

## Disease Management's Role In Reducing Hospitalizations

By: **Marian Essey**, RN, BSN, Director, Health Care Quality Improvement, Quality Insights Of Pennsylvania

### Home Health Quality Improvement (HHQI) National Campaign Update

The Home Health Quality Improvement National Campaign is led by the Quality Improvement Organization (QIO) Program, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services, and is guided by a group of national stakeholders, including Lisa Remington, Publisher of *The Remington Report*.

The year-long home health campaign to reduce avoidable hospitalizations will end in February 2008. At this time, approximately 40,000 visitors have accessed the campaign Web site at [www.homehealthquality.org](http://www.homehealthquality.org). During the first three business days of each month, 11,000 visitors go to the campaign Web site to obtain the newly released monthly Best Practice Intervention Package. A new Best Practice Package is available the first business day of each month.

The monthly Best Practice Intervention Packages contain tools and resources for the "best practice of the month." Each monthly best practice is a tool or technique to assist agencies in reducing avoidable hospitalizations and improving quality of care. With a monthly calendar of best practices located on the campaign Web site, agencies are encouraged to select best practices that their agencies would like to work on during the campaign. Not all agencies work on all best practices, but agencies are encouraged to become familiar with all best practices. Home health agencies should educate their clinicians on the best practices to reduce avoidable hospitalizations even if the agency is not aggressively working to implement a specific best practice. This will assure that all participating agencies will improve the quality of care provided to their patients.

Improving quality of care, as meas-

ured by the individual participants' reduction in their Acute Care Hospitalization rates, is the tangible measure of success for the campaign. The intangible measure of success has already been achieved in the commitment of over 5,000 home health agencies to rally around a national quality of care project.

### ACH Best Practice Series

This article is the sixth in a series that explores the key best practice strategies promoted by QIOs to assist home health agencies to reduce avoidable hospitalizations and improve their publicly reported ACH rates. This series complements the best practices that are highlighted in the HHQI National Campaign.

In the previous issues of *The Remington Report*, we looked at the best practices of hospitalization risk assessment, patient emergency planning, and physician relationships. In addition, the May/June 2007 edition explored project management as it applies to successfully implementing best practices or quality improvement initiatives. In this issue, we will explore disease management and ways that home health agencies can embark upon establishing a foundation for disease management prior to developing a full service disease management program.

### Disease Management: A Best Practice For Reducing Hospitalizations

Disease management is currently being used by many health care organizations as a mechanism to improve quality, increase efficiencies in care, improve patient safety and satisfaction, and reduce costs. Disease management has also been identified as a strategy to reduce avoidable hospitalizations. Although it is a best practice in the HHQI campaign, it is being highlighted near the end of the campaign, since implementation of disease management requires a significant invest-

ment of time, planning, and resources. For purposes of the campaign, it is not expected that an agency could implement a disease management program and have measurable results quickly. In this article, we will discuss how an agency can create a foundation for disease management. This discussion is for agencies that do not have a program or those that need to assess their existing program. Disease management is an important best practice in reducing avoidable hospitalizations with programs rapidly growing or expanding in all health care settings, especially managed care.






### Understanding Disease Management

A review of literature unveils many definitions for disease management. One of the most commonly cited definitions comes from the Disease Management Association of America: a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant (DMAA, 2007). When we think of disease management, there are some key concepts and challenges to keep in mind.

First, disease management is related to chronic illness. CHF and Diabetes are the two most common diagnoses that come to mind when disease management is discussed; however, the list of diagnoses is significant as disease management can pertain to ANY chronic condition. Second, it is quite common for patients with one chronic condition to have multiple chronic conditions; therefore a disease management program developed solely around CHF will service patients with not only CHF, but also diabetes, end stage renal disease, COPD, coronary artery disease, arthritis, etc. Third, disease management relies upon evidence-based care and protocols and differentiates  
*(more on page 40)*

