Heartland Home Care Uses Successful Model for Coordinating Client Care

Heartland Home Care, in Roseville, MN, provides care to more than 400 home care and hospice clients, and keeps its rates for acute care hospitalizations low. Dr. Ed Ratner, Heartland medical director, attributes this achievement to a successful model for coordinating care as clients transition from hospital to home care, including attention to assessment at admission, having a strong interdisciplinary team, and clinical education.

Assessment integrated into admission process
Heartland customized a risk assessment tool provided by the national Home Health Quality Improvement campaign, and integrated it into its admission assessment process to improve client transition from hospital to home care. Dr. Ratner describes a thorough intake process, “We’re touching on all areas that indicate a client might be at high risk for rehospitalization—the same areas hospitals look at. Rather than having to handle another sheet of paper, we integrated the risk assessment tool into our admission process.”

Strong interdisciplinary team
Heartland has a strong interdisciplinary team that includes nurses, rehabilitation therapists, full time social workers, dieticians, and a medical director. Weekly case conferences promote collaboration and the addition of staff, such as therapists or social workers, who are not necessarily ordered on admission. The team also routinely considers whether clients are eligible for hospice.

Focus on clinical education
Clinical education is key to good care transition. Heartland provides clinical education specific to particular diseases, such as congestive heart failure and chronic obstructive pulmonary disease. The team develops protocols according to guidelines, focuses on the interventions, and provides self-care management education for patients that are high-risk for hospitalization. Patient education focuses on factors that exacerbate the disease, such as providing weight gain parameters and monitoring weight for patients with congestive heart failure.

Dr. Ratner says, “We attribute a lot of our success to strong staff development and an OASIS (Outcome and Assessment Information Set) education program for all of our clinicians, focusing on how to assess and answer OASIS questions on admission. Initial orientation and annual refreshers have helped improve accuracy of OASIS coding, leading to optimal care plans, and ultimately, better outcomes for patients.” Heartland’s multi-pronged approach exemplifies a successful process for helping clients as they transition from the hospital setting to home care, and has resulted in a continually declining rate of rehospitalizations—well below the state average.

Material for this article was provided by Deb Blanz, Heartland Home Care quality improvement manager.
**Update on the QIO Contract**

Stratis Health support under current QIO contract continues through July 2008

As the Medicare Quality Improvement Organization (QIO) for Minnesota, Stratis Health has provided support to home health agencies in our state on Outcome Based Quality Improvement (OBQI) for the past six years. Stratis Health has worked with agencies to implement the OBQI model to improve care and outcome measures, and has supported agency improvement efforts focusing on reducing avoidable hospitalizations, managing oral medications, promoting influenza and pneumococcal immunization, and promoting use of telehealth technologies. A targeted group of agencies in the Minnesota Home Health Collaborative, as well as agencies statewide, demonstrated improvement in these areas. Stratis Health will continue to support agencies on these topics through July 2008, when our current contract with the Centers for Medicare & Medicaid Services (CMS) ends.

Continue to contact Kelly or Janelle for resources on these topics, and watch our regular communications for tools, resources, and educational opportunities.

**New QIO contract different from current work**

Stratis Health has received the CMS request for proposal for the Medicare QIO ninth scope of work, which runs from August 1, 2008, through July 31, 2011. The work outlined in the RFP is quite different from our current QIO work. CMS has organized the work into three core themes: 1) beneficiary protection (focus on case review of complaints, denials, certain notices), 2) patient safety (focus on hospitals and nursing homes), and 3) prevention (focus on clinics), and two potential projects (improving care coordination across settings of care and preventing and improving care management for chronic kidney disease). Stratis Health is developing a proposal for the core themes and the optional projects.

This work offers a limited amount of support for home health quality improvement initiatives, mostly in the areas of Medicare beneficiary protection through case review and patient safety related to Methicillin resistant Staphylococcus aureus (MRSA) and prescription drug therapy. If an optional project in improving coordination of care across settings of care is awarded to Minnesota, that project would involve the home health agencies in one larger community. For more details on the 9SOW, contact Kelly or Janelle.

**More Minnesota Home Health Agencies Are Assessing for Immunizations**

Stratis Health conducted a survey of Minnesota Medicare-certified home health agencies in summer/fall 2007 to determine how many agencies had integrated immunization assessment for influenza and pneumococcal disease into their comprehensive assessment, how many administered the immunizations, and how many conducted follow up activities. Since the initial survey, the rate of agencies assessing for immunizations has increased from 50% to 86%—a great improvement!

**Free Resources Still Available as HHQI Campaign Ends**

Nearly 5,600 Medicare-certified home health agencies participated in the national year-long Home Health Quality Improvement campaign (HHQI) to reduce avoidable hospitalizations. Although the campaign ended in February, all the best practice tools and guidelines are still available to download and use, free of charge, at [www.medqic.org](http://www.medqic.org).

