, Depression (specify):
❑ Hospice/Palliative Referral	❑ Front-loading Visits	❑ Influenza Immunization ❑ Pneumococcal Immunization (M1040, M1045, M1050, M1055)
❑ Wound Care Specialist Referral	❑ Added to Case Conference List as Risk for Hospitalization	
❑ Individualized Patient Medical Emergency Plan	❑ Scheduled Telephone Calls	❑ Care Coordination (Physicians, Hospitals, Nursing Homes…)
❑ Fall Prevention Program	❑ Remote Telehealth Monitoring	❑ Other:

Notify the following when appropriate for the patient at risk for hospitalization:

❑ Notify Physician: • May Fax this HRA • Timely Physician Contact Regarding the Best Practices for the Plan of Care (Review OASIS-C M2250)	❑ Interdisciplinary Team Members	❑ On Call Staff	❑ Payer: (if requires HRA, e.g. Managed Care)
	❑ Patient and/or Family/Caregiver	❑ Agency Case Manager ❑ Case Conference Team	❑ Other: (e.g. Hospital/Partners)

❑ Provided "Call Me First" Home Poster to Patient and/or Family.

Clinician/Team Member Signature: ________________________________ Date: ___________

Notes:

Revised 2010/GHC/je from HHQI. Revised 12/21/09 to correlate with OASIS-C. The following articles provide more information on risk assessments: Rosati, R.J., Liping, H., Navaie-Waliser, M., & Feldman, P.H. (2003) Risk Factors for Repeated Hospitalizations among Home Healthcare Recipients. *Journal for Healthcare Quality*, 25(2). Fortinsky, RH, Madigan, EZ, Sheehan, TJ, Tullai-McGuinness, S. & Fenster, JR. (2006) Risk factors for hospitalization among Medicare home care patients. *West J Nurse Res,* 28(8).

Call Me First!

Stay safe and well at home.
Avoid unnecessary trips to the hospital.
Tell me when you have health changes,
Or if you get sick,
Or if you just don't feel right,
When harder getting out of a chair to stand,
I can help you if I know you need help!

Call Me First!

Because I Care!

Name:______________________________

Local Number: _______________________

(Anytime: 24 Hours/7 Days a Week)

Home Telehealth Disease Management Series

Patient Selection Criteria: Home Telehealth for HEART FAILURE

Consider Telehealth* Options when patients meet the following criteria:

Clinical Status:

- ☐ History of more than 1 hospitalization for disease exacerbation in the last 6 months
- ☐ Require at least 2 skilled nursing visits per week
- ☐ Symptom management issues:
  - **dyspnea, fatigue, cough, mucous production, edema**
- ☐ Deficits in **HF** self-care management:
  - **medications, diet, activity and exercise, preventive strategies, weight monitoring**
- ☐ History of problems adhering to disease management recommendations

Functional Considerations

Phone Monitoring Criteria:

- ☐ Able to hear, answer, and communicate clearly on a telephone
- ☐ Able to perform and communicate the results of self-monitoring activities

Telemonitoring Criteria:

- ☐ Able to read and safely connect to or use a telemonitoring unit
- ☐ Able to understand directions
- ☐ Adequate manual dexterity
- ☐ Able to perform and communicate the results of self-monitoring activities

Willingness to Use Telehealth

- ☐ Patient is willing to consider use of Phone Monitoring
- ☐ Patient is willing to consider use of Telemonitoring
- ☐ Patient consents to selected telehealth option

Physicians Orders

- ☐ Physician orders are obtained for the use of the selected telehealth option

***Telehealth Options**

Phone Monitoring Patient Encounter: Involves the use of a telephone for the communication between the health care provider and the patient/caregiver. See **Staff Education Tool Heart Failure: Phone Monitoring Assessment Guide** for guidance in questions regarding clinical status and direction for patient education.

Telehealth Patient Encounter: Involves the use of electronic information processing technologies. This may include a video conference between the health care provider and the patient/caregiver or the interactive transmission of a set of vital sign data to a health care provider who can make a clinical decision regarding the data received. See **Staff Education Tool Heart Failure: Telehealth System Monitoring**.

This is only "part" of the puzzle:

This tool is a component of the "*Home Telehealth Disease Management Series*".