**Table 1 DISEASE MANAGEMENT TOOLBOX**

Tools to Create a Foundation for a Disease Management Program

Actions	Interventions	Resources
 <p><b>Provide Clinician Education</b></p>	<ul style="list-style-type: none"> <li>■ Educate clinicians on current evidence-based clinical practice guidelines</li> <li>■ Educate clinicians in patient self-management</li> <li>■ Educate clinicians on chronic disease vs. acute disease management</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Helping Patients Manage Their Chronic Conditions</b> (<a href="http://www.chcf.org/documents/chronic_disease/HelpingPatientsManageTheirChronicConditions.pdf">www.chcf.org/documents/chronic_disease/HelpingPatientsManageTheirChronicConditions.pdf</a>)</li> <li>➤ <b>National Guideline Clearinghouse</b> (<a href="http://www.guideline.gov">www.guideline.gov</a>)</li> <li>➤ <b>The Chronic Care Model</b> (<a href="http://www.improvingchroniccare.org/">www.improvingchroniccare.org/</a>)</li> <li>➤ <b>ACC/AHA Guidelines for the Evaluation and Management of Heart Failure in the Adult</b> (<a href="http://circ.ahajournals.org/cgi/content/full/112/12/1825">http://circ.ahajournals.org/cgi/content/full/112/12/1825</a>)</li> </ul>
 <p><b>Build Collaborative Partnerships</b></p>	<ul style="list-style-type: none"> <li>■ Establish "partnering" relationships with the patient's care team: patient, caregivers, agency staff, physicians, etc.</li> <li>■ Expect clinicians to assist patients in shared decision making and action planning</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Organizational Self-Assessment Tool: Elements of Patient- and Family-Centered Care</b> (<a href="http://www.ihj.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/EmergingContent/PFCCOrgSelfAssess.htm">www.ihj.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/EmergingContent/PFCCOrgSelfAssess.htm</a>)</li> <li>➤ <b>Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System</b> (<a href="http://www.familycenteredcare.org/tools/downloads.html">www.familycenteredcare.org/tools/downloads.html</a>)</li> <li>➤ <b>Patients and Families as Advisors: A Checklist for Attitudes</b> (<a href="http://www.familycenteredcare.org/tools/downloads.html">www.familycenteredcare.org/tools/downloads.html</a>)</li> </ul>
 <p><b>Engage &amp; Motivate Patients</b></p>	<ul style="list-style-type: none"> <li>■ Assist patients in creating their own goals</li> <li>■ Include patients and caregivers in care planning; focus care plans around the problems or goals that are important to the patient</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>My Shared Care Plan</b> (<a href="http://www.sharedcareplan.org">www.sharedcareplan.org</a>)</li> <li>➤ <b>Motivate Healthy Habits</b> (<a href="http://www.ihj.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/Tools/DecisionBalanceWorksheet.htm">www.ihj.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/Tools/DecisionBalanceWorksheet.htm</a>)</li> </ul>
 <p><b>Support Collaborative Self-Management</b></p>	<ul style="list-style-type: none"> <li>■ Provide self-management support by giving patients and caregivers the information, education, and resources, to help them deal with their illness</li> <li>■ Assist all patients to strengthen their competence and confidence to manage their condition, make informed decisions about care, and adopt healthy behaviors</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>New Health Partnerships Web site</b> (<a href="http://www.newhealthpartnerships.org">www.newhealthpartnerships.org</a>)</li> <li>➤ <b>Video: Techniques for Effective Patient Self-Management</b> (<a href="http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673">http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124673</a>)</li> <li>➤ <b>Symptom Log</b> (<a href="http://www.newhealthpartnerships.org/TopicTool.aspx">www.newhealthpartnerships.org/TopicTool.aspx</a>)</li> <li>➤ <b>Doc Talk Form</b> (<a href="http://www.newhealthpartnerships.org/TopicTool.aspx">www.newhealthpartnerships.org/TopicTool.aspx</a>)</li> </ul>
 <p><b>Optimize Remote Care/ Telehealth</b></p>	<ul style="list-style-type: none"> <li>■ Efficiently provide care by use of telephone interventions such as planned phone monitoring</li> <li>■ Use telemonitoring if available</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>Using Telephone Support to Manage Chronic Disease</b> (<a href="http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=111784">www.chcf.org/topics/chronicdisease/index.cfm?itemID=111784</a>)</li> <li>➤ <b>Frontloading and Phone Monitoring Best Practice Intervention Package</b> (<a href="http://www.homehealthquality.org">www.homehealthquality.org</a>)</li> </ul>

chronic care versus acute care. Many clinicians have received limited education in chronic disease management and may not be up-to-date on current evidence-based care guidelines. Think of the mix of staff at a home care agency. New hires from an acute care setting may be very knowledgeable of current care guidelines, but will probably have limited knowledge of chronic disease management. Conversely, seasoned, long-time home care staff may be highly skilled in chronic disease management, but may be somewhat challenged in their knowledge of current practice guidelines. Fourth, disease management requires that patients self-manage their chronic conditions. Although home health clinicians are experts in patient education, patient self-management education is another ball game, requiring exploration of patient needs and abilities and also providing support for successful change.

