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DVT treatment opens new niche of patients for home health agencies

Wisconsin home health agency develops DVT pathway

Deep-vein thrombosis (DVT) patients typically have been treated in a hospital for five to six days with an intravenous infusion of heparin and concurrent oral anticoagulant therapy. Recent medical advances now make it possible for some of these patients to be treated safely in their homes by home health nurses. This possibility opens up a potential new market niche for home health services, particularly among patients covered by commercial insurers.

A Milwaukee home health agency has developed a clinical pathway for DVT treatment in the home as a way to ensure quality care. The pathway also makes it easier for the agency to market the program to insurers and referral sources.

"A DVT program probably isn't going to be a huge moneymaker; however, in home care we're going to see these referrals and we should know how to have a good quality approach to providing DVT care," says **Lisa A. Gorski**, RN, MS, CS, CRNI, a clinical nurse specialist with Covenant Home Health and Hospice in Milwaukee. Covenant serves six counties and the Greater Milwaukee area in southeastern Wisconsin. Gorski spoke about DVT home care at the National Association for Home Care's 19th Annual Meeting & HOMECAREExpo, held in New Orleans in September.

Promising outcomes noted

The agency's outcomes have been promising. Of 62 DVT patients treated in the home, 61 were discharged to self-care and had follow-ups with their physicians. Only one patient had to be rehospitalized for excessive bleeding. The patient later went home without complications.

"About 2½ years ago, we put together a pathway on how to treat these patients at home in a straightforward, simple program that provides continuity of treatment," Gorski says. "There's a significant

amount of nursing education that goes along with this." Here's how Covenant developed its DVT program:

1. Assess need. Low-molecular-weight heparin has been used since 1993 for the prevention of DVT in high-risk patients after surgery. More recently, the Washington, DC-based U.S. Food and Drug Administration (FDA) approved the use of a specific low-molecular-weight heparin, Lovenox, for treating DVT.

Clinical trials have assessed the safety and efficacy of using Lovenox in an outpatient setting for treating DVT, and the research has shown that its safety is comparable to heparin use in the hospital for most patients.

About four in five patients are good candidates clinically for treatment in the home setting, Gorski says. Since Lovenox is considerably more expensive than heparin, and Medicare does not cover medications, most Medicare patients will opt to be treated in a hospital setting where the care will cost them less out-of-pocket. However, this still leaves a younger population of DVT patients whose private insurance will cover the drug costs because of the less expensive medical care in the home setting vs. the hospital setting.

The cost savings and the desire of some patients to be treated at home have made Lovenox treatment for DVT a viable alternative to the traditional treatment in a hospital setting.

2. Educate staff. Home health nurses may be familiar with low-molecular-weight heparin, but they likely have been using it in different doses than what is required for treating DVT. So education is extremely important.

Covenant Home Health trains all staff nurses to treat DVT patients because it would be difficult to provide consistent coverage for all potential patients if this diagnosis was handled strictly by a team of specially trained nurses. "A number of patients will go see their doctor on Friday; their doctor sees the problem, and on Friday night they are started on DVT treatment," Gorski explains.

The nurse education included teaching them how to use the DVT treatment pathway. Gorski provided some education at staff meetings and also developed a self-study packet and a competency test.

DVT training now is included in the home care agency's orientation for nurses, and nurses are observed performing the skills involved, Gorski says. "It's important that nurses understand what the treatment doses are, so we teach them about the disease and how to minimize the risk at home."

Gorski gives nurses an overview of DVT that includes the following:

— DVT and pulmonary embolism are venous thromboembolism diseases.

— Lower extremity thrombosis may include superficial leg veins, deep veins of the calf, and proximal veins.

— Thrombosis in other veins is less common, although the frequency of upper extremity venous thrombosis is increasing due to use of long-term venous access devices.

— DVT development may be caused by venous stasis, hypercoagulability, and vein wall trauma.

— Patient risk factors include being over age 40, having surgery, previous DVT diagnosis, pregnancy, cardiac disease, malignancy, and obesity.

— DVT can become a chronic disease, especially in patients with ongoing risk factors.

— Valve damage can lead to venous hypertension that causes recurrent leg swelling and pain.

— Pulmonary embolism is the occlusion of a portion of the pulmonary blood vessels by an embolus.

