EXCELLENCE IN CARE: PARTNERSHIPS FOR BETTER OUTCOMES

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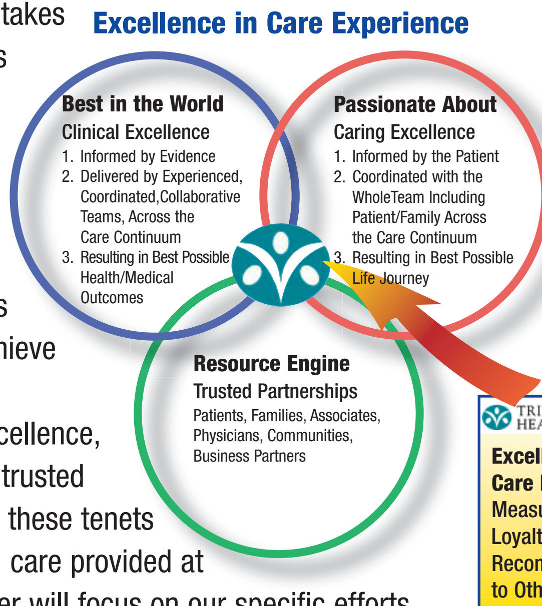
Purpose

At Trinity Home Health Services, we strive for increased client comfort and satisfaction that results in being recognized as a "trusted health partnership for life." We work by doing what it takes to exceed expectations of care by living our mission, vision and cause (see sidebar).



Our agency utilizes three key tenets to achieve excellence in the care experience: clinical excellence, caring excellence and trusted partnerships. Although these tenets guide all of the clinical care provided at our agencies, this paper will focus on our specific efforts for our ostomy population and the methodologies we used. We developed new tools, put key measurements in place and established strong partnerships to achieve positive patient outcomes.

Adapted from "Good to Great and the Social Sectors" Jim Collins, 2005

Trinity Home Health Services is a ministry organization of Trinity Health that consists of seven home care agencies and three hospices throughout Michigan and California.

- Our Mission: "We serve together in Trinity Health, in the spirit of the gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us."
- Our Vision: "Excellence in Care Experience"
- Our Cause: "Inspiring Care in our Communities"

Clinical Excellence

Informed by Evidence

Education promotes competency, confidence and personal commitment. Continuing education encourages and supports clinicians to learn and develop to their greatest capacity. Education provides the confidence for the nurse to be more creative, productive and satisfied with their work.

The key tools we developed to promote clinical excellence included:

- Ostomy Self-Study Guide: All clinicians must read the guide and score at least 80% on post-test before caring for ostomy clients. In this guide, we developed some of our own materials, but we also used existing educational tools available from our ostomy manufacturer partner (Hollister Incorporated). Examples are shown in Figure 1.
- Evidenced-based ostomy policy and procedure manual
- Ostomy product formulary
- Yearly clinical competency demonstrated via skills fair

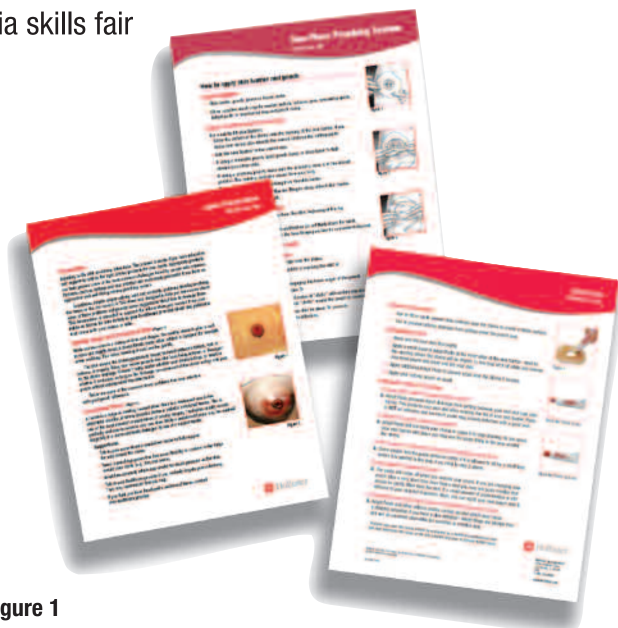


Figure 1

Coordinated, Collaborative Team across the Care Continuum

Patients and families define caring and healing environments as those in which they are actively involved in their own care. They need to feel as though they are seen as whole people, where they have established an individualized relationship with their healthcare providers throughout the continuum of care.

