

Acute Care Hospitalization (ACH)
Conference Call

Acute Care Hospitalization (ACH)

December 6, 2005

Conference Call

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Objectives

- Explain 7th Scope of Work (7SoW) findings and understand ACH focus in the new phase of the Home Health Quality Initiative (HHQI).
- Relate use of the ACH Change Binder to development of Plans of Action (POAs).
- Identify Home Telehealth as a mechanism to reduce ACH.
- Understand how to incorporate OBQI into quality improvement (QI) work.
- Explain the purpose of the Immunization and Culture Change surveys being conducted by HSAG.

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CMS QI Roadmap

VISION: The right care for every person, every time

- AIMS:**
- Safe
 - Effective
 - Efficient
 - Patient-centered
 - Timely
 - Equitable

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Transformational Change

- **Definition:**
Care is consistently safe, timely, effective, efficient, equitable, and patient-centered
- **Key strategies**
 - Performance measurement and public reporting
 - Process redesign
 - Effective use of health information technology (HIT)
 - Organizational culture change

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HHA Priority Topics

- ACH
- Telehealth
- Organizational Culture Change
- Selected Outcome Measure
 - Arizona selected Improvement in Management of Oral Meds
- Immunizations

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Next Three Years

Intensive work with two groups

- A. Clinical Performance (CP)
 - ACH
 - One additional measure—oral meds or *Home Health (HH) Compare*
- B. System Improvement & Organizational Culture Change (SIOC)
 - Use telehealth to reduce ACH
 - Improve organizational culture
 - One additional measure—oral meds or *HH Compare*

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Next Three Years (continued)

- Statewide Improvement
 - Reduce ACH and
 - Improvement in Management of Oral Meds or
 - Another measure as found on *HH Compare*

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National Episode Hospitalization Rate

Observed Episode Rate

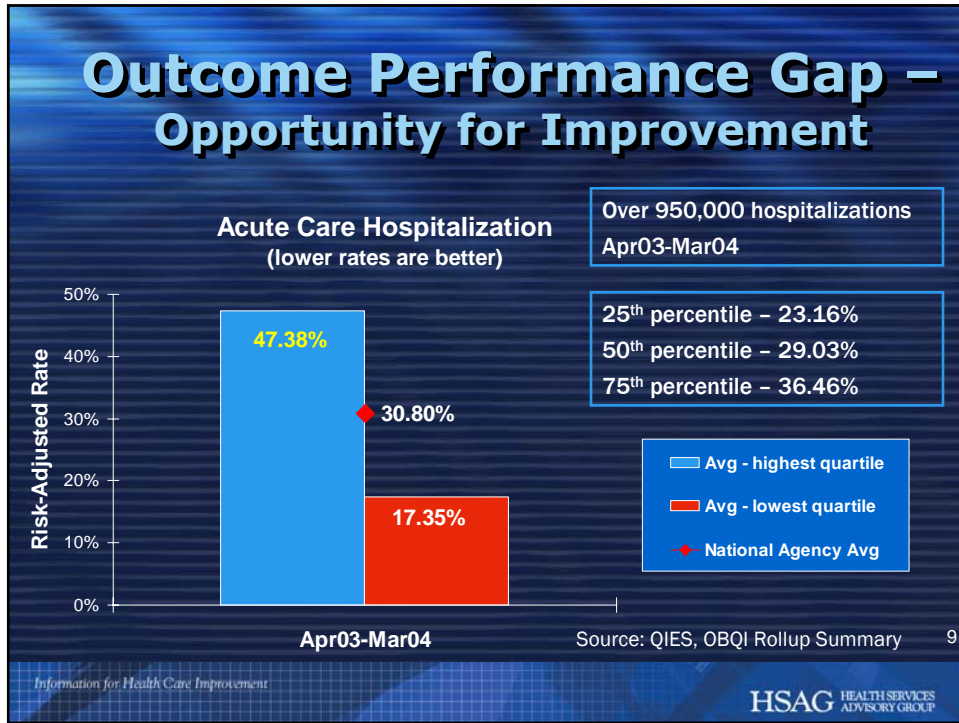


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ACH

- Percentage of home health episodes in a 12-month period that ended with hospitalization (emergent, urgent, and elective)
- Numerator—all episodes with a hospital inpatient facility admission
- Denominator—all episodes except patients non-responsive on admission or episodes with death
- Risk-adjusted

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ACH (continued)

- Proxy measure for deterioration in health status
- Do not expect 0%
 - Nature of some illnesses/limits of medical science
 - Elective reasons for admissions
- Goal: to reduce avoidable hospitalizations
 - Prevent deterioration
 - Identify warning signs for early interventions