- ✓ **Patient Selection Criteria**
- ✓ Staff Education Guide
- ✓ Patient Self-Care Workbook
- ✓ Decision Support Tool
- ✓ Patient Encounter Documentation Tool

Visit www.medQIC.org to access other patient and provider materials designed to improve home health patient outcomes.

This material prepared by OASIS Answers, Inc. (www.oasisanswers.com), and is provided by the West Virginia Medical Institute, Inc. the Quality Improvement Organization supporting the Home Health Quality Campaign, 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: 9SOW-WV-HH-BBK-012711L App. 01/11.

Success Stories

There are three success stories featured in the Cross Settings II BPIP. The success stories will give your agency and staff some tangible ideas for improving care transitions. The featured agencies are:

- Virtua Home Care
- SunCrest Healthcare
- Visiting Nurse | Hospice Atlanta

There is also a patient success story included in this BPIP as well. A Georgia couple, under the care of SunCrest Healthcare, shares a telemonitoring success story.

INSIGHTS

Commit to improve nursing skills and education!
Our company is educating/cross training nursing staff and employing nurses with specialized skills by:

- Hiring a nurse practitioner from Vanderbilt to prepare education for nursing staff
    - Includes DVD sessions and onsite training focused on patient assessment/interventions
- Using clinical pathways to guide nurses what to teach and when to intervene
- Hiring telehealth nurses with current or recent critical care experience—the telehealth nurses make recommendations to field nurses
- Providing current pharmacology information and guidance to nursing staff
- Preparing patient education guides based on information from *American Heart Association, Heart Failure Society of America* and input from cardiologists and primary care physicians

Karen Malin Garfield, RN, BSN Corporate Director, Program Development
SunCrest Healthcare
Nashville, TN

*Read the **SunCrest Healthcare Success Story***

Physician Advisory Group

Using Telehealth to Reduce Readmission Rates in Chronic Illnesses

Telemonitoring is one component of a disease management program. Using telehealth (phone monitoring and/or telemonitoring) to enhance a disease management program can be effective. Share with physicians that telehealth is one of the interventions used to effectively manage chronic illnesses. However, make sure to also include information on the other components of your agency disease management program.

> "Home care is an instrumental part of the chronic disease management model, and home telemonitoring is an extension of health–care delivery in a patient's home environment."
>
> *Polisena, Tran, Cimon, Hutton, McGill, Palmer, and Scott, 2010.*

Telehealth benefits to share with physicians include:

- Daily monitoring
  - Vital signs, weight, blood sugar, pulse oximetry
- Improved Quality of Life
  - Hospitalizations are reduced and disease exacerbations prevented
- Improved access to health care services
  - Data monitoring allows for quicker interventions
- Electronic record of health data
  - Transmitted data may be sent to physician

> "Some physicians may see telehealth as causing an increase in paper work across their desk and are concerned about timely reporting by home care agencies with abnormal results. By working with a trusted home care agency that is willing to work with the physician to develop protocols that include panic levels, frequency of reporting results to physician to streamline the process and prevent delays or cluttering of physician desks is the key. Through the use of telehealth the physician is able to improve the patients' outcome of chronic medical problems before they lead to complications and new health problems." (For the entire letter for physicians click here)
>
> *Joseph E. Gerhardstein, MD, FAAFP*
> *University of KY Dept Family Medicine*
> *Lexington, KY*
> *Rebecca Cartright, MSW, MHA*
> *Director Central Baptist Home Care/Home Infusion*
> *Lexington, KY*

"The frequent monitoring and telephonic encounters associated with the monitoring can reinforce to patients the impact of their medication and behaviors (such as diet and exercise) on key health parameters like their blood pressure and weight." (The entire excerpt from Dr. Landers is on the following page.)

Steven Landers MD, MPH
Director, Center for Home Care and Community Rehabilitation. Cleveland Clinic

Thanks to Bayada Nurses for sharing information on telehealth.

