AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

INSIDE

AUGUST 2000

VOL. 6, NO. 8
(pages 85-96)

Agency philosophy says outcomes measurements vital to clinical success

Tie outcomes studies to cost savings

It's not easy being a home care quality manager these days. Staff time and cost pressures have created an environment in which there's little time or enthusiasm for outcomes measurements and quality studies that are mandated.

Still, quality managers can do this type of research. It only has to be tied to actual work, says **Deeley Close Middleton**, RN, MS, senior director at Johns Hopkins Pediatrics at Home in Baltimore. The agency provides skilled services for pediatrics in central Maryland and durable medical equipment and infusion therapy for the state.

"Incorporate outcomes measurements in your pathway and make it automatic," she advises. "You have to make it inherent in the process, whether it's a clinical program or disease pathway that you've written."

For instance, if an agency has a disease pathway that establishes a process a patient should follow on each visit, then outcomes measurements can easily be tied to that pathway. The first step is to define what you're measuring, with what frequency you'll measure it, and how the data will be sorted and stored. For example, Johns Hopkins Pediatrics at Home tracks outcomes related to rehospitalization of the agency's new natal IV population. This directly relates to the agency's quality of care.

"You need to measure whether your action effected any change within the program you put together," Middleton says. "Are you

Clarification

The June 2000 issue of *Homecare Quality Management* references a series on discharge planning. The two-part series appeared in the April and June issues of *HQM*.

achieving what you are supposed to be doing?"

Middleton suggests quality managers make the most of their outcomes studies by incorporating these processes:

• **Catch trends early.** The pediatric agency tracks asthma patient outcomes. It tracks hospital days, following those around the asthma pathway. It records data about how many times patients return to the emergency department. If a trend appeared that patients have preventable emergency department visits, then the agency will go back and examine the pathway, perhaps making changes to improve the outcome, Middleton says.

Assess and improve

The asthma outcomes measurement also looks at the number of hospital days and readmissions. By tracking this data, the agency satisfies two goals: First, quality managers will know very quickly whether there are any problems with the asthma management program. Any unexplained spike in rehospitalizations or emergency department visits will result in an investigation. Second, the agency can present its positive outcomes to payers and others as proof that the asthma management program works.

• **Look for the root cause.** Quality managers need to find out why a particular trend is occurring. They need to make sure the outcomes measurements relate to the root cause of what the agency is trying to accomplish.

"Make sure what you're using to measure the outcomes trend is a true correlation," Middleton says. "If you're looking to change asthma behavior and supposing a child has 40 emergency department admissions, the analysis should show the true cause of the child's having a positive change in these admissions."

For example, the agency decided to provide an analysis of emergency department admissions of asthma patients because those are the biggest health care costs those patients face, particularly now that hospitalizations have been reduced due to managed care pressures.

Therefore, a good indicator that asthma patients are having trouble managing their disease would be an increase in emergency department visits. The root cause of poor asthma management could be measured indirectly through monitoring those visits.

• **Keep data aggregation clean.** The staff hired to aggregate the data may change, but this should not result in sloppy data compilation. That's why it is important for agencies to have specific data aggregation processes in place, so that everyone who does this task will do so the same way.

"It should be a part of the clinical program, and it should be inherent in any company's clinical operations," Middleton says. "This is part of the performance improvement mission, so it's inherent and continuous."

Form partnership to collect data

One inexpensive way to collect and keep the best data is to form a partnership with another party. For example, Middleton's agency formed a partnership with Johns Hopkins Healthcare (JHH), which is a third-party administrator. JHH keeps records and collects data on all of the people it covers so the home care agency can develop outcomes projects with JHH that use those data. The projects can tie clinical data to financial data, Middleton says.

"If companies can partner with payers, you will really get some great results," she says.

• **Prepare presentation material.** Johns Hopkins Pediatrics at Home uses its quality projects in presentations to the agency's advisory committee board on a quarterly basis.

This gives board members a timely look at how the agency is doing with regards to its clinical outcomes before and after a new pathway has been implemented.

The agency also presents results to referring physicians, specialists, and case managers to show them the progress in patient care.

"That's also a way to use it as a marketing tool if you have good results," Middleton says.