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The Challenge

- Multidimensional
- Evidence hospitalization rates can be decreased
- Gap between science and practice

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The Mission

- Implement care delivery systems that prevent deterioration resulting in the need for hospitalization and emergent care

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The Solution

- Multidimensional
- Home Health Agencies (HHAs)
 - Improve care processes
 - Lead and influence improvements across settings
- Focus improvement on:
 - Coordinating care transitions
 - Identifying patients at risk
 - Stabilizing and managing complex/chronic conditions
 - Supporting patient/caregiver self-management
 - Improving communication
 - Creating systems to support these practices

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HHA–Quality Improvement Organization (QIO) Partnership

- Use the OBQI process to systematically identify problems and improvement actions
- Use strategies and actions identified in the ACH Change Binder to help build a POA
- Engage in a QI community to share lessons learned (HHAs and other providers)
- Continuously improve quality

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Top 10 7SoW Target Outcomes

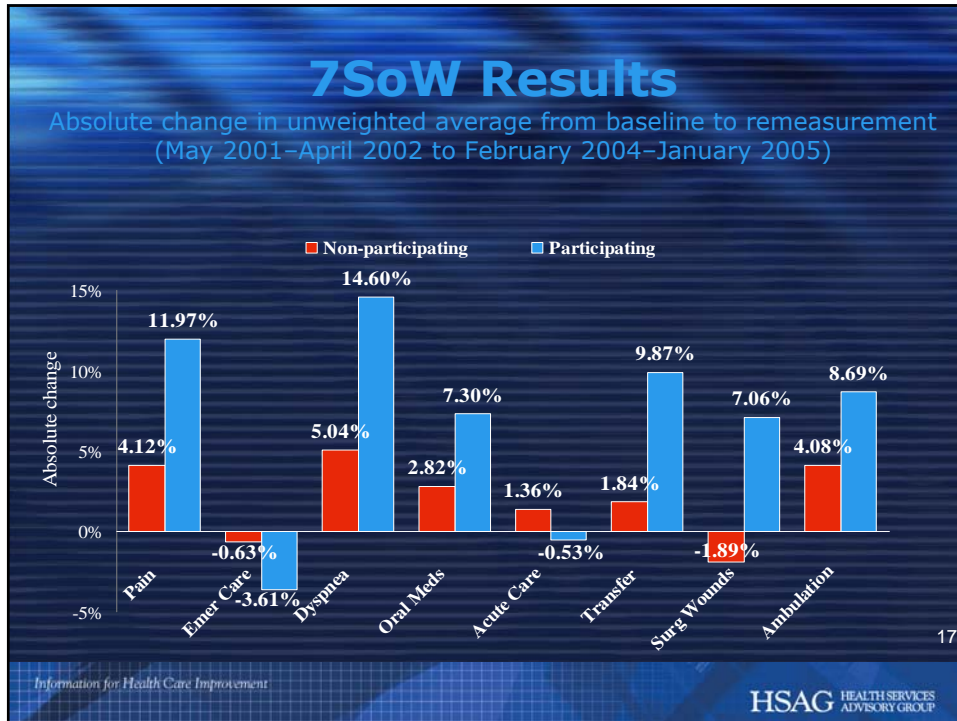
1. Improvement in Pain Interfering Activity	691
2. Any Emergent Care	613
3. Improvement in Dyspnea	565
4. Improvement in Management Oral Meds	521
5. Acute Care Hospitalization	482
6. Improvement in Transferring	458
7. Improvement in Status Surgical Wounds	368
8. Improvement Ambulation/Locomotion	349
9. Improvement in Bathing	280
10. Improvement Urinary Incontinence	256

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Analysis of CY 2003 Data

- OASIS (national) and hospital claims (5 states)
- No single diagnosis or set of diagnoses account for most of the hospitalizations
- Many hospitalizations occur shortly after the home health episode begins
- Patients who are hospitalized are more functionally impaired, have higher severity, and poorer prognosis

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Reasons for Hospitalization (M0890)

- Emergent 84.63%
- Urgent 6.19%
- Elective 5.89%

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Reasons for Hospitalization Percentage for Responses on M0895

Respiratory	19.31	MI/stroke	2.41
Exacerbation of CHF	9.37	Hypo/hyperglycemia	2.20
Wound	6.68	Medication	1.38
Injury at home	4.20	Psychotic episode	1.36
Scheduled surgery	3.59	Deep vein thrombosis	1.03
Unknown	3.30	Chemotherapy	0.55
Uncontrolled pain	3.20	IV catheter infection	0.17
GL bleeding	2.91	Other than above	48.35
UTI	2.73		