— Minor pulmonary embolism is subacute and has insidious onset, whereas major pulmonary embolism may be identified with symptoms of syncope and low blood pressure.

— Nurses need to learn how to monitor the patient's therapy and their bleeding. They need to set treatment goals focusing on preventing local extension of the clot and preventing the thrombus from embolization.

— Patients need concurrent oral anticoagulation therapy to prevent the formation of fibrin, the component that holds a clot together.

Develop useful pathways

3. Establish clinical pathway. Covenant Home Health developed an extensive treatment pathway for treating DVT with low-molecular-weight heparin. It covers three days with categories of outcomes, focused assessment, treatments, activity, medications, and tests.

"The pathway's key pieces are to look at outcomes, which includes the goal of having patients do injections independently," Gorski says.

The pathway's assessment includes having nurses check patients for pain and discomfort. They also check the patient's lower extremity for circulation / sensation problems, inflammation, swelling, and skin integrity.

Nurses look for signs and symptoms of bleeding or pulmonary embolism. And they assess the patient's readiness and ability to learn how to do their injections and whether the patient has caregiver support.

The low-molecular-weight heparin injection is given in a 1 mg/kg dose of Lovenox every 12 hours. **(See American Academy of Home Care Physicians' treatment protocol insert.)**

4. Educate patients. It's crucial that nurses teach patients how to monitor their own care after the home care visits end.

"Patients who learn how to do these injections very quickly are discharged quickly, too," Gorski says. "A couple of days after a patient is discharged from home care, the nurse needs to call them and make sure they are taking their injections on time."

Nurses remind patients of scheduled lab work and ask if they have had any problems with bleeding. Patients also must understand the signs and symptoms of pulmonary embolism.

When patients are willing, nurses will teach them how to inject the medication following safety precautions, such as never administering Lovenox intramuscularly.

Patients learn prevention strategies such as wearing elastic stockings, walking more frequently, and sitting with uncrossed legs. Also, nurses teach them the various risk factors including recent surgery and obesity.

5. Monitor outcomes. Covenant Home Health has kept data on 62 patients ages 15 to 92. Thirty-eight or 61% of the patients were admitted after a hospitalization in which they had a mean length of stay of three days.

Another 24 patients were directly admitted to home care without having any acute-care days.

Of all of the cases, the number of home care visits ranged from one to 30 visits with a mean of 7.1 visits. Of the 38 patients who became independent in self-injection technique, the number of home care visits ranged from one to 12, and the mean number of visits was 3.2.

Most of the 24 patients who did not learn how to self-inject failed to do so because they were unwilling to give themselves the injections. Three had a fear of needles; three had functional limitations and no caregiver, and four had their therapy discontinued early. Of all 62 patients, only one patient had to be rehospitalized due to bleeding.

6. Market program to payers and referral sources. "We let payers know about our program, and we did one formal presentation for an HMO," Gorski says.

Sources

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The agency also worked with physicians, showing them how patients who met certain criteria could be treated with DVT in home care as safely as they could be treated in the hospital.

Not surprisingly, a majority of the patients (61%) were covered by managed care companies. Only 8% of the referrals were Medicare patients. Other reimbursement sources were Medicare plus a secondary payer and Medicare HMOs.

The pathway, staff training, and informal marketing have been successful. The agency rarely was referred a DVT patient previously, and now it's a much more common referral, Gorski says.

"This program helps us pick up a new group of patients who were historically managed in the hospital," Gorski says. "The program is reaching out and providing quality and cost-effective care to a particular population with a well-validated treatment." ■

Illinois agency's wound care preparation pays off

Education, review smooth transition to PPS

As agencies adjust to the new demands of the prospective payment system (PPS), one area of concern has been a patient with wounds whose complex care and supply costs can strain budgets.

But one Joliet, IL, agency has seen a smooth transition, thanks to thorough preparation of staff and a review of the wound care program to ensure its effectiveness and efficiency.

"We could see the writing on the wall," says **Sharon Baranoski**, MSN, RN, CWOCN, and director of Silver Cross Home Health, a hospital-based agency. "We started preparing for this about three years ago — really starting to look at cost-effective measures and educational components."

Baranoski says agencies can adjust to wound care under PPS by providing specialized help to nurses, reviewing and standardizing supplies,

and promoting a multidisciplinary approach.