Promoting Telehealth as part of a Chronic Illness Program

Physicians should be aware that home telehealth monitoring is an emerging tool in health care that can help safely manage patients with serious chronic illness in the comfort of their homes. Many home health agencies include telehealth monitoring as part of their care model for patients with certain conditions. The first generation of telehealth in the home care setting has typically involved monitoring of blood pressures, weights, other vital signs, and symptom scales using a device linked by telephone to a monitoring professional with an electronic "dashboard" is alerted to patients with monitoring parameters outside of normal values and then makes contact with the patient and/or their physician or other appropriate caregiver. In the real world, there is variability in the frequency and duration of monitoring and the content and context of associated telephonic encounters. Newer telehealth concepts are using cellular and broadband internet connections and may include two-way video conferencing to the home, more customizable educational content and care paths, and are increasingly similar in look and feel to the widely available consumer mobile devices such as Apple's iPad.

Monitoring provides several potential benefits in reducing avoidable hospitalizations and improving clinical outcomes. Early identification of concerning scenarios (such as fluid retention in a heart failure patient) can allow for early intervention before the condition warrants hospitalization. The frequent monitoring and telephonic encounters associated with the monitoring can reinforce to patients the impact of their medication and behaviors (such as diet and exercise) on key health parameters like their blood pressure and weight. For patients doing well, the monitoring can sometimes provide reassurance about a patients' well being and success on a care plan so that scarce skilled human resources can be triaged more appropriately.

Because health care has been so focused on encounters, monitoring can be disruptive in that it can generate data and "issues" outside of the context of historical health care workflows. Thus, anyone considering using home monitoring as part of their health care delivery must consider how workflows and communication patterns must change. In driving toward good outcomes the resourcing of the monitoring team with strong clinical leadership, the engagement of physicians and their office staff, and having resources for escalating care are all important aspects of a successful monitoring program. Ultimately, these factors are probably more important than the specific devices. The monitors are tools for a non-encounter based care team to use to manage to better outcomes, and to some extent the monitors are tools that can promote and support self management by patients and families. Over time the technology will change and physicians should focus on sound care protocols, strong clinical leadership, resources for managing problems in the home and coordinating care.

Steven Landers MD, MPH
Director, Center for Home Care and Community Rehabilitation. Cleveland Clinic

INSIGHTS

Reducing ACH (whether readmissions or avoidable hospitalization) is the overarching goal of our program. We have linked the following programs to achieve this goal:

- Identification of patients at risk for rehospitalization: At the start of care, every admission is assessed for risk factors that could increase the likelihood of rehospitalization (Use the ACH Risk Assessment- See the January 2010 BPIP). Using our current technology, interventions have been built into our EMR to assist the clinician in developing the plan of care for at risk patients. Interventions include: Telephone monitoring, creating "My Emergency Plan", utilization of available community resources, and medication management.

- Additional programs to support the patients and reduce rehospitalization are:

    - Telehealth –offers the use of innovative technology to improve clinical outcomes while keeping patients safe at home.

    - Transitions in Care Program (TCM) – the goal of the TCM Program is to improve self management of the chronic disease process. The program is a hybrid of the evidence-based Transitional Care Model (TCM). TCM trained RNs utilize evidence-based assessment tools to identify the patient's ability, knowledge, and willingness to manage their chronic illness and transition back to the community.

    - Chronic Navigation - A telephone support service implemented which provides personal navigation services for our chronically ill patients and their physicians to better coordinate care and improve access to health care services. The service is supported by Virtua.

Diane Costanzo, RN, MSN, MSHA, CMSRN, CNA-BC Director of Nursing Virtua Home Care West Jersey

Pat Quackenbush, BC-RN MBA Director Quality Management Virtua Home Care

Read the ***Virtua Home Care Success Story***

TRACKING DATA AND MEASURING PROGRESS

What are they?

- Your agency's FREE reports for **ACH** and **Oral Medications** based on **OASIS-C data.**
- A **unique look into the potential causative factors** focusing on M2020 from OASIS-C for the Oral Medication report and M100 for the ACH report
- Agency, state and national rates are **not** risk adjusted
- Have a look at the first page of the ACH report (next page).

How do I access the HHQI Data Reports?

- Step 1: Go to the HHQI Web site, www.homehealthquality.org
- Step 2: Click on the Quick Link (right side of the page) for HHQI Data Access.
- Step 3: Now, log in with your Data Access username and password. If you do not have a Data Access username and password yet, please click on the link to "Register" on the Data Access page.
- For more detailed instruction on registering for the data site, please download our Quick Start Guide or view the new Data Reports Webinars under "Resources" at: https://secure.homehealthquality.org

GREAT NEWS!