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Hospital Claims— Principal Diagnosis

- Circulatory system disease 27.11%
- Congestive heart failure 9.65%
- Respiratory system 14.47%
- Pneumonia 5.74%
- Injuries and poisonings 9.94%

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Home Health Length of Stay (LOS) Prior to Hospitalization

Home Health LOS	%
Within 1 week	25.44%
Within 2 weeks	44.65%
Within 3 weeks	57.83%

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Characteristics of Hospitalized Patients

- More functionally impaired prior to and at beginning of episode
- Fewer with moderate recovery prognosis
- Fewer with good rehab prognosis
- More had hospital discharge within 14 days

Source: CY2003 OASIS

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Patient Characteristics

Patient Characteristic	Hospital- Yes	Hospital- No
Moderate recovery prognosis	82.37%	92.43%
Good rehab prognosis	61.48%	79.61%
Terminal condition	13.44%	6.76%
Intractable pain	16.13%	12.51%
Hospital discharge within 14 days	68.04%	58.37%

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**Patient Characteristics
(Continued)**

Patient Characteristic	Hospital- Yes	Hospital- No
IV/infusion therapy	4.56%	2.67%
Enteral nutrition	3.25%	1.32%
Black	15.01%	11.33%
Medicaid payment	16.23%	11.14%

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**Patient Characteristics
(Continued)**

Patient Characteristic	Hospital- Yes	Hospital- No
Dependence in living skills	61.19%	46.55%
Dependence in personal care	46.34%	32.29%
Dependence in med admin	61.72%	47.08%
Impaired ambulation/mobil	28.27%	19.05%
Urinary incont/catheter	30.37%	21.77%

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Emergent Care

- Episodes with hospitalization
 - 66.43% emergent care
- Episodes with emergent care
 - 83.73% ended with hospitalization

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What Can be Achieved?

Technical Expert Panel

- There is opportunity for improvement
- 23% represents a high performance goal
 - 25% of HHAs have achieved or are lower
- May not be achievable for all HHAs
 - Imperfect risk models
 - Greater volatility of rates for small agencies
- **Caution**—Should not be achieved at the cost of denying high-risk patients access to home health care services or necessary hospitalization

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Change Framework and Change Binder

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Background on Development

- Partner with VNSNY's Center for Home Care Policy and Research
- Data analysis
- Literature search
- Consultation with experts
- VNSNY Home Health Expert Panel
- Pilot test—113 HHAs in 12 states

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The Chronic Care Model: Rationale

- 75% of hospital inpatient stays attributable to people with chronic conditions
- Chronic care poorly managed in U.S. health care system
- Need to overcome health care silos
- Model widely used in improvement efforts across country

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Key Findings/Issues Shaped Change Binder

- Chronic conditions
- Multiple diagnoses
- Transitions
- Hospitalizations occurrence in home health episode
- Stages of care
- Multiple factors—complexity

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Pilot Test March—July 2005 Thanks Participants!

11 QIOs (12 states) and 113 HHAs

Arizona	New York
Idaho	Rhode Island
Louisiana	Tennessee
Maryland/DC	Utah
Michigan	Virginia
	Washington

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Pilot Test Highlights

- Not just a test of the ACH Change Binder—QIO assistance was integral
- 113 HHAs submitted POAs AND outcome and process measure data
- HHAs tested a wide variety of change concepts
- HHA data showed improvement in outcome and process measures
- All QIOs and 83 HHAs participated in surveys—46 HHAs participated in interviews

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Pilot HHA Risk-Adjusted Hospitalization Rates

March 2004 – February 2005	Pilot	National
25th Percentile	23.46	23.31
Mean	28.85	29.29
75th Percentile	33.48	37.29

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HHA Participants

- 119 HHAs recruited
- 117 HHAs submitted POA
- 113 submitted data for at least one time period
 - 30% hospital-based
 - 46% proprietary
 - 50% voluntary
 - 4% government

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Additional Information on Pilot HHAs from Survey

- 51%—entire agency participated in the pilot
- 96%—used OBQI approach at least once prior to this pilot
- 56%—engaged not at all/little in efforts to reduce ACH
- 91%—leadership enthusiastic
- 51%—nursing staff enthusiastic

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Use of Change Binder Materials (Based on QIO POA Review)

Overall

- 24 of 26 strategies
- 56 of 74 specific actions
- 53 of 68 tools/resources

Per POA

- 76% used 1–3 strategies
- 67% used 2–5 specific actions
- 56% used 1–2 tools

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Pilot Results— Outcome Measures

- Small decrease in average of hospitalization measure
- Increase in LOS until hospitalization
- Of the 101 HHAs with data for first and last time points, 47.52% showed improvement