When Silver Cross began its review of wound care prior to the rollout of the interim payment system, Baranoski says the first order of business was to assess the nurses' level of competence — and comfort — with wound care skills.

"We had a meeting with our entire staff and did a needs assessment of what they felt their skill levels were in wound care," she says. "We had an open discussion of what they were comfortable with and what they weren't. What they felt they needed and what they already knew really well."

She says she was surprised to find that some nurses weren't completely confident in their own wound-assessment skills. She found that the nurses weren't necessarily lacking in the skills, but needed validation — "They needed someone to come out and say yes, I agree with you." It was a role that Baranoski, with her own wound ostomy training, was able to provide one on one as she accompanied nurses on rounds.

"I spent a day with everybody," she says. "We went out and saw all kinds of patients to see what [nurses'] skill levels were. I wouldn't tell them the answers, but I'd ask them to tell me what they saw and thought."

She says the support helped give the nurses confidence in their personal assessments. "Some of them even said, 'Wow, I'm so glad to know that I am doing this right, because you never really know for sure.'"

Silver Cross held regular inservices on all aspects of wound care, including conducting assessments and learning about the range of wound care products on the market. The agency tapped company reps, as well as the hospital's wound ostomy nurses, to provide information on using supplies.

"We did some training on how to apply and take off dressings appropriately and how to do certain types of compression therapy appropriately," she says. We did mini-competency testing on different practices."

Baranoski also standardized the terminology staff were using in their documentation to provide continuity in patients' charts.

"We had nurses calling a bedsore a decubitus, and other nurses calling it a pressure ulcer," she says. "On any given patient chart, you could read documentation from different nurses using different terms. We needed to have some kind of standard to it so when we were reading each other's charts or picking up a case for a nurse, everyone was of the same mindset."

Nurses were instructed on the correct terms to use — in this case, pressure ulcer — and they reviewed the meaning of all the terms used in wound care documentation. Pictures describing conditions such as granulation and contraction helped drive the point home.

Creating consulting role on staff

After a six-month period of assessing and augmenting nursing skills in wound care, Baranoski knew the staff would need more specialized help to continue the progress.

She hired a wound, ostomy, continence nurse (WOCN) to serve as a consultant to the nursing staff — reviewing charts, occasionally making rounds with nurses , keeping up with improvements in wound care, and serving as a resource when nurses had specific questions.

Unfortunately, Silver Cross' first wound care nurse left after a short time. "Home care wasn't what she really wanted," Baranoski says. She then took a different approach, looking internally to find a home health nurse with clinical and administrative experience and to train in wound care.

She was aided in this effort by Silver Cross Hospital's Wound Center. "We sent the nurse to work with our WOCNs in the hospital, and they trained and educated her in wound care," Baranoski says. "She had been involved in wound care in little bits and pieces throughout her career so it came to her naturally."

While the nurse is not a certified WOCN, she has the necessary skill level, Baranoski says. "And when she gets into any situations where she's not comfortable, or needs someone to case-conference with, then she case-conferences it with me."

The new wound care nurse has become a valuable resource for the nursing staff who come to her with referrals and questions. "She's quite busy," Baranoski says.

She adds it's vital to have someone with wound care expertise monitoring an agency's progress.

"Someone — whether it be an administrator, a nurse assigned to the role, or a WOCN nurse — has to be monitoring what's going on with the staff, what's going on with the patients, what's going on with the products," she says. "Finding the right person to be that wound nurse is a very important part of the efficiency and effectiveness of a program."

Home health agencies already have expressed

concern that Health Care Financing Administration policies regarding supplies will make caring for wounds under PPS a real challenge.

The final PPS rule does not provide case-mix adjustments for supplies, instead including an average supply cost in every episode payment. Agencies handling significant numbers of wound care patients could find themselves losing money under this system.

In addition, under the current interpretation of PPS, agencies are responsible for providing non-routine supplies, even those unrelated to the care they are providing.

The home health industry currently is petitioning Congress for changes that would eliminate some of those burdens. But in the meantime, Baranoski says it's more important than ever that agencies review the use of wound care supplies and keep careful track of their inventories.

First, she says, an agency should standardize its inventory to ensure that staff are using the best products available, and that supply shelves aren't groaning with rarely used products ordered for one patient or one physician.