As disease management is well-known to the managed care industry, it's important to understand some of the terminology prior to discussing or marketing a disease management program with a managed care organization. First, a true disease management program, or a "full-service" disease management program MUST include the following six components:

1. Population identification processes;
2. Evidence-based practice guidelines;
3. Collaborative practice models to include physician and support-service providers;
4. Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance);
5. Process and outcomes measurement, evaluation, and management;
6. Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

Programs that do not contain all six components are considered disease management support services (DMAA, 2007).

**Preparing For Disease Management**

For those that have had little previous exposure to disease management concepts, the six components probably seem more than a little complicated. However, do

not despair if your agency would like to embark upon a formal disease management program. There are actions that can be taken to PREPARE for a disease management program without actually creating a program:

**Provide Clinician Education** – Provide education programs to clinical staff related to the chronic disease(s) that you may target. If you have no target, consider starting with CHF or Diabetes, since many ready-to-use resources are currently available. In addition, educate staff on self-care management and chronic disease management and the Chronic Care Model.

**Build Collaborative Partnerships** – Create a partnership with the patient, caregivers, physicians, and all health care providers to assure that care is patient-centered. In true disease management, the patient is the focus and will need to understand how to communicate with his or her health care providers and family members related to his or her problems. Home health agencies can adopt a model in which all patients are assisted in communicating their health needs and actively participate in decision-making.

**Engage And Motivate Patients** –

Successfully impacting chronic illness requires real work and dedication on the part of the patient, family, and caregivers. Home health agencies embarking upon disease management programs will need to have staff that can engage and motivate patients to set goals, work toward those goals, successfully change behaviors, and improve health.

**Support Collaborative Self-Management** – Patient self-management is a vital component of all disease management programs and can greatly impact quality of care for all patients. Home health agencies considering beginning disease management programs should prepare by educating staff on how to best support patients in self-management.

**Optimize Remote Care/Telehealth** – Generally, patients with chronic diseases require many more resources than patients with acute conditions. To assist in leveraging resources, agencies can begin by beginning or enhancing programs to provide remote care. A great example of this is with planned phone monitoring where patients receive telephone calls regularly from the agency to assess the patient, provide education, and offer support for self-management.

Table 1 lists resources to assist home health agencies create a foundation for a disease management program.

### Lift Off A Disease Management Program

Developing a disease management program takes a great deal of planning and education. The worksheet provided in Table 2 can assist in assessing an agency's readiness for beginning a program or assist in evaluating an existing program. As many home health agencies already have either a full-service disease management program in place, or have components of a disease management program fully operational, this worksheet can be helpful in assessing their program's compliance with the six components of disease management.

Although disease management is certainly not one of the simpler best practices in reducing avoidable hospitalization, it is an important tool to improve quality of care. Agencies that implement even a few of the components of disease management, or develop a foundation for a program, will raise the bar for the quality of care they provide. **RR**

References available upon request.

Table 2 Strategy	Quick Assessment	☺	☹	☑	Comments/Notes
		Yes/ HHA does this	No/ HHA does not do this	Action Item for Follow- up	
#1 – Identify Patient Population	a. If your HHA has a disease management program, are all staff aware of this program?				
	b. Have more staff than your special disease management "team" received education in the program?				
#2 – Create a Culture for Disease Management	a. Do you have trained experts in your HHA that support one or more specific chronic conditions?				
	b. If yes, do all staff consistently turn to these experts prior to making physician contacts or changing the plan of care?				
#3 – Educate on Evidence-Based Practices	a. Have you sent your clinical experts to training outside your organization to keep them up to date with current practice guidelines?				
	b. Have you recognized your experts as clinical leaders for disease management in your organization?				
#4 – Establish a Collaborative Practice Model	a. Does your HHA routinely update and collaborate with all providers on the patient's care team?				
	b. Does your HHA have an easy and effective rapport with your managed care organizations?				
#5 – Educate STAFF on Patient Self-Care Management	a. Does your HHA provide education to staff on HOW to educate patients and WHAT to educate patients?				
	b. Does your HHA clinical staff expect your patients to become independent in self-care management? Or do you expect to have revolving door patients?				