The HHQI Data Reports will no longer include scheduled admissions in your agency's ACH rates. If the clinician assesses the patient on M2430, answer 19 ("scheduled treatment or procedure"), then the patient will be excluded from the calculation. For data tracking, the ACH rates *including* scheduled hospitalizations will still be available as the last table on the report, but all other tables will be calculated based upon your *unplanned (or unscheduled)* ACH rate.

- Have you checked your monthly HHQI data reports?
- How much did your ACH rate drop (or improve) this month?
- What percentile ranking is your agency for ACH and Oral Medications?

Contact HHQInfo at HHQI@wvmi.org for further assistance.

Acute Care Hospitalization Monthly Report

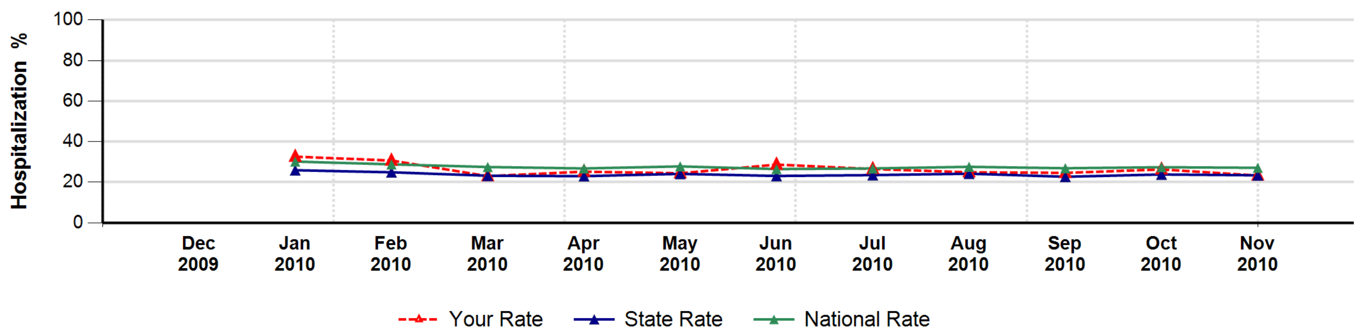
Name: ACH Sample Agency **Medicare#:** 999999

Location: Any City, PA **Report Date:** 01/10/2011

Monthly Hospitalizations vs. Transfers/Discharges

Number of Monthly Hospitalizations out of Total Transfers/Discharges (Excludes planned hospitalizations)

	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	Jul 2010	Aug 2010	Sep 2010	Oct 2010	Nov 2010	Total
Hospitalizations		261	257	245	257	222	283	238	243	232	243	222	2703
Transfers/Discharges		801	836	1064	1021	911	986	897	975	944	924	952	10311
Hospitalization %		32.6	30.7	23.0	25.2	24.4	28.7	26.5	24.9	24.6	26.3	23.3	26.2
State Rate %		25.9	24.9	23.2	23	24.1	23.1	23.5	24.2	22.7	23.8	23.4	23.7
National Rate %		30.2	28.8	27.5	26.8	27.8	26.5	26.8	27.6	26.9	27.4	27.1	27.5



Data shown is from the Oasis. January 2010 and forward utilizes Oasis-C data.

Best Practice Intervention Package Timeline

HHA BPIP Implementation Timeline

Release Date begin on 1/28/2011	Within 3-4 weeks _/_/2011	Within 4-6 weeks _/_/2011	Within 6-8 weeks _/_/2011	Within 8-12 weeks _/_/2011
Download BPIP package	Schedule team to review package	Plan higher level educational opportunities for staff	Implementation of new tools/process changes	Begin evaluation of process changes
Begin preliminary staff education on care transitions concepts and why agency needs to get involved	Does your agency have a disease management program? Do your clinicians understand self-management support (SMS)?	Conduct small tests of change (e.g., Plan/Do/Study/Act)	Meet with other providers to see how a disease management/ telehealth program can be used across settings to improve patient care.	Revise process as necessary
Schedule a brainstorming session and seek staff input in other ways—through email or other means	Do you have a telehealth program and is it used effectively? (Phone or Telemonitoring) Does it enhance your disease management program? What measures do you use to assess this?	Review your data collection to assess the effectiveness of your Telehealth program	During team meetings discuss patient/ caregivers input and seek additional input from staff	
Identify ways your agency may need to improve care to chronically ill patients.	Team decides on a plan and selects tools/resources based on audit and staff input	Talk with patients/ caregivers to get their perspective on self-care management		