"You don't need three transparent films. You need one good one," she says. "You don't need 10 different hydrocolloid dressings, you need one. So when a physician calls and says, 'I want you to use Brand X,' you can say, 'We have Brand Y hydrocolloid dressing, and this is what we use.'"

If the agency doesn't have a designated wound nurse who can conduct this review, Baranoski says it would be worth contracting with an outside WOCN nurse to do so.

The goal isn't necessarily to find the cheapest supplies available, but those that are best suited to your nurses, patients, and their family caregivers, she says.

"I think it would be a big mistake to go out and buy the cheapest barrier ointment instead of one that you know has worked well and you've had good success with," she says. "I think it's a big mistake to downsize to an inferior product, because in the long run, the patient's not going to heal as well, and you may end up being in there longer because of complications that could occur."

An agency has to look at its own practice patterns, the success it has had with various products, and what its physicians are most comfortable with.

Baranoski advises putting together a wound care list or formulary and distributing it to physicians. If they ask to add to the list, the agency can evaluate the suggested product.

"The care of the patient shouldn't be based on the cost of the product at all," she says. "If the patient needs an expensive product and that's what the physician has deemed is the best avenue for that patient, then that's what we need to provide. But what's needed along with the products is good wound care, wound assessment, documentation, and follow-up."

Bottom line, says Baranoski, "Products don't heal wound care patients; good wound care heals patients' wounds."

In addition to reviewing the list of supplies, Silver Cross upgraded its supply closet to a computerized system that keeps better track of how the products are used.

Previously, when a nurse went to the closet to get a product, she could simply take out what the patient needed and make a notation on the patient's billing.

Invariably, that led to problems keeping track of items. "You had people who took extras, because maybe they were going to need it," Baranoski says. "[The products] would freeze up in the trunk of their car in the winter, or maybe it's 98° out and it melted. So the product got ruined. It wasn't being billed to anybody, but you were still paying for it."

Now, in order to remove items from the cabinet, a nurse must punch in his or her ID code, as well as the patient's name.

"At the end of a day, we know where the products went, we know who took them out, and we know which patients have them," she says. "It has decreased our costs immensely because we don't have the waste of products."

Although the agency no longer can bill the patient, keeping track of what products a patient uses can help gauge the effectiveness of different wound care products, Baranoski says.

Keeping detailed records of patients' supplies also will come in handy if supplies are eventually unbundled from the episodic payment and agencies can begin billing for them again.

Other tips for effective wound care

Baranoski offers other suggestions for improving wound care while adjusting to the demands of PPS:

• **Promote a multidisciplinary approach.** At Silver Cross, case conferences on wound care can involve nurses, physicians, physical therapists, dietitians, and social workers.

Physical therapists don't do wound care themselves, but work to get the patient out of bed and moving around to improve circulation. The

Source

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agency contracts with a dietitian who reviews charts to ensure that patients are getting needed nutrition for healing. Social workers help with other issues that might impair a positive outcome and refer patients to community services that might help them after discharge.

"If agencies aren't doing case conferencing with a multidisciplinary team approach, they're going to fall behind," Baranoski says. "They have to look at involving all the disciplines in wound care. That certainly includes the physicians."

• **Prevention is key.** "If you're not looking at preventing the wound care insults that can occur from immobility and your various diagnoses, your patients are going to develop all kinds of wound care problems that are going to keep you in there much longer and cost you a lot of money to manage," she says.

Silver Cross uses a risk-assessment tool and nutritional screening to determine high risks for wound problems. Patients are taught the importance of ambulation, nutrition, and other approaches to avoid wounds.

• **Be sure staff is up to date on documentation.** Baranoski has quizzed her staff on all the documentation required by PPS, including Outcome and Assessment Information Set (OASIS) assessments. She notes that one good thing to come out of the final PPS rule was some case mix adjustment for complex cases including wound care. But that requires proper documentation.

"Having the right documentation tools is very important," she says. "Are you using an outdated computer system that doesn't have some of the things you need? We all have to transmit OASIS data, but you also need your other documentation that supports what are you doing."