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Pilot Results— Process Measures

- All measures showed improvement
- 53.99%–93.20% average rate of attainment with 3rd data period
- 42.86%–91.18% of agencies improved

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Agency Prediction of Success

- 66.6% of HHA survey respondents predict they will reduce hospitalizations over time
- For HHAs that felt it less likely, the reasons were:
 - lack of physician support
 - particular patient population
 - results of poor hospital discharge planning
- 13 of 46 HHA interviewees expressed they had or could envision transformational change

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Shared Lessons from HHAs

- Most useful activities for focusing QI
 - 71%—record review
 - 64%—OBQI Process of Care Investigation (POCI)
- Identified barriers
 - Physicians, patient compliance, staff buy-in, staff workload
- Moving forward
 - Look at hospitalized patient characteristics and patients at risk on an ongoing basis
 - Review and expand POA
 - Continue what they started

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HHA Advice

- Get staff buy-in/input
- Keep it simple at first
- Allot time to accomplish the work
- Do an extensive POCI
- Request assistance from your QIO
- Get buy-in from leadership
- Data collection

HHAs would like to learn more about the approaches
of successful agencies

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Change Binder

Reducing Acute Care Hospitalization



Produced by:
Delmarva Foundation for Medical Care, Inc.

In Partnership with:
The Center for Home Care Policy and Research
Visiting Nurse Service of New York

With Support from:
The Centers for Medicare and Medicaid Services (CMS)

Quality Care
Quality Life



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Definitions

- **Change Framework**—entire set of change concepts organized into Areas for Improvement and Stages of Care
- **Improvement Matrix**—“big picture” of the organization and high-level strategies
- **Strategy**—high-level change concept (represents a series of actions designed to achieve a specific objective)
- **Action**—specific change idea that can be tested and implemented at the agency level
- **Tool**—a form, instrument, or manual that can be used as-is or modified to support strategies and actions
- **Resource**—a reference for more information related to implementing specific strategies and actions

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Improvement Matrix				
The strategies marked with an asterisk (*) are considered high leverage as identified by experts and supported in the literature.				
AREAS FOR IMPROVEMENT				
A. Promoting Patient Self-Management	B. Implementing Evidence-Based Practices and Guidelines	C. Using Systems and Technology to Promote Effectiveness and Efficiency	D. Improving Care Delivery Systems and Mobilizing Community Resources	E. Creating a Culture of Quality
STAGE OF CARE— BEFORE THE HOME HEALTH AGENCY ACCEPTS THE PATIENT FOR CARE Ensure that agency accepts patients who are suitable candidates for home care and has sufficient information to care for them appropriately				
A.1 Engage patients and caregivers in the determination of whether home care is the right option	B.1 Use evidence-based guidelines to assess clinical readiness for hospital discharge	*C.1 Increase home health agency organizational capacity to screen patients for safe/appropriate admission	*D.1 Collaborate with hospital to establish key criteria for safe, appropriate discharge from the hospital to home care	*E.1 Secure commitment of senior leaders to address the issue of reducing hospitalizations
STAGE OF CARE— THE FIRST WEEK OF CARE Identify patients who are at risk of hospitalization, and put a plan in place from the start to make that less likely				
*A.2 Provide patients and caregivers with information and options to address immediate/urgent care needs	*B.2 Use evidence-based risk assessment tools to identify high-risk patients, and incorporate risk factors in to individualized patient care plans	*C.2 Implement systems to identify and track patients at increased risk for hospitalization and related problems	*D.2 Establish transition protocol for tracking from hospital or other facilities (e.g., SNF) to home care	E.2 Work collaboratively with hospital to establish a joint hospital/HA quality agenda
*A.3 Establish patient and caregiver expectations and assess their capacity to engage in self-management			D.3 Organize care teams to promote consistency and continuity	*E.3 Establish an organizational quality improvement plan of action and allocate resources to implement and monitor it
STAGE OF CARE— THROUGHOUT THE EPISODE OF HOME CARE Ensure that the agency's systems maintain a high level of vigilance for high-risk patients				
A.4 Prepare patients and caregivers to participate in self-management and monitoring of conditions e.g.: <ul style="list-style-type: none"> • Heart Failure (HF) • Diabetes • Chronic Lung Disease • Pressure Ulcer • Pain management • Fall prevention • Medication adherence 	B.3 Use evidence-based condition-specific/problem-specific interventions, e.g.: <ul style="list-style-type: none"> • Heart failure • Diabetes • Chronic Lung Disease • Pressure Ulcer • Pain management • Fall prevention 	*C.3 Use systems to enhance effective internal and external communication and continuity of care <ul style="list-style-type: none"> • Staff communication with and between disciplines (including paraprofessionals), between orthopedists and non-orthopedists • Communication with patients/families • Communication with primary care providers and specialists 	*D.4 Mobilize ability of clinical resources and services to provide risk reduction/assessment <ul style="list-style-type: none"> • Attend to individual patient level • Attend to care load/population level 	*E.4 Integrate and establish organizational changes to ensure that all are working together to achieve possible improvement
A.5 Prepare patients and caregivers to identify and manage problems that may arise after discharge from home care	B.4 Screen patients for depression and refer for treatment when appropriate	C.4 Use decision support tools that prompt clinicians to implement evidence-based practices	D.5 Coordinate with primary care providers and specialists to promote continuity of outpatient/home care	
		C.5 Use telehealth/telemonitoring systems to supplement care of patients at risk of hospitalization	D.6 Identify the gaps in care with community medical/social resources	
STAGE OF CARE— IF THE PATIENT HAS REACHED THE EMERGENCY DEPARTMENT Prevent hospital admission for patients who can be stabilized and returned home safely				
A.6 Prepare patients and/or caregivers to maintain and convey key health and treatment information		C.6 Implement systems to track patients who go to the emergency department	D.7 Coordinate with ED to rework patients home rather than to hospital upon stay	

