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Collaborative Learning for Home Health Providers Results in Improvements to Care

Improving quality performance in home health care

SUMMARY

From 2001 to 2007, project staff at the Center for Home Care Policy and Research engaged home health agencies in two different "learning collaboratives"—one small and the other large scale—aimed at improving patient care. A learning collaborative is a structured initiative where providers from various organizations work together to improve a common process of care by sharing experiences and best practices.

Project staff also hosted two conferences and commissioned papers synthesizing evidence-based knowledge on critical issues related to quality and performance in the home health setting.

Key Findings

Eight home care agencies participating in the 11-month-long Home Health Diabetes Learning Collaborative produced these changes in diabetes care:

- An increase of more than 50 percent of patients who received a comprehensive foot examination within 10 days of admission to home care. (People with diabetes are more prone to foot problems due to blood vessel and nerve damage caused by the disease.)
- An increase of 34 percent of patients whose medications were reviewed for contraindications.
- An increase of 42 percent of patients with individualized glycemic (blood sugar) control plans.
- An increase of 44 percent of patients testing their blood glucose according to their plans most or all of the time.
- An increase of 56 percent of patients receiving education about foot care.

More than 150 home health agencies participating in the Reducing Acute Care Hospitalization (ReACH) National Demonstration completed two waves of a learning

collaborative over a two-year period. The following changes for patients identified as at risk for acute care hospitalizations were produced in Wave II:

- Home care episodes resulting in acute care hospitalization decreased 7 percent.
- Patients with completed risk assessments increased 41 percent.
- Patients with customized care plans specific to their own risks increased 44 percent.
- Patients identified as at risk of acute hospitalizations decreased by eight percent.
- The average number of home care visits in the first two weeks to patients identified as at risk of hospitalization increased by 1.9 (6.8 to 8.7 visits).

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through an unsolicited grant of $1,514,231.

THE PROBLEM

Home health services include care provided by registered nurses, licensed practical nurses, therapists and other professionals, as well as personal care provided by paraprofessionals and home health aides. In 1996, home health care provided by freestanding home health agencies accounted for $38 billion or 4.2 percent of U.S. personal health care expenditures (*Health Affairs*, 17(1): 35—51, 1998).

Home health care is likely to remain a significant and growing part of the health care system, because of:

- The continued aging of the population.
- The increased capacity to provide high tech-care outside hospital walls.
- Consumer preferences for long-term care at home.
- The growing costs and increased awareness of the health risks associated with hospitalization.

There is a growing body of evidence-based knowledge on improving chronic care outcomes in various health care settings. But home health providers often are unclear about which part of the new knowledge applies to their work and how to put it into practice.

Learning collaboratives have emerged as a means for implementing existing knowledge and spreading innovation across institutions. Working through a collaborative, teams from a variety of health care organizations have come together to achieve notable improvements in a number of clinical areas, including diabetes, adverse drug events,

asthma and cancer care [IHI (Institute for Healthcare Improvement) white paper, 2003]. Such a model held promise for making improvements in the home health setting.

CONTEXT

In 2001, the year RWJF issued this grant to the Visiting Nurse Service of New York, the Foundation aimed to improve care and support for people with chronic health conditions. Chronic Health Conditions was one of four goal areas RWJF pursued that year. RWJF had chosen to focus on this goal because it was, according to the 2001 Annual Report, "long-term, not easily solved, yet ultimately will affect millions of Americans." Other grants issued in 2001 included:

- A $3.4-million project at Georgetown University to promote long-term care policy and debate.
- 14 grants nationwide under RWJF's *Improving Chronic Illness Care* national program.
- A $1.5-million grant to the National Association of State Units on Aging to promote consumer direction in home and community services.

THE PROJECT

The Center for Home Care Policy and Research is the research arm of the Visiting Nurse Service of New York. Its mission is to advance knowledge that will promote the delivery of high-quality, cost-effective care in the home and community.