Each quarter, the presentation focuses on a different outcomes project. One time it might be asthma management and the next time it could be neonatal care.

Also, board members, physicians, and others who hear those presentations are asked for their feedback on the processes. Then, their suggestions can be incorporated into pathways and care plans. ■

SOURCE

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HHA offers preventive care for flu, pneumonia

Program protects clients, caregivers, staff

Most often, home health agencies must be in a reactive mode, responding to patients' symptoms or changes in conditions. But one Wisconsin agency has undertaken a full-scale proactive effort to immunize its clients — and others — against influenza and pneumonia.

The result: Ministry Home Care of Marshfield, WI, has an 80% flu vaccination rate, says **Dorothy Flees**, MSN, RN-CS, quality improvement and staff education coordinator.

"I often hear in home care that we're primarily here to do acute and chronic care, and we have so little opportunity to do preventive care," Flees says. "This is really one avenue where, as a home care provider, we could do preventive care."

Ministry Home Care carefully tracks participation in the immunization program, and refines it each year to serve new populations and better understand the factors driving patients' decisions to get vaccinated. One vital piece of the program is reimbursement, Flees says, noting that Medicare Part B covers both influenza and pneumococcal vaccines in home care.

Ministry Home Care's immunization program began in 1996, when it was a single-site agency. Now Ministry has grown to a corporation that includes three home health agencies — Saint Joseph's Hospital Home Health in Marshfield, Sacred Heart-Saint Mary's Home Health and Hospice in Rhinelander, and Saint Michael's Home Health Center in Stevens Point — and two hospice agencies.

Fall 1999 was the first flu season in which the flu and pneumonia immunizations were offered at all of the agencies.

"It's been kind of interesting trying to look at data from a small number of staff compared to a whole corporation," Flees says.

Infection tracking leads to program

The Atlanta-based Centers for Disease Control and Prevention (CDC) has targeted a number of groups as being at high risk for complications from influenza **(see box, p. 88)**. Among them are those ages 50 and older, those with chronic medical conditions such as cardiovascular disorders or diabetes, and people taking immunosuppressant drugs — in short, a large part of the home health population.

Healthy People 2000, a federally led national health initiative, has set a goal of having 90% of all people ages 65 and older get flu and pneumonia vaccinations by 2010.

Flees says the impetus for Ministry's immunization program came from data collected on pneumonia in the agency's elderly population. She says the agency wanted to know more than simply how many cases were out there.

"We tried to pin down some of the causes to that. When did they occur, whether it was the typical flu season of October to March, or were they more physical-type pneumonias from swallowing disorders and so on," she says. "As a result of that program we thought we really should try to perfect a preventative program."

Physician OK required

Prior to the immunization program, Ministry's nurses simply administered vaccinations when physicians ordered them. They still wait for physicians' orders, even though they're only required for pneumococcal vaccines. Flu vaccines technically can be administered without an order, Flees says. "We don't just go ahead and give the flu vaccine because the patient requests it. We still call the physician and say, 'So-and-so would like to have a flu vaccine; is that OK with you?' and then we go ahead and give the vaccine."

Flu shots are offered to all of the agency's adult population, Flees says. Previously, Ministry Home Care had refrained from attempting to vaccinate children because they required a different vaccine formula. Those patients were instead referred to their physicians to be vaccinated.

She says this past flu season was the first time the agency was offered a vaccine that would have worked for younger patients."We really went with the recommendations that are out there for the influenza vaccine — any person because of age or underlying medical condition who is at increased risk for complications of influenza."

Although both flu and pneumonia vaccines are offered, participation in the pneumonia program is much lower — 13% to 20%, as opposed to the 80% who get the flu shot. Flees says the difference is due to different criteria for who gets the pneumococcal vaccine. Here's how the program works:

CDC recommends flu shots for specific groups

The Atlanta-based Centers for Disease Control and Prevention recommends influenza vaccinations for the following groups who are at increased risk for complications of influenza:

- people ages 50 and older;
- residents of nursing homes and other chronic care facilities that house people with chronic medical conditions;
- adults and children with chronic disorders of the pulmonary or cardiovascular systems, including asthma;
- adults and children who have received care in the previous year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medication);
- children and teens who are receiving long-term aspirin therapy and may be at risk for developing Reye's syndrome;
- women who will be in the second or third trimester of pregnancy during the flu season.