Methods used to enhance collaboration in the care continuum included:

- Coordination with hospital CWOCN to implement an ostomy program
- CWOCN/home care coordinator visit ostomy patients in hospital before discharge to explain home care experience to the patient and family
- Lunch-and-learn sessions with discharge planner in hospitals to educate about home care programs

ICD-9 V55	# of Episodes	# of Visits Episode	Case mix	Average Episode Length	Profit/Loss
Beginning of program 10/01/06 - 12/31/06	32	15.6	1.06	53.9	- $9,746
01/01/07 to 03/31/07	29	12.3	1.009	43.2	$982
04/01/07 to 06/31/07	29	16.2	1.115	53.1	- $1.274
07/01/07-09/30/07	24	15.3	1.132	51.5	$4,443
10/01/07-12/31/07	39	14.2	1.129	49.0	$6,390

Figure 2

Best Possible Quality Outcomes

As with other programs in our agencies, we track outcomes and measure the success of programs. Since the initiation of the **Secure Start** Discharge Program, we have seen improved patient and financial outcomes. Of note, in months when we demonstrated a loss on our ostomy cases, we could always correlate it to a lapse in the use of the Secure Start Discharge Program.

Our coordinated Ostomy Program has resulted in the following:

- Quarterly monitoring of clinical and financial outcomes of ostomy patients
- 100% goals met for finding "perfect pouching system" for new ostomy patients through use of the Secure Start Discharge Program (Hollister Incorporated)
- Number of ostomy referrals from physicians and hospitals have increased since the start of Ostomy Program
- Financial outcomes for our ostomy patient case mix have increased from a loss to profitability (Figure 2)
- Quality Assurance monitoring tool to assure that all patients are enrolled in the Secure Start Discharge Program

Caring Excellence

Informed by the Patient

When patients and families are informed about their illness and are actively involved in their plan of care, they feel involved and confident in their care. Education allows activities of care to be organized around the needs and priorities of the patient and their family.

The key tools and services we utilize to promote caring excellence include:

- Educational booklet that helps our patients develop skills and routines to manage their lives and resume the lifestyle that they want
- Patient education handbook
- Ongoing CWOCN support

Moments of Excellence

The home care CWOCN was finally ready to discharge a patient from an extended care facility to their home. The client was crying that she was not going to be visited by this nurse anymore because his visits were the "highlight of her day." The nurse had worked with this patient and her daughter to make them comfortable with caring for her permanent colostomy. The CWOCN assured the family that if they had any concerns they could contact him at any time through the home care on-call system even after discharge.

Coordinated Team Effort with Focus on Client/Caregiver

A coordinated effort facilitates a seamless transition from hospital to home care to DME supplier utilizing ostomy program.

Methods used to enhance caring excellence include:

- Home care coordinator/CWOCN visit in hospital before discharge to home care
- Home care transition to community with DME supply orders placed before discharge
- Availability to consult with CWOCN after discharge with Secure Start Discharge Program to enhance patient satisfaction through continuum of care

Moments of Excellence

A 77-year-old housewife had a urostomy for three years as a result of many years of pain and suffering from interstitial cystitis. When the patient came home from the hospital, she received regular home care visits by the CWOCN for a few weeks until she was independent with her urostomy care. During the next three years, her abdominal contours changed from weight loss. She began to develop peristomal macerations and partial-thickness ulceration as a result of excessive moisture from urine brought on by urine leakage. During her urologist evaluation, the CWOCN was contacted to evaluate this patient at home. She was instructed on the need for more frequent skin barrier changes and ways to acidify her urine. She was enrolled in the Secure Start Discharge Program to obtain sample pouches and accessory products to find the "perfect pouching system" for her at this time. During the following weeks, she was contacted by her Secure Start Coordinator, the CWOCN, and a DME supplier who were able to provide her with valuable information about her supplies. Upon discharge from home care, she was fully healed and was quite complimentary about the services that she had received from home care and the follow up from their Secure Start Coordinator.

Best Possible Life Journey

A healing relationship is created when care is provided while maintaining the patient and family as the central focus and knowing that each person's unique life story will determine how he/she will experience an illness. This caring relationship conveys respect and personal concern for the patient, and understands what is most important for this patient and their family, while safeguarding the dignity and well-being and actively engaging them in all aspects of care.