The project team conducted this project, which they called the Effort for Quality Improvement and Performance in Home Health Care (EQUIP), to:

- Assess the current knowledge base for supporting home health care quality improvement.
- Develop a model of collaboration that would help bring that knowledge into practice in home health settings.

An initial 11-member national steering committee of experts representing research institutions, government agencies and providers was established to advise on the initiative and the first National Meeting. (See Appendix 1 for list of members.) As additional activities and collaborative projects were developed, additional experts were engaged. An advisory committee was established for the ReACH collaborative (see Appendix 2 for a list of members).

Developing the Collaboratives

In developing the collaborative model, the project team worked closely with another initiative of the Center for Home Care Policy and Research—the Partnership for Achieving Quality Homecare.

Funded by the Agency for Healthcare Research and Quality for $913,667, that initiative identified priorities for improvement and developed a toolkit of methods, tools and materials necessary to conduct a quality improvement effort based on the evidence. The EQUIP project team used these resources in conjunction with the resources from RWJF to develop the collaboratives.

The Home Health Diabetes Learning Collaborative

The project team developed and implemented an 11-month-long Home Health Diabetes Learning Collaborative to assess the practicality, viability and potential replicability of a small-scale model to make sustained, positive changes in the way home care is provided to diabetes patients.

The diabetes learning collaborative was based on the collaborative learning models developed by the Institute for Healthcare Improvement (IHI). IHI is a nonprofit organization that provides opportunities for health care practices to participate together in a structured process to improve the quality of care they deliver; details on their collaborative "Innovation Communities" are available online. See also Appendix 3 for more details on how the collaborative operated to change diabetes care.

The project team selected eight home care agencies of different sizes, locations and sponsorship to participate. The agencies had the following characteristics:

- They served predominantly urban and suburban areas in seven states around the country.
- Seven were nonprofit; one was for profit.
- Five were freestanding agencies; two were freestanding agencies within health care networks; one was a hospital-based agency.
- Diabetic patients represented slightly more than 25 percent of the total annual patient census.

The ReACH Collaborative

As the Home Health Diabetes Learning Collaborative was coming to a close, the project team was contracted by the Easton, Md.-based Delmarva Healthcare Foundation, a nonprofit organization helping to facilitate quality improvements in health care, to

develop a comprehensive change framework, a corresponding measurement strategy and a toolkit for reducing acute care hospitalization among home care patients.

The effort led to an unexpected opportunity to develop, implement and assess a second model learning collaborative: a two-year Reducing Acute Care Hospitalization (ReACH) National Demonstration Collaborative.

The project team recruited Quality Improvement Organizations (QIOs) as active members of the collaboratives. The QIOs then recruited agencies from their states and assisted them in making improvement changes.

The collaborative was deployed in two waves, each a year long, with the second wave applying lessons learned in the first. Some 157 home health agencies participated in the collaborative. See Appendix 4 for details about how the collaborative operated.

Communications

The project team produced and/or commissioned 19 articles related to the project, one book chapter and two reports. In addition, team members made six presentations at conferences sponsored by professional organizations.

A Web page within the Center for Home Care Policy and Research's website provided a project summary and facilitated public access to products produced during the project, including executive summaries of commissioned papers and a policy brief.

RESULTS

- **Project staff convened two conferences to focus attention on critical quality and performance issues and identify strategic priorities.** Representatives from home health care agencies, home care regulation and accreditation organizations, industry associations, consumer groups and nurse educators attended.
  - The 2003 National Meeting, held June 30 to July 1 in New York, drew 57 participants. Informed by a series of commissioned papers, discussions produced a set of six broad aims for charting and improving the course of home care quality, as well as a set of action steps to achieve those aims. The six aims included:
    - Improving and developing the home health knowledge base.
    - Infusing all aspects of home care management and delivery with the best available evidence and information.
    - Engaging patients, caregivers and their physicians as partners in care.
    - Empowering middle managers and frontline staff at home health agencies.

- Supporting continuous collaborative learning and teaching.
- Continuously advocating for quality.