The CDC also recommends vaccinations for health care personnel, nursing home employees, and household members of people in high-risk groups. For more information, check out the following Web sites:

- **www.cdc.gov/ncidod/diseases/flu/fluvac.htm** — CDC's vaccination site.
- **www.healthypeople.gov** — Healthy People 2000, which lists immunization goals for 2010. ■

At the start of the flu season — basically, whenever the agency gets its yearly supply of the flu vaccine — nurses are told to begin asking patients if they want to receive vaccinations.

The nurses carry tracking reports that note the name of each patient, where he or she received a vaccination (at a home health agency, physician's office, clinic, or other program), or the reason the patient gave for not getting vaccinated.

Flees says those who refuse the shots tend to fall into a few main groups:

• **Patients who don't think they're at risk for flu or pneumonia.** "They say, 'I never had the flu; so why would I want to have a shot?' They think they're not at risk," Flees says. She adds that nurses bring along education sheets from CDC that explain the rationale for getting immunized.

• **Patients who fear they'll get the flu from the shot, or are worried about other side effects.**

"Some people had [the flu vaccine] back in the days when the vaccines were first given and they recall becoming quite ill," Flees says. "Or they don't want the muscle soreness or they don't like some of the side effects they get from the flu vaccine."

She says nurses explain that shots might cause a sort of "mini-flu" — a low-grade fever, some arm soreness — but not the full-blown illness.

• **Patients with physical barriers to vaccination, such as an allergy or an ailment that makes it a bad time to get vaccinated.** While it's important to explain to patients why the vaccinations are a good idea, ultimately the decision is up to the patient. "It's like anything else; you can try to get them to buy into it, you can educate, but you also have to respect their refusal," Flees says.

Normally, vaccinations are offered from October to December. In addition to making a sweep of current patients, the agency also offers it to new patients who begin care during the immunization season. A separate form similar to the tracking form is placed in the patient's file at admission. **(See tracking form and admission immunization record, inserted in this issue.)** It too, keeps track of where the patient might have gotten vaccinated or what reason he or she gave for refusing.

Outreach to others

As the program has matured, Ministry Home Care has begun offering shots to other at-risk populations. The first group targeted — at their own request — was at-home caregivers.

"For the first two years, we chose to only offer [vaccinations] to our patients," Flees says. "Then we had requests out there from spouses who sometimes are as homebound as patients."

Now, nurses offer the shots to the client and anyone else in the home. Next, the corporation offered shots to its own employees and began branching out to the community at large, holding some clinics at local churches and grocery stores.

"We didn't want to duplicate services somebody else is offering," Flees says. "We didn't want to compete with them. We wanted to be part of the continuum of care in the community, looking for places where we could fill a gap."

The tracking forms help identify those gaps, since they show where patients might be receiving vaccinations outside of home health. Those receiving shots who are not home health clients

are billed for the service either through their own insurance or by cash.

Flees eventually hopes to expand the program even further, setting up at large companies to make it easy for workers to get vaccinated. Agencies can be limited by the amount of vaccine they receive.

At Ministry, the first priority is the patients, then their caregivers. While providing shots for employees is important, Flees says they are more likely to have other outlets for getting vaccinated.

Tracking flu shot success

The agency did not keep track of the number of patients vaccinated prior to 1996, so Flees says she has no way of knowing how high participation was before the program began. But in the first year, flu vaccination participation was pegged at 61%, which includes patients vaccinated by home health nurses, as well as those who received their shots through some other source.

In 1997 and 1998, the rate was 80%, which Flees says actually tracked quite closely the rate of vaccinations communitywide. "We feel pretty fortunate to have hit that 80% acceptance rate," she says, attributing it in part to a greater awareness in a community with a large medical facility.

So far, there's no data showing whether the vaccination program has actually resulted in fewer flu cases among the clients who got the shots. Flees does hope to gather that data in the future, though. "I guess that's our dream for next year," she says.