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D. Improving Care Delivery Systems and Mobilizing Community Resources

STAGE OF CARE— BEFORE THE HOME HEALTH AGENCY ACCEPTS THE PATIENT FOR CARE

*D.1 Collaborate with hospitals to establish key criteria for safe, appropriate discharge from the hospital to home care

STAGE OF CARE— THE FIRST WEEK OF CARE

*D.2. Establish transition protocol for transfers from hospital or other facilities (e.g., SNF) to home care

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AREA FOR IMPROVEMENT: IMPLEMENTING EVIDENCE-BASED PRACTICES AND GUIDELINES

Strategy	Action	Tools and Resources
Stage of Care: First Week of Care		
Strategy #B.2 *Use evidence-based risk assessment tools to identify high-risk patients and incorporate risk factors into individualized patient care plans	B.2.1 Identify/adapt/adopt an evidence-based assessment tool to identify patients who are at risk of hospitalization and train clinicians in its use	Assessment of Risk Factors for Hospitalization and Emergent Care (34) Pra™ Assessment Criteria (35) Naylor Screening Tool (36) Patient Hospitalization and Emergency Care Risk Assessment Tool (37) Fall Risk Assessment Tool (38) Safety and Fall Evaluation Form (39)

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Promoting Patient Self-Management

- Rationale and description (p. 17)
- Focus on problem-solving skills and self-efficacy
- Role of home care nurse in assessing, motivating, and empowering patient self-management
- Evidence that effective self-management associated with better outcomes

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Implementing Evidence-Based Practices and Guidelines

- Rationale and description (p. 21)
- Strong foundation of evidence-based guidelines and tools exists
- Demonstrated impact on hospitalization for selected interventions
- Guidelines and tools need to be adapted for home care
- Focus on getting clinicians to know and use the evidence base

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Using Systems and Technology to Promote Effectiveness and Efficiency

- Rationale and description (p. 24)
- Systems and technology key to supporting and sustaining use of guidelines and tools
- Systems range from simple to complex
- Key functions:
 - Identification and tracking
 - Internal/External communication
 - Decision support and “just-in-time” information

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Improving Care Delivery Systems and Mobilizing Community Resources

- Rationale and description (p. 28)
- Delivery systems problems lead to avoidable hospital admissions
 - Poor planning
 - Poor communication
 - Insufficient information transfer
- Growing body of research demonstrates effectiveness of better discharge planning and improvements in transitions across settings
- Effective changes include
 - Collaborative planning with hospitals
 - Use of transition protocols
 - Use of interdisciplinary teams

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Creating a Culture of Quality

- Rationale and description (p. 32)
- QI is a complex process
- Requires top-down/bottom-up involvement
- Commitment of senior leaders key at every stage—launching, implementation, and sustainability

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Evidence Base for Change Strategies

- Face validity—“no-brainers”
 - Urgent care plan
 - Patient tracking system
- Reviews, syntheses, meta-analyses
 - Front-end strategies
 - ✓ Discharge planning
 - ✓ Transitions
 - Long-term strategies
 - ✓ Evidence-based disease management
 - ✓ Self-care management