Moments of Excellence

Mrs. H is a 72-year-old housewife and a recluse because of obesity and a meek personality. She has only left her home a couple times a year for the past six years. She was emergently hospitalized for perforated diverticulitis that resulted in the creation of a diverting colostomy. The home care CWOCN was contacted to see this patient in acute care to discuss ostomy care and home care management following her surgery. Upon discharge from the hospital, she was transferred to an ECF for rehabilitation. During this time, her stoma recessed. This made pouching difficult and resulted in numerous skin barrier changes and leakage that caused frustration to the patient and nursing staff. The home care CWOCN who had seen the patient in the hospital was called into the ECF to consult. She was able to make the necessary pouching changes, enabling this lady to have an improved quality of life with fewer pouch changes, healing of eroded peristomal skin and improved confidence. Upon her return home, the same CWOCN was called for the referral for wound and ostomy management. At first, the client was nervous about having a man come into the privacy of her home and looking at her abdomen. Mrs. H was immediately at ease by the CWOCN's calm, professional caring demeanor. She soon looked forward to the home visits. The nurse worked closely with Mrs. H's elderly, attentive 76-year-old husband, ensuring he was comfortable with the pouching changes. Within a few weeks, he was completely comfortable with the required care and independent management of her ostomy. After successful healing of a significant midline abdominal incisional wound, she was discharged from home. Following discharge, the CWOCN received a passionate thank-you note from the family detailing the gratefulness for the special services provided by the agency and the CWOCN. The note specifically highlighted how Mrs. H went from fearing a male stranger entering her home to developing a close, trusting relationship.

Clinical Excellence

Caring Excellence

Trusted Partnerships

Trusted Partnerships

Community Benefit

Community benefit is a planned, managed, organized and measured approach to a healthcare organization's participation in meeting identified community health needs. It implies collaboration with a "community" to "benefit" its residents–particularly the poor, minorities and other underserved groups–by improving health status and quality of life.

> ***Moments of Excellence***
>
> *Over the past two years, the CWOCN from Muskegon had identified a need in the community to visit ostomy patients in their home for troubleshooting of pouching issues, leaking, etc. from referrals received through community resources. These patients had immediate needs, but not the resources to improve their quality of life. Most of these patients were not homebound so they did not qualify for home care. Each patient began the Secure Start Discharge Program knowing that they would receive follow-up after the CWOCN's one visit. Different product samples are invaluable to a patient who has no idea what types of product are available to them. Each and every patient was extremely grateful for this unique service.*

Business Partners

As a healthcare provider, we collaborate with business partners with the objective of improving our quality of service for our patients. The Secure Start Discharge Program is one example where we have been able to successfully accomplish this. An article was published as a result of our successful collaboration with this program in our quarterly GPO magazine, *The Source*. (Figure 3)

THE SOURCE

IMPROVEMENTS IN Ostomy Management in the Continuum of Care

Figure 3: Article published on our collaborative approach to ostomy care

Family, Physician, Associates

As a result of our continued focus on the needs of the ostomy patient, we have seen an increased number of physician referrals for the CWOCN. We also have documented a number of positive comments about the ostomy program from families, physicians and other colleagues.

Moments of Excellence

- In hospital, a surgeon placed an order in the chart that the home care CWOCN be called to meet him the next day in the patient's room, so the patient's plan of care could be discussed with CWOCN. The nurse went to physician's office with the patient to discuss plan of care. While there, the physician had CWOCN consult with another patient while in office.
- Comments from patients that physicians have made about nursing staff, such as "the doctor thinks you are the best," and another doctor told their patient to "do whatever the nurse wants you to do because he knows what he is doing."
- Associates call the CWOCN, "doctor" out of respect because he is so helpful with troubleshooting and education during the skills fair, nurses' meeting and for consultation.

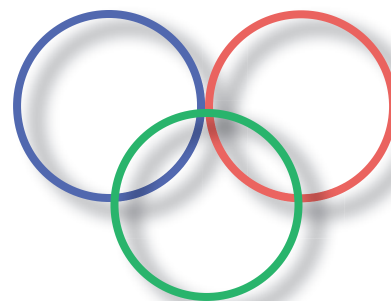
Conclusion

Excellence in care occurs when one human being connects to another. A healing relationship is created when compassion and care are conveyed through touch, a kind act, through competent clinical interventions or through listening and seeking to understand the other's experience.

Through a successful partnership and a defined plan, we were able to document a reduction in our visits per episode and an improvement in our financial outcomes. In addition, we demonstrated increased patient satisfaction through the selection of the correct pouching system and improved client education.

Our outcomes would have been difficult to achieve without a successful partnership. Our collaboration with the ostomy manufacturer and the Secure Start Discharge Program helped us to create a seamless transition through the continuum of care for our ostomy patients.

Excellence in Experience



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