Title: Impacting Diabetic Foot Care though Comprehensive Care Management in Home Health

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Text:
Diabetes is ranked second behind congestive heart failure as the primary diagnosis at entry into home care.

For patients with diabetes, Signature Health Services Home Health Nurses created
a goal to prevent new diabetic foot ulcers in >95% of all home health patients over a 3 year time period. Outcomes exceeded 97% during that time period. in addition a threshold of 99% was met when measured on how often the home health team got doctor's orders specific to care of the diabetic patient, how often the team provided comprehensive foot care, and how often team taught patients about foot care.

There are 11 components to the model of care that were applied to the diabetic patients who were admitted without diabetic foot wounds.

1)Comprehensive assessment by all disciplines ordered to see patient- inclusive of specific testing

2)Standardized collection of OASIS (The Outcome and Assessment Information Set) **items at specific times during the stay with home care**
(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions
(M2250) Plan of Care Synopsis:
monitoring for the presence of skin lesions on the lower extremities and patient/ caregiver education on proper foot care
M2401) Intervention Synopsis:
Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care

3)Complete access to diabetic educator-community based, insurance provided, on staff CDE, hospital based

4)Engagement with teaching tools (in native language) to be left in home and

regarded as "homework" for next discipline visit

5) Provision of glucometer in each patient home-provided for free or with insurance. insurance that all supplies to set up autoship. Nursing staff requires patient and caregiver to be independent in operation of glucometer within 2 visits.

6) HGA1C - Payor requires team insure labs drawn every 90 days while on service. Internal agency benchmark is to help pt to get below 5.7 percent

7)Implementation of templates/clinical pathways tailored to patient´s co morbidities as well

8)Support through RN case management model- each patient designated as RN who will provide OASIS collection as well as guide all care and coordination.

9) Provision of telehealth nursing for days between discipline visits

10) Referral in in home podiatrist´s service to maintain the nails and feet and present damage while patient is homebound.

11) Referral to visiting physician if patient´s PCP unable to manage remotely.

Preferred Presentation Type: No preference