Flees notes that even with high participation, agencies may have some years where flu rates aren't affected, since those creating the vaccine are guessing at which strain will be most prevalent that year. "That doesn't mean you aren't going to get the flu from some other strain that's out there — it's not a cure-all."

She says that one of the most cumbersome aspects of the vaccination program is the process to track it, requiring nurses to fill out forms with more and more detailed information. Every year, she refines those forms. Most recently, she added another category for patients who discontinue home care after the first few visits.

"We couldn't get caseload numbers to match the amount of information that came back from the staff," she says. "We learned that we didn't have anything on the form to say that this person was no longer seen after the day we started this flu vaccine, so [we] lost those numbers."

Flees says agencies have to decide how much information they need to gather. "We want to collect a lot of information so that we can make our program the best that it can be. It's really according to the perspective you want to take. If you simply want to give the vaccine and promote it as a healthy measure of preventative care, that's pretty simple.

"But you've still got to battle how you're going to get reimbursed. What is the success of the program? Is it cost-effective? We're trying to collect information to be able to tell that, to look at the difference that this made." Here are Flees' other tips to agencies beginning an immunization program:

- **Start early.** Flees says an agency needs two to three months' advance work to put a program in place. "Starting in September is too late," she warns.
- **Consider patient/client outcomes and benefits with each step of the process.**
- **Debrief at the end of each flu season.** What worked? What didn't? Were there missed opportunities? What are things that could be changed for next year?

Flees says she has no doubts that Ministry's program is improving patient health. "This is a patient outcome-oriented initiative," she says. "The way I look at it, you can't go wrong by doing it. You can only improve the quality of life and cut costs by doing something preventative." ■

SOURCE

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Improve your QI process, manage costs under PPS

Benchmarking partnerships offer solutions

If you want to know how to cut costs and improve a certain process or clinical service, your best bet might be to call someone who has already made the improvements. That is the theory behind a networking process or benchmarking partnership program.

The Healthcare Management Council Inc. in Lyme, NH, brings different health care organizations together, pairing them in partnerships that

give them an empowered approach to management. "We thought it'd be much better to put these folks together face-to-face so organizations that learn from one another are talking directly to one another and take out the middleman," says **Martha B. Tecca**, MBA, founding partner of The Healthcare Management Council.

"But we decided not to take out the ability to synthesize things that organizations can learn from one another, so we initiated a benchmarking partnership that includes an analysis of all the data collected from client organizations," she adds.

Participants provide their data to the partnership program and offer consultation on particular issues. "People who participate say, 'I'll give you data, and in addition to data, I'll be here to answer any questions you have about my organization,'" Tecca says. "'If you find out I have the most cost-effective admitting process, I'll be here to tell you how it works, the challenges I faced, and how to move to this new method.'"

Performance strategies

Tecca's role is to help managers ask better questions to find out specifics about any changes or new processes. The consulting firm has compiled and compared some of this information to formulate strategic ways health care companies can make performance improvements while remaining profitable.

Drawing on some of the strategies suggested by health care businesses involved benchmarking partnerships, Tecca offers these suggestions for how home care quality managers can improve quality while cutting costs:

1. Create a framework for performance improvement (PI) while cutting costs.

From the functional and clinical sides, this means quality managers need to implement a comprehensive assessment for data collection and data reporting. For the customer's benefit, they need to tie all PI work to diagnoses. And for the financial/administrative benefit, they need to manage costs of both direct care and business processes and grow the business to increase referrals and optimize contracts.

Perhaps the most important of these priorities is to manage costs, Tecca suggests. "Left to their own devices, home health agencies are going to give high-quality care because they go out there and do the best job they can to serve patients well," she says. "But, left to their own devices their care will be very expensive, so there are a lot of drivers in the industry to keep customer satisfaction high and quality high."

Typical business cost model

Tecca finds that a typical business cost-management model works well. On the top line of the model, an agency will calculate the average total cost per admission or per episode. Below that are two lines, one for direct costs and one for indirect costs. The direct costs are sorted by discipline, diagnosis, and home health-related group category. The indirect costs are sorted by business processes and support services, including human resources and scheduling.