Baranoski says it's too soon to see how PPS will affect wound care in the long run. "It's going to be interesting to see how wound care evolves through the use of all the documentation through OASIS," she says. Ultimately, though, she says agencies will have to continue to monitor their standards and adapt as necessary. "Constantly evaluating on an ongoing basis ways that you can improve and enhance your practice is something we all need to be doing," Baranoski says. ■

'PRAISE' program boosts patient satisfaction

Agency's action plan puts it on the right track

Patient satisfaction is such an integral part of clinical care and administration at the Shore Health System in Easton, MD, that employees' raises partly are based on how well they have satisfied their patients.

The health system, which includes a small home care agency that makes about 22,000 visits each year to an area encompassing Maryland's Eastern Shore, recently was named a finalist in the South Bend, IN-based Press, Ganey Associates' client success stories contest.

"Our patients trusted our technical ability to deliver health care, but they wanted more," says **Brian H. Childs**, PhD, director of ethics and organizational development for the health system.

Patient lists needs

Patients told the health system:

• They wanted their emotional and spiritual needs.

• They wanted their privacy protected.

• They wanted some appreciation for the inconvenience they had to go through in order to receive health care.

• They wanted to perceive that there was team work among the various health care professionals.

• They wanted to know that they received all the necessary information.

"If each department were to approach those things they needed, we knew we would increase our ability to make patients satisfied through one of the most personal experiences of their lives," Childs says.

The health system formed a committee called Promoting Responsive Attitudes in Service Excellence (PRAISE) that developed a program to enhance patient satisfaction. After one year, the health system's patient satisfaction scores on Press Ganey surveys rose from the 20th percentile to the 80th percentile.

Employee bonuses are given to show staff how seriously the health system takes in pleasing patients. Employees receive bonuses when the hospital system's patient satisfaction level rises and when the operating margin increases.

"Right now, the bonus is based on patient

Sources

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satisfaction and on our fiscal responsibility in keeping expenses down and quality up," she explains.

"Last year, each employee got a percentage increase in base pay and a cash bonus," Childs adds. "The greater the patient satisfaction, the greater the market share."

Shore Home Care built on the systemwide program with its own patient satisfaction measures after experiencing a drop in its satisfaction rating between its baseline quarter and the second quarter. The satisfaction rate went from an 88.5 percentile to 81.8 percentile. "Our staff were just devastated and very upset," says **Kay Satchell**, RN, a performance improvement specialist at the agency.

"We immediately formed five performance improvement teams that focused on the plan of care, complaints, home health aides, scheduling, and our on-call process," Satchell says. "It took a huge effort, and almost everyone on the staff is involved in a team."

The efforts showed an immediate payoff. The agency's patient satisfaction rate bounced back to an 87.7 percentile. Here's how the agency's conducted its performance improvement (PI) program:

1. Form charters. Each of the five PI teams formed a charter developed from an overall action plan. **(See P1 Action Plan insert.)**

Teams were multidisciplinary, and each selected a team champion. "The champions were the volunteers who had the most interest in the project and would have day-to-day involvement," Satchell says.

The champions recruited volunteers to help with the project. Then teams made a priority list with the highest priority going to the customer satisfaction areas in which the agency did the worst.

2. Develop plans to improve care. Each PI team identified problems within their sphere of concern and developed possible solutions. **(See story on solutions identified during patient satisfaction PI process, p. 8.)**

For example, the PI team that focused on the plan of care saw that patients did not feel they were truly involved in planning their own care and wanted to be a part of the process.

Involving patients in creating care plans can enhance patient motivation as well as patient satisfaction, Satchell says. The plan of care team decided that the agency needed a new patient orientation booklet for the staff. This would better educate employees about how to include patients into the plan of care during the admission process.

3. Change policies and encourage patient input. One of the changes Shore Home Care made to promote better patient satisfaction was to provide merit raises that are based, in part, on patient satisfaction.

"Our annual performance evaluations are based on job responsibilities and care factors, which talk about community and allegiance, responsiveness, and excellence, and then significant contributions, training, and development," Satchell says. "This links their patient satisfaction and the care factors to their performance evaluation and merit raise."

Any comments made on patient satisfaction surveys go into the employee's file and those comments are brought out during the performance evaluation process, she adds. Patients can compliment employees through "CAREgrams." CARE is an acronym for community allegiance, responsiveness, and excellence.

The idea is that employees should focus on the community they serve, placing their patients and co-workers first. The characteristics of an employee who does this are commitment, decency, employee relations, fortitude, and perceptiveness.