SN Track: Focus on Improving Care Transitions with Chronic Care Patients

SN CHECKLIST:

Do you:

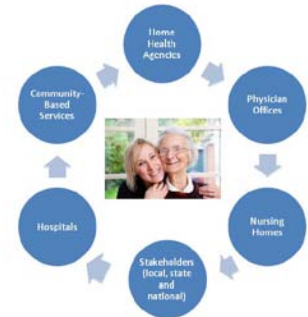
- ☐ Understand the Chronic Care Model? A diagram of the Chronic Care Model is included in this BPIP (page 9).
  Elements of the Chronic Care Model are:
  - community
  - health system
  - self-management support
  - delivery system design
  - decision support
  - clinical information systems
- ☐ Recognize the importance of patient activation and action planning?
  - The term "***patient activation***" refers to having the knowledge, skills, beliefs, and confidence to manage one's health" [Hibbard and Cunningham, 2008].
  - Lorig states that ***action planning*** is a "tool or technique that helps people change their behavior over a short period of time" (HHQI BPIP, 2007, p. 66).
    - Examples of Action Plans are included in this BPIP(page38-39) and on the BPIP Web page.
- ☐ Participate in agency educational programs? Offer your clinical expertise to other staff and providers?
- ☐ Recognize and act on opportunities to improve care transitions' management with chronic care patients?
- ☐ Do you use any form of hand- over communication (voice, paper, electronic) to your discipline or other providers? (Provider to Provider communication tool is available in this BPIP)
- ☐ Work with other upstream and downstream providers to improve patient safety between transitions?
  - Upstream Providers: Provider you are *receiving* patients *FROM*
  - Downstream Providers: Provider you are *sending* patients *TO*

> "Medical care for chronic illness is rarely effective in the absence of adequate self-care. Self-care and medical care are both enhanced by effective collaboration among chronically ill patients and their families and health care providers."
>
> Von Korff, Gruman, Schaefer, Curry, Wagner, 1997, p. 1097.

> "Every day, patients with continuous, complex care needs make hundreds of thousands of transitions across different sites of care. The many adverse effects of poorly executed transitions on patients and their informal caregivers are potentially preventable with the implementation of evidence-based and clinically sound interventions." *Coleman, 2003, p. 554-555.*

> Both the sender and receiver have a responsibility to ensuring *all* pertinent patient-centered information has been communicated.

Therapy Track: Focus on Improving Care Transitions with Chronic Care Patients



THERAPY CHECKLIST:

Do you:

- ☐ Understand the Chronic Care Model? A diagram of the Chronic Care Model is included in this BPIP (page 9).Elements of the Chronic Care Model are:
    - community
    - health system
    - self-management support
    - delivery system design
    - decision support
    - clinical information systems
- ☐ Recognize the importance of patient activation and action planning?
    - The term "***patient activation*** refers to having the knowledge, skills, beliefs, and confidence to manage one's health" Hibbard and Cunningham, 2008.
    - Lorig states that ***action planning*** is a "tool or technique that helps people change their behavior over a short period of time" (HHQI BPIP, 2007, p. 66).
        - Examples of Action Plans are included in this BPIP (page 38-39) and the BPIP Web page.
- ☐ Participate in agency educational programs? Offer your clinical expertise to other staff and providers?
- ☐ Recognize and act on opportunities to improve care transitions' management with chronic care patients?
- ☐ Do you use any form of hand-over communication (voice, paper, electronic) to your discipline or other providers? (Provider to Provider communication tool is available in this BPIP)
- ☐ Work with other upstream and downstream providers to improve patient safety between transitions?
    - Upstream Providers: Provider you are *receiving* patients *FROM*
    - Downstream Providers: Provider you are *sending* patients *TO*

"Medical care for chronic illness is rarely effective in the absence of adequate self-care. Self-care and medical care are both enhanced by effective collaboration among chronically ill patients and their families and health care providers."

Von Korff, Gruman, Schaefer, Curry, Wagner, 1997, p. 1097.