Indirect costs are often referred to as "free money," because if a business can cut those, it will not affect patient care but will have an overall cost savings, especially under the prospective payment system (PPS), Tecca says. "If you make those nondirect care parts of your business as cost-effective as possible and service-oriented, you will increase business and decrease costs."

2. Devise strategies to cut indirect costs.

"First, you have to understand what you're doing by analyzing your own operation and business processes," Tecca says. She breaks the basic business processes into four categories, including:

• **Preadmission process.** This begins when the referral arrives, and it includes everything that occurs up to that first admission visit. Ask:

— Who receives the referral?

— What are the different ways referrals arrive, i.e., telephone, fax, e-mail?

— What is the disability level of the patient?

— What kind of information system exists to capture the patient's health information from the referral source?

— Who verifies insurance and notifies the nurse and team leader of the case?

— Who assigns the case to field staff?

— Who creates a medical record, reviews services with the family and patient, and determines which supplies are needed?

• **Admission process.** These costs are related to the staffing issue of how much experience and training is required to initiate the admission process. For instance, some agencies will use nurses and others will use clerks for much of the process.

Some questions to ask are:

— What new technologies would make this process easier and less labor-intensive?

— Who sends the nurse a notice of the

admission appointment?

— Who reviews the admission report, and does everyone who currently reviews it need to see it?

— Who develops a treatment plan?

— Who reviews services with the family and patient?

— Who completes and enters documentation?

— Who determines which supplies are needed?

— Who assigns other disciplines to the case?

It's important to eliminate all the tasks that add no value to patient care or the organizational process, Tecca says.

Use technology to stop duplication

For example, if an agency is computerized, then staff should use computers to enter all documentation information, eliminating the need to make copies and rewrite reports. Also, the support staff should correct all documentation errors as they crop up. It's less costly to correct errors during the process than to wait until the bill is sent out and returned due to errors, Tecca says.

• **Care management and provision.** This includes scheduling, education, and other activities that support the provision of care.

Questions to ask include:

— Are there less expensive ways to educate staff?

— Could the scheduling process be more efficient?

— Who supervises staff, and can this role be combined with others?

— Who manages office and clinical operations?

— How are data entered for continuing orders?

— How are visits documented and are any of those ways redundant?

— Who performs care and case management?

— Who performs the quality improvement (QI) processes?

— Who maintains clinical and nonclinical stock?

Some of those processes can be changed fairly easily, Tecca suggests. For example, there are ways to have ongoing educational certification become a part of an agency's daily or monthly routine. "If you do these things on an incremental basis, you won't have big chunks of change go into the educational process," she says.

• **Claims processing.** This involves the entire process, from logging in the initial data to checking for accuracy to verifying insurance coverage, monitoring claims, and collecting accounts.

"For each of those you need to identify steps and then figure out how many resources are used for each step, like staffing and computers," Tecca says. "Also, do you do the activity in the patient's home or the nurse's home or back in the office?"

Also, look for any sharing of resources, such as in a centralized admitting process, she adds.

Some other considerations are:

— Who logs in the initial data and checks for accuracy?

— How is the bill generated and who verifies it?

— Who submits the final bill?

— Who monitors claims and collects patient accounts?

— Who verifies continued insurance coverage and recertifies patients?

Home care agencies could benefit from some technology improvements at hospitals by interfacing with the hospital's information systems to reduce the amount of intake patient information. Some agencies also use modems to verify insurance.

3. Cut direct costs where possible.

Direct costs need to be analyzed thoroughly. Start with a flowchart that lists the average direct cost per admission at top. Below it are boxes for the average cost per visit and visits per admission. Under the average cost per visit are the further categories of discipline-specific cost per visit and skill mix.

Then, determine direct costs by calculating cost by diagnosis and further determine the impact of case mix to develop care paths. "Do as much job sharing as you possibly can," Tecca suggests. "If you're a stand-alone agency, is it necessary to have a human relations department, or can you think about outsourcing some of those things?"

Share support services with other agencies

Freestanding agencies could also consider sharing billing and staff with another freestanding agency, a process that already has occurred in many areas where home care agencies merge or form partnerships with competitors.