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Reducing Acute Care Hospitalization Index of Tools and Resources					
The numbers in this index map back to the number of the Tools and Resources identified in the Change Framework for each Area for Improvement.					
The Tools and Resources that are provided in a separate Toolkit are indicated by an triangle (▲).					
Number	Title	Source	Description	Area for Improvement	Topic
1	"Total Living Choices' Care Interpreter™"	Total Living Choices' Seattle, WA http://www.tlchoices.com/	Free services for seniors and their families to help them find long term care solutions. Gives brief definitions of medical care, personal care services, medical equipment, etc.	Promoting Patient Self-Management	Care Transitions
2	Discharge Preparation Checklist	Care Transitions Project The Division of Health Care Policy and Research University of Colorado Health Sciences Center http://www.caretransitions.org/documents/checklist.pdf	A structured set of critical activities designed to empower patients before leaving the hospital or nursing facility.	Promoting Patient Self-Management	Care Transitions
3▲	Zones for Chronic Disease Management - Diabetes	Adapted from Alaska Native Medical Center, Anchorage, AK http://www.improvingchroniccare.org/improvement/docs/vgdm.doc	Information for patients as to whether they are in a healthy zone according to their symptoms and appropriate actions to take if they are not.	Promoting Patient Self-Management	Diabetes
4▲	Zones for Chronic Disease Management - CHF	Improving Chronic Illness Care http://www.improvingchroniccare.org/improvement/docs/vgchf.doc	Information for patients as to whether they are in a healthy zone according to their symptoms and appropriate actions to take if they are not.	Promoting Patient Self-Management	CHF
5▲	Zones for Chronic Disease Management - Asthma	Asthma Initiative of Michigan Lansing, MI http://www.getasthmahelp.org/MARK%20Professionals/AMaductactionplan.pdf	Information for patients as to whether they are in a healthy zone according to their symptoms and appropriate actions to take if they are not.	Promoting Patient Self-Management	Asthma
6▲	Sample Transition Coach Charting Form	University of Colorado Health Sciences Center Division of Health Care Policy and Research Denver, CO http://www.caretransitions.org/documents/Intervention-Pillars.pdf	Checklist clinicians can use to document areas covered during a home health visit. Areas include medication management, personal health record, medical care follow up, and red flags.	Improving Care Delivery Systems Promoting Patient Self-Management	Care Transitions

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References					
This section contains a summary of the evidence cited for each Area for Improvement, followed by additional references for all sections of the Change Binder.					
Summary of Evidence – Acute Care Hospitalization Areas for Improvement					
Following are the references cited for in the description and evidence for each Area for Improvement. The assessment of the strength of the evidence was based on the following criteria.					
Strength Criteria					
A Recommendation is supported by scientific evidence from properly designed and implemented controlled trials					
B Recommendation is supported by scientific evidence from properly designed and implemented research studies					
C Recommendation is supported by synthesis of literature compiled by expert researchers and clinicians					
D Recommendation is supported by expert opinion					
Reference Number	Author/Citation/Source	Purpose	Study Design/ Data source	Findings	Strength of Evidence
Area for Improvement: Promoting Patient Self-Management					
1	National Center for Chronic Disease Prevention and Health Promotion. Chronic Disease Prevention. http://www.cdc.gov/nccdphp/	To determine the number of Americans affected by chronic disease. Statistic includes those who have illness and/or disability caused by chronic disease, as well as people who have died due to chronic disease.	Statistics compiled by the CDC	Statistical data on people affected by chronic disease	B
2	Partnership for Solutions; Robert Wood Johnson Foundation, Johns Hopkins University, 2002. <i>Chronic conditions: Making the case for ongoing care.</i> Baltimore, MD: Johns Hopkins University.	Provides an overview of chronic health conditions in the United States and the impact of these conditions on individuals and their caregivers, as well as on the U.S. health care system.	Chartbook prepared by the Partnership for Solutions; data compiled from a number of sources	"People with multiple chronic conditions have substantially more physician contacts and are more likely to be hospitalized each year than those with only one chronic condition. As the elderly age, they face an increased risk of having multiple chronic conditions."	C

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Using the Change Binder with OBQI

- Where and how to start—**key issue**
- Comprehensive Change Framework
 - Represents excellent system of care required to make transformational change
 - Not intended to do everything
 - Add strategies over time
- Issues not the same in every agency
- The OBQI process—along with some additional diagnostic tools—can help HHAs narrow their focus (p. 9)