Allegiance means the employee focuses on communication and cooperation, delegation, integrity, and perseverance. Employees demonstrating responsiveness show a high energy level, independent judgment, industry, planning, and professional presence. Those exemplifying excellence have accountability, adaptability, creativity, knowledge, and technical expertise. "We have little cards that say 'CAREgram,' and these lists the care factors and a heart on the left hand corner," Satchell says.

The card's text reads, "To: ____ I want to thank you for showing care in the following way . . ."

The completed CAREgrams go to the human relations department. Then each quarter, the agency has a celebration with ice cream for employees who have received CAREgrams.

"We gather to recognize the employees for doing a good job, and they get a little pin," Satchell says. ■

Agency focuses on causes of dissatisfied patients

Solutions ranged from easy to time-consuming

Raising patient satisfaction can be difficult, particularly when home care agency managers do not fully understand the causes of a lower-than-desired satisfaction rating.

This is why a performance improvement (PI) program usually is necessary in order to bring about any lasting changes in how patients perceive a home care agency. Such a program can highlight the problem areas and offer clues to turning these around.

Shore Home Care in Easton, MD, is a good example of an agency that treated a patient satisfaction program as it would any PI program, with committees dedicated to various areas in which improvements needed to be made.

Here's an example of how such a PI program might work. **(Shore Home Care focused on the five previously mentioned areas related to patient satisfaction; see related article, p. 6.)** The following changes were made:

• **Plan of care:** Patients expressed a desire to be more involved with the care-planning process. Since it's very easy for nurses and therapists to overlook the patient's involvement in planning, the PI team developed a 31-page patient orientation booklet that educates home care staff on how to involve the patient from the onset of care.

"From the start, we talked about the patient being the partner with us," says **Kay Satchell**, RN, performance improvement specialist at Shore Home Care.

"We have a welcome letter that [explains] how their medical treatment is important to us, and we talk about our mission as promoting physical and emotional wellness," Satchell says. "We talk about their rights, respect, our policies, and our criteria for admission."

The PI team decided the agency had not been educating patients well on how they were included in the plan of care.

The booklet covers all areas of home care visits and details how the patient can be included in each step of the care process. Another change was to color-code the agency's two home care teams so that it's easier for patients to ask for assistance when they call the agency. The staff have sweatshirts and hats with their team's color, and the patient folders are the team color. When a patient calls for help, the home care receptionist only has to ask them what color is on their folder and their team can be easily found.

"Before, when a patient called in for assistance, we'd say, 'Where do you live?' and 'Who is your nurse?'" Satchell says.

• **Complaints:** Previously, the agency identified patient complaints when the care had ended and someone had called the patients to ask how they were doing.

At the PI team's suggestion, the agency has begun to call all patients at two weeks after admission. "Instead of waiting until the end of care, we try to identify these issues as soon as possible," Satchell says.

The intake liaisons that accept referrals call the patients to set up an initial visit. Two weeks later, the liaisons contact the patients and ask whether they are pleased with their services or are having any problems.

During the PI process, the agency had the staff call most patients at two weeks. But that has proved to be time-consuming; eventually, it will be changed to a smaller sample of patients who are contacted.

The PI team also made a change to improve staff communication. Many employees were unaware that they could send a voice mail message simultaneously to several colleagues, which saves a lot of time. The agency then taught staff how to use all of the phone system technology.

Home health aides

The agency increased the face-to-face supervision of aides from once every 60 days to twice every 60 days. This will better ensure the aides are following the patient's plan of care.

Patients expressed concern about aides understanding their need for privacy and being more sensitive in the scheduling of visits. Aides were then taught patient privacy issues.

Also, the agency now has a central binder that holds all plans of care for aides. This way, the scheduler will know when an aide visit needs to be changed because it coincides with another health care need of the patient.

In assessing patients' comments about aides, the PI team realized that the agency needed to provide more aide services. But this couldn't be done with the current aide staff level.

"What caused our patients' dissatisfaction was that we really had to give a little bit of service to

everyone, and we weren't meeting their needs, so we went to our vice president and said, 'Our satisfaction shows that we aren't providing as many services as we need to,'" Satchell recalls. "So, management gave us a special exception to hire another home health aide even though that position wasn't in our budget."

Keeping patients informed

The home health agency's therapists come from the health system and have separate scheduling through the rehab department. It's often difficult to make sure all staff are informed about when the therapists will be visiting patients.