Other strategies are to:

• **Eliminate redundant and nonvalue-added tasks.**

• **Redefine accountability.**

• **Reduce lag time.**

• **Correct errors at the earliest point in the process.**

• **Employ technology where appropriate to support new processes.**

SOURCE

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4. Make cost improvement a QI project.
PI and financial considerations have to be tied together, Tecca states. "There's a cost to quality improvement, and there's a clinical component to managing your expenses," she says.

Quality managers need to know everything they can about expenses and cost cutting so an agency won't simply be subjected to a financial person making decisions to cut staff. If they don't start to manage costs more efficiently for each case, then the agency eventually will have to start refusing care to some people, she adds.

"Start at the top: What is your overall cost position?" Tecca says. "How serious is your cost problem or how great is the cost improvement opportunity?"

Steps to success

Here's how to make this a QI project:

- **First, create a matrix which has one side managing operating efficiency, and the other side involving care paths and care management.**
- **Second, under the operating efficiency category, make sure each discipline is as cost-efficient as possible.** This possibly could be done through forming a committee in which representatives from each discipline bring in suggestions for improving efficiency in their areas. Managers would look at whether the skill mix is right, particularly for PPS, which will have an impact on the ratio between nursing and aide staff.
- **Third, compare costs by discipline, looking at how much nurses cost per visit, how many visits by nurses are recorded per admission, and how many visits are made per day.**
- **Fourth, analyze your cost findings.** For example, if nursing costs are higher than desired per visit, then analyze whether this is because the nursing salaries are higher than the industry norm or there are not enough nursing visits.
- **Fifth, develop solutions.** If nursing salaries are too high, then design a different type of compensation package that contains the right amount of incentives so nurses will provide as many visits as possible within their salary range, Tecca says. "And do the same thing with home health aides and decide whether to manage your own aides or find a contract home health aide service."
- **Lastly, understand the costs by grouper or patient group or by diagnosis.** For care planning, managers need to recognize the distinctions."Then once you have that information by diagnosis, you can also do a case-mix adjusted comparison across agencies, which is valuable," Tecca says. "OASIS [the Outcome and Assessment Information Set] should give you the utilization component you need, and you should have your own cost report forms because you absolutely should know this information." ■

Quality manager offers tips to eliminate OASIS errors

Your guide to improving data quality oversight

As time draws closer to the implementation of home care's prospective payment system (PPS), agencies will need to pay more attention to their Outcome and Assessment Information Set (OASIS) data collection and data quality oversight.

Tiny errors will cost agencies money, and those mistakes add up. At the VNA Health at Home of Watertown, CT, quality managers noticed a recurring problem of one or two discrepancies with a number or letter over several months. As minor as the error was, it could have easily added up to a double-digit error rate on certain OASIS items. So the agency implemented an improved data quality oversight program.

"Data quality oversight is difficult but it's something that's worthwhile, and especially with PPS it's very important," says **Sara Szafranski**, RN, quality improvement manager of the agency, which serves 18 towns in western Connecticut.

Conduct data entry audits

State Medicare reviewers will expect agencies to have a quality oversight program in place, she adds. Here's how the Connecticut agency designed its OASIS data oversight program to capture all errors:

- **Pay close attention to data entry audits.**

VNA Health at Home conducts one of these audits each month, comparing scanned data input with paper documentation.

"We feed five data sets into the scanner and compare what the scanner has read into the software with what it says on paper to check the accuracy of the scanning software and the scanner itself," Szafranski says.

Agencies that have data clerks type in the information would have to do a similar comparison. However, agencies that use hand-held computers in which staff put in the data will have to handle this audit a little differently. Instead of comparing the input with a printed version, quality managers will need to do spot audits to check for numbers that are out of place or similar errors.

90% accuracy wasn't good enough

The scanner used by VNA Health at Home initially had a 90% accuracy rate, which caused too many errors, so the agency fine-tuned the software to bring the accuracy rate to 95%, Szafranski says. "This means it's scrutinizing little lines that make up handwriting in a box, and it asks for more verification from the data entry person," she adds. "So in that respect, it slows down the process, but it will reduce your errors, and we haven't had a problem with it since then."

Now the scanner software is programmed to stop and request confirmation before inputting the data. It won't recognize data that is outside of OASIS parameters. This way if the scanner reads a zero as a six at the start of care, the software will reject the data.