"Every day, patients with continuous, complex care needs make hundreds of thousands of transitions across different sites of care. The many adverse effects of poorly executed transitions on patients and their informal caregivers are potentially preventable with the implementation of evidence-based and clinically sound interventions." *Coleman, 2003, p. 554-555.*

Both the sender and receiver have a responsibility to ensuring *all* pertinent patient-centered information has been communicated.

Medical Social Worker Track: Focus on Improving Care Transitions with Chronic Care Patients

MEDICAL SOCIAL WORKER CHECKLIST:

Do you:

- ☐ Understand the Chronic Care Model? A diagram of the Chronic Care Model is included in this BPIP (page 9).
  Elements of the Chronic Care Model are:
  - community
  - health system
  - self-management support
  - delivery system design
  - decision support
  - clinical information systems
- ☐ Recognize the importance of patient activation and action planning?
  - The term "***patient activation*** refers to having the knowledge, skills, beliefs, and confidence to manage one's health" Hibbard and Cunningham, 2008.
  - Lorig states that ***action planning*** is a "tool or technique that helps people change their behavior over a short period of time" (HHQI BPIP, 2007, p. 66).
    - Examples of Action Plans are included in this BPIP (page 38-39) and the BPIP Web page.
- ☐ Participate in agency educational programs? Offer your clinical expertise to other staff and providers?
- ☐ Recognize and act on opportunities to improve care transitions' management with chronic care patients?
- ☐ Do you use any form of hand-over communication (voice, paper, electronic) to your discipline or other providers? (Provider to Provider communication tool is available in this BPIP)
- ☐ Work with other upstream and downstream providers to improve patient safety between transitions?
  - Upstream Providers: Provider you are *receiving* patients *FROM*
  - Downstream Providers: Provider you are *sending* patients *TO*

> "Medical care for chronic illness is rarely effective in the absence of adequate self-care. Self-care and medical care are both enhanced by effective collaboration among chronically ill patients and their families and health care providers."
>
> Von Korff, Gruman, Schaefer, Curry, Wagner, 1997, p. 1097.

> "Every day, patients with continuous, complex care needs make hundreds of thousands of transitions across different sites of care. The many adverse effects of poorly executed transitions on patients and their informal caregivers are potentially preventable with the implementation of evidence-based and clinically sound interventions." *Coleman, 2003, p. 554-555.*

> Both the sender and receiver have a responsibility to ensuring *all* pertinent patient-centered information has been communicated.

Home Health Aide Track: Focus on Improving Care Transitions with Chronic Care Patients

HOME HEALTH AIDE CHECKLIST:

Do you:

- ☐ Know which of your patients have chronic diseases?
- ☐ Understand the limitations from chronic diseases and how it impacts each patient? Discuss disease limitations and strategies to help the patient with the nurse and therapist.
- ☐ Do you use any form of hand- over communication (voice, paper, electronic) to your discipline or other providers? (Provider to Provider communication tool is available in this BPIP)
- ☐ Know that nurses/therapists and social workers may be using a technique called ***action planning.***
    - Examples of Action Plans are in the BPIP—ask your manager for a copy
- ☐ Encourage patients to participate in their bathing and personal care (as directed by SN/Therapist).
- ☐ Participate in educational offerings at your agency. Also look for additional educational opportunities (community, healthcare journals, etc) to gain more knowledge about caring for patients with chronic diseases.

> Lorig states that **action planning** is a "tool or technique that helps people change their behavior over a short period of time."
>
> *HHQI BPIP, 2007, p. 66.*

> ***Chronic conditions*** is a general term that includes chronic illnesses and impairments. The term includes conditions that are expected to: last a year or longer, limit what one can do, and/or may require ongoing medical care.
>
> ***Serious*** chronic conditions are a subset of chronic conditions that require ongoing medical care and limit what a person can do.
>
> ***Chronic illnesses*** are conditions that are expected to last a year or more and require ongoing medical care. Activity limitations are functional limitations and disabilities that restrict a person from performing normal activities without assistance—such as walking, dressing and bathing—or affect a person's ability to work or attend school.
>
> One-fifth of all people who have a chronic condition also have activity limitations.
> Robert Wood Johnson Foundation, *p. 13.*

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