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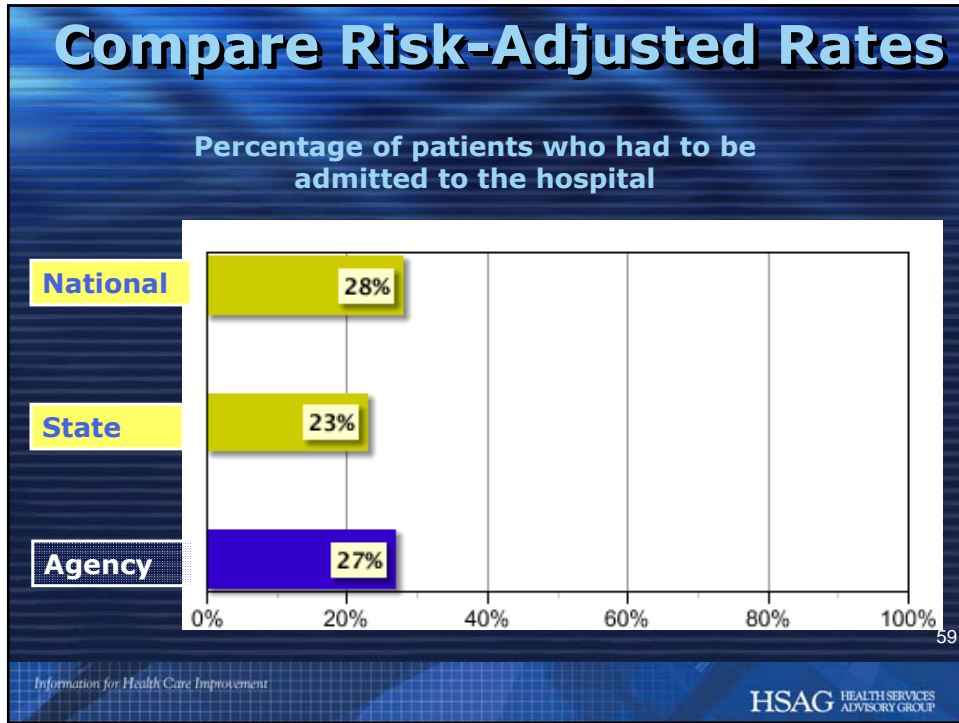
Interpret Outcome Reports and Specify Target Outcome

- Compare agency risk-adjusted rate to other agencies in state and other benchmarks (e.g., 23%)
 - Average rate is not necessarily the goal

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Review Case Mix Report

- Extend the review of the Case Mix Report to examine case mix differences between patients who are and are not hospitalized
 - Can help focus POCI
 - Excel-based tool or gather during POCI (sample p. 76)

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Investigate Care Processes

- Begin with an organizational assessment
 - Improvement Matrix checklist or survey (pg. 72)
 - Is the HHA fully implementing the change strategies?
 - Helps focus the POCI

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POCI

- Identify a list of "should be done" care processes
- Narrow the "should be done" list to the MOST IMPORTANT
- Develop a chart audit tool or clinician interview guide
- Randomly select up to 30 patient care episodes
- Review the care episodes
- Summarize findings

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Identify Problems/Strengths and Best Practices

- Identify the problem or strength
- Specific actions from the Change Framework can be considered for **clinical best practices**
 - Promoting patient self-management
 - Implementing evidence-based practices and guidelines

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Problem/Strength Statements

- Describe specific aspects of care that demonstrate inadequate care (or excellent care)
- Contain specific, concrete wording to which clinical staff can relate
- Address issues within the agency's control
- Focus on patient care delivery instead of documentation
- Contain a sufficiently narrow focus to keep a POA manageable

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Best Practice Statements

- Focus on specific clinical actions
- Relate directly to the target outcome
- Use specific, concrete wording to identify what the clinician should do and when and how to do it
- Focus on patient care delivery instead of documentation
- Address issues within the agency's control
- Adequately address the identified problem (or strength)

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Develop Action Plan

- Specific actions can be considered for **intervention activities** to implement clinical actions (best practices), especially system changes:
 - Using systems and technology.
 - Improving care delivery systems.
 - Creating a culture of quality.

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Intervention Actions

- What is to be done
- When it is to be done
- Who is responsible
- How action is to be monitored

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Strategy Combinations

- Identifying patients at risk and implementing actions to address the risk
- Disease management
- Transition from hospital to home health care

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Acute Care Hospitalization (ACH) Conference Call

Identifying Patients at Risk of Hospitalization <u>and</u> Implementing Actions to Address the Risk Factors	
Number	Description
A.2	Provide patients and caregivers with information and options to address immediate/urgent care needs
B.2	Use evidence-based risk assessment tools to identify high-risk patients <u>and</u> incorporate risk factors into individualized patient care plans
C.2	Implement systems to identify and track patients at increased risk for hospitalization and related problems
D.4	Match intensity of clinical resources and services to patient risks/conditions/problems as identified by risk assessment at individual patient level and staff caseload/population level