• **Audit clinical records.** Each month, the agency reviews a sample of records and discharges and compares them with the start-of-care OASIS. "We compare the start-of-care OASIS with information gathered on the intake with regards to patients' admission functional status, checking this against any therapy evaluations that were done," Szafranski says.

Then the same process is followed for discharge documentation, comparing OASIS data with nursing discharge notes. "If a patient has a wound, and the nurse is documenting that the wound is healed, then on the OASIS form it should show up that the wound is healed," Szafranski says.

Medicare reviewers will want to make sure that agencies haven't beefed up patients' diagnoses to make them look sicker than they are for the purpose of increasing reimbursement, she adds.

• **Check staff's OASIS assessment skills.** Each quarter, the agency's supervisors or peer reviewers make home visits with clinicians to determine the accuracy of the interview process in collecting data, Szafranski explains. "Both the peer reviewer and the clinician complete an OASIS tool, and I look at the two and compare them as to accuracy," she adds. "They don't talk to each other about it, and they arrive at the same time and leave at the same time so they will get the same information."

Szafranski has found that one of the biggest problem areas is in identifying the primary caregiver. "I found a fair number of discrepancies there," she says.

Staff had trouble describing caregiver

For example, on the caregiver question, the OASIS tool wants to know whether the primary caregiver is taking the lead and responsibility in providing and managing a patient's care.

"Our staff have had a little discrepancy in describing who this is," Szafranski says. "One might say this is paid help, and another might say this is the daughter, a friend, or a neighbor."

Patients often say that everyone helps out, so they could be of little help in determining the primary caregiver.

Staff sometimes have disparities in listing diagnoses. Nurses are instructed to discuss any primary care diagnoses that are questionable because there often are secondary diagnoses that are more important to the home care plan of care. If a patient has chronic lung disease and diabetes, the agency might have been referred the case to stabilize the patient after a lung disease exacerbation. But when the nurse visits the home she may discover that the patient hasn't been taking diabetes medications and has difficulty managing that disease.

"Diabetes becomes the primary diagnosis in home care, whereas the lung disease was the primary diagnosis in the hospital," Szafranski says. "We're justified in doing this as long as we can show that the person's bulk of need for skilled home care services relates to the diabetes diagnosis."

Also, some nurses may list more secondary diagnoses than do others. This sometimes is due to different observational skills. For instance, a patient's paperwork may indicate that the patient doesn't have seizures, but when the nurse visits the home, she might see new seizure medications.

The joint clinical audits have highlighted problems in how staff interpret the OASIS questions. The agency held counseling sessions with clinicians on a one-to-one basis to ask them to explain

SOURCE

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certain answers. For example, one nurse was not correctly interpreting the question about intractable pain. The nurse was going by her mental knowledge of intractable pain rather than reading the OASIS question and going by what that said.

"To her it meant you had pain that could not be relieved, such as appendicitis before a person goes to the emergency room," Szafranski says. "But the definition on the OASIS form is that it's pain that's not easily relieved and limits the patient's ability and desire to perform physical activity."

The two interpretations are very different and could result in different payments from Medicare under PPS, she adds.

Szafranski says the agency's goal is to provide those joint supervisor/clinician visits at least once a year for each field nurse and therapist. The agency will continuously educate staff as OASIS documentation issues arise, she adds.

"We'll go over the individual OASIS indicators, helping staff assess these and learn more about how OASIS is designed and how to interpret the question so that you get the most accurate information," Szafranski says. ■

Study: Daily calls boost medication compliance

PPS may make phone contacts more practical

Ensuring that home health patients take their medications regularly can be difficult, since patients can forget doses or fail to take them because of financial or other difficulties. This problem becomes especially acute when dealing with patients who have complex illnesses, in which the failure to take medicine on schedule can be more compromising.

Elderly patients living at home are considered to be at high risk for complications from poor medication compliance. Those complications, in turn, often necessitate a trip to the emergency room and rehospitalization.

A simple solution

A study of medication compliance has found a surprisingly simple remedy — just calling patients on a regular basis to see if they've taken their pills.[1]

Terry Fulmer, PhD, RN, FAAN, professor of nursing at New York University in New York City, says that in a recent study, daily phone calls made a significant difference when compliance was measured later. "For those individuals who were called, their compliance was substantially higher."