— The 2005 National Meeting, held March 31 to April 1 in New York, drew some 80 participants. Informed by commissioned papers, discussions focused chiefly on the following topics:

- Improving the functioning of home health patients.
- Care during transitions for patients between hospital and home.
- Pain management for home health patients.
- Knowledge transfer and utilization for the field of home health care.
- Organizational culture in the home health industry.

- **Project staff commissioned 11 synthesis papers that they used to guide the deliberations at each of the national meetings.** The papers, written by prominent quality experts, were published chiefly in the May/June 2004 and January/February 2006 issues of *Journal for Healthcare Quality*.

  Topics included:

  — The evidence base for improvement of care for the most prevalent home care conditions (e.g., heart failure, diabetes, depression, falls).

  — The adequacy of data used to measure home care quality.

  — The challenges to home care posed by the nursing shortage.

  — Reviews of evidence-based interventions to improve pain function, reduce hospitalizations and improve pain management.

  See the Bibliography for details.

FINDINGS

Home Health Diabetes Learning Collaborative

As reported in a 2005 article in *Home Healthcare Nurse* ("Improving the Delivery of Care for Diabetes Patients with Collaborative Model," 23(3): 177–182):

- **The agencies collectively recorded significant increases in the percent of patients receiving care associated with quality diabetes treatment:**

  — **50 percent increase in the proportion of patients with diabetes who received a comprehensive foot examination within 10 days of admission.**

- **34 percent improvement in patients' medications being reviewed for contraindications.**
- **42 percent improvement in patients having an individualized glycemic control plan.**
- **44 percent improvement in patients testing their blood glucose according to their plans most or all of the time.**
- **56 percent improvement in patients receiving education about foot care.**

- **Home health staff who participated in the collaborative viewed the following components of the model most positively:**
  - Getting the latest evidence about diabetes from experts.
  - Being able to interact with other agencies.
  - The measurement strategy for tracking goals.
  - The opportunity for front-line staff to focus on strengthening clinical skills.

  Members cited costs and overburdened staff as the main barriers to implementing and spreading changes, but said that the monthly coaching calls helped by providing the opportunity to brainstorm about these problems and to maintain momentum.

ReACH Collaborative

The project team reported the following findings to RWJF:

Wave I:

- **Home care episodes resulting in acute care hospitalization for the targeted group (i.e., patients at risk for acute hospitalization) decreased four percentage points (31.7 percent to 27.7 percent).**
- **Targeted patients with a completed risk assessment increased 46 percentage points (35 percent to 81 percent).**
- **Targeted patients with customized care plans specific to their own risks increased 50 percentage points (22 percent to 72 percent).**
- **Total patients in targeted group identified as at risk of hospitalization increased 17 percentage points in (27 percent to 44 percent).**
- **The average number of home care visits in the first two weeks for patients in the targeted group increased by 1.5 (6.6 to 8.1 visits).**
- **In addition, 71 percent of the home health agencies had begun to spread their improvements beyond their target population.**

Wave II:

- **Home care episodes resulting in acute care hospitalization for the targeted group decreased seven percentage points (36.2 percent to 28.8 percent).**
- **Targeted patients with completed risk assessments increased 41 percentage points (47.1 percent to 87.7 percent).**
- **Targeted patients with customized care plans specific to their own risks increased 44 percentage points (18.4 percent to 62.8 percent).**
- **Total patients in the targeted group identified as at risk of hospitalization decreased eight percentage points (56.6 percent to 48.3 percent).**
- **The average number of home care visits in the first two weeks for patients in the targeted group increased by 1.9 (6.8 to 8.7 visits).**

Strategies Used

- **The most commonly used ReACH improvement strategies in both waves included:**
  - Assessing patients' risk for acute hospitalizations.
  - Front-loading visits and increased contacts, including use of phone calls and telemedicine. (Front loading visits consists of providing more visits early after enrollment with the expectation that more frequent visits will not only increase symptom surveillance but also promote more intensive patient teaching.)
  - The creation of emergency plans and risk-appropriate plans of care.
  - Medication reconciliation, i.e., regimented, documented review to avoid drug errors.
  - Communication strategies, particularly the SBAR (Situation-Background-Assessment-Recommendation) technique, which provides a framework for communication among members of the health care team about a patient's condition.