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Implement the Action Plan	
	<ul style="list-style-type: none">• Clinical staff informed• Responsible persons carry out intervention activities• Specified activities occur as planned

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Acute Care Hospitalization (ACH) Conference Call

Small Tests of Change

HOME HEALTH
the outcome-based quality improvement process

Plan a change
Do it on a small scale
Study the results
Act to refine the change as needed

IHI	OBQI POA
1. What are we trying to accomplish?	*Target outcome *Improve-Remediation *Strengthen-Reinforcement
2. How will we know that a change is an improvement?	*Monitoring activities *Evaluate impact on outcome
3. What changes can we make that will result in improvement?	*Clinical care behaviors/processes *Organizational intervention

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Monitor the Action Plan

- POA is a dynamic tool
- Monitor
 - Intervention actions occurred
 - Best practices used consistently
 - Outcome
- Measure outcome and process
 - Measurement strategy

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Acute Care Hospitalization (ACH)
Conference Call

POA

- Review Case Mix Analysis (if available)
- Complete Improvement Matrix Checklist
- Review results of POCI
- Begin drafting POA
 - Identify relevant actions from the Change Framework

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Next Steps



- Discuss with team
- Further Investigation?
- Finalize POA
- Implement POA
- Set target rate(s)
- Conduct small tests of change
- Measure and monitor
- Work collaboratively with the QIO and other HHAs

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Measurement of Improvement

7SoW

Statistically Significant Improvement (SSI)

- Disadvantage for small agencies
- Improvement without achieving SSI
- Impacted by prior year results

8SoW

Reduction in Failure Rate (RFR)

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Setting Target Rates

- Goal: reduce avoidable hospitalization
- Target rate provides goal to achieve
- Utilizing RFR
- Example
 - National rate is 23%
 - Current rate is 34.8%
 - Current – National = Failure Rate
 $\checkmark 34.8\% - 23\% = 11.8\%$

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For an ACH Failure Rate of 11.8%

Statewide Goal 30% RFR

- $11.8\% \text{ FR} \times 30\% \text{ Reduction Goal} = 3.5\%$
- $34.8\% \text{ (current rate)} - 3.5\% = 31.3\% \text{ Goal Rate}$

Participant Goal

- $11.8\% \text{ FR} \times 50\% \text{ Reduction Goal} = 5.9\%$
- $34.8\% \text{ (current rate)} - 5.9\% = 28.9\% \text{ Goal Rate}$
- Identified Participant Group (IPG) needs to maintain low ACH rate

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Equitable Method

- The percent of RFR the same for every agency
- Each agency—different amount to achieve
- Agencies with better outcomes, don't improve as much—the better the outcome score, the harder it is to move the rate
- Agencies with the worst scores expected to improve the most—the greater the FR the more room for improvement

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Focus on Publicly Reported Outcomes

9 Outcomes—Emergent Care Excluded

- Improvement in Ambulation/Locomotion
- Improvement in Bathing
- Improvement in Transferring
- Improvement in Management of Oral Medications
- Improvement in Pain Interfering with Activity
- Improvement in Dyspnea
- Improvement in Urinary Incontinence
- Improvement in Status of Surgical Wounds
- Discharge to Community

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Expectations—Clinical IPG

- POA on ACH
 - Use of Change Matrix
 - Incorporate into OBQI process
- POA on one additional measure
 - Statewide focus on Oral Medications
 - Use of *HH Compare* Measures

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Expectations—Culture Change and Systems Performance

- POA on ACH using Telehealth
 - Telehealth Reference Manual
 - OBQI Process
- POA on Culture Change
 - Survey results for agency
 - Continuous Quality Improvement (CQI) Process

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Culture Change POA

- Administer survey to staff—include “variety”
- Share results with HSAG
- Tabulate results—identify trends
- Focus on areas that require improvement—
apply CQI/OBQI techniques
- Develop a POA based upon changing culture
to support QI activities
- Submit POA to HSAG

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Influenza & Pneumococcal

- Assessment
- Follow-up/Interventions
 - Provide injection
 - Refer patient
 - ✓ Physician office
 - ✓ Clinic or "Fair", etc.
 - Document!!!



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HSAG Can Help

- POA development
- Respond to questions
- Tech support
- Conference calls
- On-site visits
- Face-to-face meetings
- Group interaction/work
- Education

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Acute Care Hospitalization (ACH)
Conference Call

HHA's Work

- Learn the processes
- Ask questions
- Meet deadlines
- Examine your agency processes—apply OBQI
- Collaborate with others
 - HHA
 - Health systems
 - Physicians

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Questions ?

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