And while the practice currently isn't covered by Medicare, another participant in the study says that could change with the imminent arrival of the prospective payment system.

"Under the old fee-for-service payment system when the agency was paid for a visit but not for any other patient interaction, such phone calls were not reimbursable expenses," says **Penny Hollander Feldman**, PhD, director of the Center for Home Care Policy & Research at the Visiting Nurse Service of New York in New York City.

"Now that home health agencies will be paid a prospective payment starting in October, we are exploring ways of improving patient management that do not necessarily involve a visit," Feldman says. "We will be re-examining telephone support as one of a variety of effective patient interventions to augment visits."

The study, which was published last August in the *Journal of Gerontological Nursing,* looked at 50 frail, elderly patients who had a primary or secondary diagnosis of congestive heart failure and were taking multiple medications.

The patients were split into three groups:

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• a control group receiving standard care;

• a second group that received additional daily telephone reminders about their medication;

• a third group that spoke to a nurse daily via a video telephone, which allowed the patient and nurse to see each other's faces while they conversed.

"Our hypothesis was that a daily video interaction, a face-to-face interaction via the daily video telephone call, would be stronger in terms of improving compliance," Fulmer says. She says AT&T donated videophones for the study.

Monitored with MEMS caps

The phone and videophone calls were made daily, at a prearranged time of the patient's choosing. Some patients, for example, would ask to be called at lunchtime, others in the afternoon after their nap. "[The patient] would say, 'Hi, Terry, how are you today?' and I'd say, 'Hi, Mrs. So-and-so, did you take your medicine today?' And she'd say yes or no."

No effort was made to directly observe the patient taking his or her pills or to time the call to coincide with the medication time. "They knew we would call and say, 'Did you take your pills?'" Fulmer says. "We did not say, 'It's time for your pills.'"

The patients' compliance was measured through the use of Medication Event Monitoring System (MEMS) caps, which electronically monitor the times that the bottles are opened. At the end of the study, Fulmer was able to retrieve the caps and study the compliance rates by computer.

The MEMS caps themselves are considered an intervention in medication compliance, since they remind the patients that their actions are being monitored, Fulmer says. Therefore, she waited two weeks after giving the patients the bottles, to give them time to get used to them, before beginning the calls. After six weeks of calls, there was another two-week monitoring period.

The difference in compliance among the three groups was striking:

• The control group showed a significant drop in compliance, from 81% at the beginning of the study to 57% 10 weeks later.

• The group receiving phone calls didn't fall nearly as quickly, going from 76% at the beginning of the study to 74% at the end.

• The videophone patients did best of all, starting at 82% and ending at 84%.

Fulmer says the difference between the compliance rates in patients who received the phone calls and those who received the videophone calls was not considered significant for research purposes.

Homecare Quality Management™ (ISSN 1087-0407) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Homecare Quality Management™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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Subscription rates: U.S.A., one year (12 issues), $299. Approximately 18 nursing hours annually, $349. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies. $179 per year; 10 or more additional copies, $120 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $50 each. (GST registration number R128870672.)

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"But we think that was because we did not have enough people in our sample. The trend was that the video telephone was very powerful."

In any case, the intervention of a daily call of some kind was linked to improved compliance in the two intervention groups, Fulmer says.

Computerized calls may have effects

Fulmer hypothesizes that a similar effect may be reached by using an electronic calling system that delivers a recorded message to patients. But she is unsure whether the loss of the live interaction between the nurse and patient would hurt results. "I think people want human contact," she says.

Fulmer believes many nurses already are conducting these types of reminder calls, despite the fact that they're not currently a reimbursable service. "Nurses want to do it," she says. "They just know that it's not in their scope of practice as it's laid out financially right now."

(For more information on medication management, please see Homecare Quality Management, *July 2000, pp. 80-84.)*

Reference

1. Fulmer TT, Feldman PH, Kim TS, et al. An intervention study to enhance medication compliance in community-dwelling individuals. *J Gerontol Nurs* 1999; 25:6-14. ■

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■