LESSONS LEARNED

1. **Home care agencies respond positively to collaborative learning.** Historically, home care agencies are isolated from mainstream academic and professional initiatives, lack prior involvement in national "breakthrough" collaboratives and campaigns, and some agencies lack quality improvement specialists. The two collaboratives established under this initiative demonstrated the interest and ability of home care agencies to work together successfully in a virtual collaborative environment. (Principal Investigator/Feldman)

2. **Efficiencies are gained and resources are leveraged when QIOs are involved to recruit and manage participation of local home care agencies.** Development of "regional partnerships" helped to strengthen the QIO role in quality improvement in this area and improved the collaborative capacity to engage home care organizations at the local level. (Principal Investigator/Feldman)

3. **Standardize data collection for organizations participating in collaboratives.** The ReACH Collaborative reinforced the project team's conviction that standardized data collection can provide significant motivation for participants. It allows them not only to clearly gauge where they started and where they ended up, but also to compare their progress to that of other participants. (Principal Investigator/Feldman)

4. **Do not rely on challenging Internet technologies.** WebEx proved to be technologically challenging for many of the QIOs hosting local learning sessions. In some cases, it was easier just to post content to the project website for easy access. (Principal Investigator/Feldman)

AFTERWARD

- After conducting additional analysis of the data from the ReACH Collaborative, the project team plans to write and publish a peer-reviewed article covering the initiative.

- The project team encouraged ReACH participants to become part of the Home Health Quality Improvement National Campaign, launched by the Centers for Medicare & Medicaid Services (CMS) in January 2007. The 12-month campaign, which involved almost 5,600 Medicare-certified home health agencies, was designed to reduce avoidable hospitalizations.

  The quality improvement activities and tools that the campaign provided to the agencies—guidelines, success stories and best practice education—focused on a different topic each month. Topics included such things as medication management, immunization and patient self-management. According to the project director, most of the ReACH participants were active in the CMS campaign.

- The Agency for Healthcare Research and Quality provided a grant to Shoshanna Sofaer, Dr.P.H., of Baruch College of the City University of New York, to evaluate aspects of the ReACH Collaborative, focusing on the Wave II participants.

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APPENDIX 1

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APPENDIX 3

The Home Health Diabetes Learning Collaborative—Structure & Process

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Teams from the eight agencies engaged in continuous testing of changes designed to improve the quality of care for patients with diabetes using the "plan, do, study, act" rapid-cycle improvement method:

- Plan: set a plan for change and data collection strategy.
- Do: carry out the change, collect data and begin analysis.
- Study: analyze data and summarize findings.
- Act: make necessary changes and start the next cycle.

The improvement work proceeded in three stages:

- Pre-work: "homework" assigned to prepare participants for taking part in a collaborative.
- Learning sessions: face-to-face meetings that brought all participants together to learn from experts, share experiences and plan strategies for making changes in their own local settings.
- Action periods: time following each of the meetings during which the participants tested and retested the change strategies.

Project staff also provided participating agencies access to a variety of team supports, including face-to-face meetings, listserv communications, toolkit materials, monthly coaching calls and "ask the expert" calls.

In addition, the agencies established baseline statistics for each of the measures, set measurable targets, monitored progress through collection and analysis of patient chart data, and provided feedback to the project team on their experience participating in the collaborative.

Participating agencies implemented changes in three core areas of improvement:

Glycemic Control

- With the patient and/or caregiver, develop an individualized glycemic control plan for patients with diabetes.
  - Include frequency of blood glucose testing and target blood sugar levels (from physician orders) and actions to take for hypo/hyperglycemia.

- Monitor and document adherence to the plan.