The best practice intervention packages provided during the last three month’s of the campaign offer strategies, tools, and decision support guides for managing patients with chronic diseases (Disease Management); empowering patients with chronic conditions to take a more active role in their own care (Patient Self-Management); and ensuring appropriate coordination of care as a patient moves from one level of care or setting of care to another (Transitional Care Coordination).

HHQI tools offer an interdisciplinary approach for home health and hospital staff. Tools targeted to leadership, nurses, rehabilitation therapists, social workers, and home health aides offer education and suggestions on how to use the resources. Focus and coordinate your quality improvement efforts by customizing the HHQI tools for your agency and integrating them into your current practices.

**Mentors Offer Meaningful, Expert Help to Their Home Health Peers**

In June 2007, Stratis Health initiated the Home Health Quality Mentoring Pilot Program for the 62 agencies in the Minnesota Home Health Collaborative. This program provided an

(continued on page 3)
opportunity for agencies to share knowledge and strategies with their peers to help them improve outcome rates for acute care hospitalization and/or oral medication management.

Stratis Health provided agencies that wanted to improve outcomes with the opportunity to connect with an agency that had already been successful in that area. Agency staff had the opportunity to network with other professionals across agencies, share common challenges and successes, and work collaboratively to learn new ways to solve problems and improve outcomes. Mentors shared tools, resources, plans of action, and strategies that had been successful for them. Mentees welcomed the opportunity to gain additional knowledge and tools.

Mentor Nancy Deiter, of Cokato Manor Home Health in Cokato, MN, enjoyed talking with mentee, Mary Ann Smith, from Ely Bloomenson Community Hospital and Home Care, in Ely, MN. Deiter shared information and tools with her mentee that have been successful for Cokato Manor, including its falls risk assessment and emergent care assessment. Cokato’s emergent care tool helped decrease its acute care hospitalization rate by ensuring that emergent care was being used appropriately. The tool helped establish a mindset among nurses to help the client pick the most appropriate type of care rather than to automatically transfer the client to the hospital.

Smith liked the concept of the mentoring program and especially appreciated her mentor’s advice regarding medication management. “Nancy shared examples of key questions her staff ask clients to get at the heart of medication management problems (e.g., ‘Can you show me how you set up your medications?’) It was great to have the chance to ask Nancy questions and get helpful answers.”

Results of participant surveys showed that mentees especially appreciated the time, effort, and advice their mentors provided. They enjoyed networking and getting a new perspective from a peer agency. Both mentors and mentees said that given the opportunity, they would participate in a similar program.

Lessons learned from this pilot program will be used to inform future mentoring relationships. 

Evidence-Based Practices and Agency Characteristics Linked to Better Medication Management Rates

In 2007, Stratis Health surveyed 204 Minnesota Medicare-certified home health agencies to determine if evidence-based practices and agency characteristics were associated with better rates for the OBQI outcome, improvement in management of oral medications. Survey findings suggest that there is a link. Of the 204 agencies surveyed, 65% (133 agencies) responded.

Prompting the survey was the fact that the Minnesota rate for oral medication management has been consistently lower (worse) than the national average ever since the rates were first publicly reported. Also notable is the fact that to date, no published research has been found that shows how to improve this outcome.

The findings of this medication survey could be particularly helpful for Minnesota agencies because home health staff play such an important role in helping patients manage their medications. Based on the findings, agencies may consider implementing the following evidence-based practices and working intentionally on improving this outcome.

Evidence-based practices:

- Telephone follow-up regarding medications
- Repeated patient education on medication management
- Reminder strategies (e.g., use of alarm clocks, locating medications strategically, notes on doors)
- Medication simplification strategies:
  - remove or discard old and expired medications
  - use a single pharmacy for each patient
  - use non-drug alternatives so that fewer medications are prescribed
  - coordinate doses with client’s established daily routines
  - use long-acting/sustained-release alternatives to reduce number of medications
  - decrease multiple medications for a single health condition
  - discontinue or substitute cautionary medications

Agency characteristics:

- Part of a health care system
- Non-profit
- Hospital-based
- In a network that focuses on quality
- Intentionally worked to improve the oral medication management outcome
Stratis Health is a non-profit organization that leads collaboration and innovation in health care quality, and serves as a trusted expert in facilitating improvement for people and communities.

1-877-STRATIS

Stratis Health is a non-profit organization that leads collaboration and innovation in health care quality, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health OBQI Contacts

Kelly O’Neill, RN, BSN, MPA, CPHQ
952-853-8507
koneill@stratishealth.org

Janelle Shearer, RN, BSN, MA, CPHQ
952-853-8553
jshearer@stratishealth.org

Amy Heikkinen, BA, CPHQ
952-853-8547
aheikkinen@stratishealth.org


Fax: 952-853-8503
www.stratishealth.org