Foot Care

- Administer a comprehensive foot examination upon admission.
  - Perform examination within 10 days of admission.
  - Perform a visual inspection and nursing vascular assessment (e.g., color, pulse, temperature).
  - Test for sensation of the feet.
- Develop a care plan for patients with insensitive feet.
- Provide a referral for podiatric care and/or additional home care visits for eligible patients.
- Teach patients and/or caregivers proper foot care.
  - Include instructions on how/how often to inspect the feet, foot hygiene, proper footwear and how/how often to check feet for sensation and circulation.

Medication Management

- Witness a successful return demonstration from patients with diabetes (or their caregivers) who use insulin.
- Review patient's prescribed medication for the presence of possible drug interactions for the presence of possible drug interactions or contraindicated medications.
- Prepare a list of all medications being taken by the patient and forward to the patient's primary care physician or specialist.
- Develop a plan for taking medications and track adherence.

Track and address reasons for missed dosages and other inappropriate use of diabetes medications.

APPENDIX 4

The ReACH Collaborative—Structure & Process

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The goal of the collaborative was to spread evidence-based strategies to reduce hospitalizations for all at-risk patients to the CMS-recommended goal of 23 percent or less by August 2007.

Key components of the ReACH Collaborative were:

- A national learning community that included monthly conference calls, WebEx learning sessions and access to a listserv and website. (WebEx is a Cisco Systems company that provides on-demand collaboration, online meeting, Web conferencing and video conferencing applications.)
- Local improvement assistance provided by the respective Quality Improvement Organizations (Q10s) under whose jurisdiction the home health agencies fell, including meetings, conference calls, site visits and technical assistance to individual agencies.
- Regional face-to-face meetings, hosted by the QIOs, which provided the opportunity for group discussions, exchange of information and collaborative learning among home health agencies.
- Targeted improvement strategies, with an emphasis on:
  - Identifying and managing patients at risk of hospitalization.
  - Strengthening care management.
  - Enhancing communication among the range of care providers.
- Standardized measures capturing processes and outcomes for reducing acute care hospitalizations. Measures included:
  - Percentage of home care episodes resulting in acute care hospitalization.
  - Percentage of patients with completed risk assessments.
  - Percentage of patients with customized care plans specific to their own risks.
  - Percentage of total patients identified as at risk of acute hospitalization.
  - Number of average home care visits in first two weeks for patients at-risk of hospitalization.
- A Web-based data collection and performance tracking system that allowed each agency to enter monthly data on specific measures and monitor progress in implementing change strategies and achieving desired outcomes.

The ReACH Collaborative unfolded in two waves.

Wave I started in September 2005 and lasted one year. Participants included 10 QIOs and 56 agencies. Quality Improvement Organizations recruited agencies from their jurisdictions, focusing on those agencies that had both a high rate of acute care hospitalizations and an interest in participating in the ReACH Collaborative.

Participating home health agencies ranged from small, independent agencies to very large network-based agencies. Agency teams had an average of two to six staff working on the ReACH collaborative, and 15 to 20 percent of all participating teams had agency leadership as active team members.

After Wave I was completed, the project team used interviews with staff from 17 of the agencies to inform recommendations for improving ReACH Collaboratives, which they incorporated in Wave II. The recommendations included:

- Better prepare agencies to participate in the collaborative by:
  - Providing simpler work instructions.
  - Clarifying expectations regarding agency time and resource commitment necessary for effective implementation.
- Sharpen the focus on leadership and staffing issues at the agency level by:
  - Emphasizing the importance of a high-level commitment.
  - Investing in staff training at the beginning of the project.
  - Ongoing efforts to gain staff buy-in and engagement.
- Provide more effective and efficient technical assistance at the local level by:
  - Encouraging and equipping the QIOs to help agencies develop and implement data collection and management systems.
  - Offering more "best practice" improvement strategies.
  - Organizing information sharing among agencies with similar characteristics (e.g., agency size, population mix).

Wave II started in October 2006 and included nine QIOs, three of whom participated in Wave I, and 101 new home care agencies.

APPENDIX 5

Glossary

Quality Improvement Organizations (QIOs): State-based private groups that contract with CMS to facilitate quality improvement of health care services provided to Medicare beneficiaries within their jurisdictions.

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