"The rehab department has commitments to inpatient, home care, skilled nursing facility, and an outpatient rehab facility," Satchell says. "That has been a challenge."

One solution has been for the home care agency to contract with two therapists who will work strictly for home care patients. This way, the agency knows exactly when they will visit and can control the scheduling process.

The therapists dedicated to home care will be placed on teams that cover a specific geographic area. "We felt that we really didn't educate our patients about the expectations for an on-call nurse," Satchell says. "We didn't do a good job of letting patients know what kind of response to expect."

Nurses were told to explain to patients how an on-call nurse might not always visit their home, but will at least call to see how to help the patient. Also, when patients call in, the phone system automatically gives them a message that says the nurse might not be able to answer their call right now; but if they would please wait, the nurse will be right with them.

To ensure on-call nurses respond in a timely manner, the agency began to keep an on-call log book that tracks staff response to calls. The phone system times the inbound calls from patients and those made by nurses. The response time now averages 30 minutes, and the PI team wanted to improve that time. Just letting staff know that their response time is being recorded has helped to improve it, Satchell says.

"We now have an administrative on-call team; if the answering service can't get through to the first-line call team within 15 minutes, then our administrative on-call team is notified," Satchell says. "That really does make us respond more quickly." ■

Ohio HHA wins JCAHO quality improvement award

Efforts led to decreased AR days

An Ohio agency's efforts to reduce its accounts receivable days in home health has earned it the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) performance improvement honor, the Ernest A. Codman Award.

HomeReach, an agency in Worthington, was recognized for a program that included enhancing computer use, doing a better job of tracking physician orders, and reviewing end-of-the-month activities. In announcing the award, JCAHO noted that the agency had reduced its accounts receivable (AR) days from 116 to 70, during a time when it was experiencing a significant increase in business.

But the initiative, which began nearly two years ago, changed more than just billing practices at HomeReach, whose services include a Medicare-certified home health agency, an infusion pharmacy, and a home medical equipment service.

Executive director **Fran Baby**, MPA, says methods used in the AR initiative have found their way into subsequent HomeReach quality improvement efforts, and notes that the entire effort required no significant investments or new hires. "It was really looking at our processes and what we had in place and saying, 'Hey, what can we do to change it?'"

Setting the goal

HomeReach is affiliated with the OhioHealth system that serves central Ohio. The agency's review of its accounts receivable process, which began back in July 1998, was prompted by OhioHealth's decision to make the issue a systemwide priority, Baby says.

"We just felt throughout the continuum that the [AR] days were not what we hoped they could be," she says. "By having a good, solid process for accounts receivable, it would help our cash positioning and allow us to meet our mission, too, in terms of providing care to the indigent."

At the same time, OhioHealth was embarking on a method of identifying goals called the "balanced scorecard." Baby describes a process by which the organization identifies goals within four areas — quality, service, work life, and finances.

HomeReach, through its performance improvement committee, made recommendations to the

JCAHO award honors PI improvement efforts

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) created the Ernest A. Codman Award in 1996 to recognize health care organizations for achievements in the use of process and outcome measures to improve performance and care. Codman has been regarded in health care as the father of outcomes measurement.

Awards are given in a number of organization categories, including home care, a category that also includes hospice and home medical equipment. In order to be eligible, an organization must hold a status of Accreditation with Recommendations for Improvement or better.

A home health agency also must have been surveyed under the home care standards in its most recent JCAHO survey.

An application form for the award will be available on the JCAHO Web site (www.jcaho org) beginning in early 2001. The entry fee is $295. An evaluation committee of national experts in performance measurement will judge entries. Finalists are subject to an on-site visit conducted by a JCAHO surveyor and office staff member who review the organization's work and validate the information in the application.

Based on the application and the on-site review, the evaluation committee makes recommendations to the executive committee of JCAHO's board of commissioners. Winners are notified in August and honored in October at an awards program in Chicago.

For more information on the Ernest A. Codman Award, contact JCAHO by telephone at (630) 792-5000 or visit the organization's Web site. ■

board of trustees regarding goals in each area. "One key area was the reduction of accounts receivable days for home health," Baby says, noting that home health consumes about 50% of HomeReach's budget.

Once the goal was approved as part of the agency's plan, it went back to the performance improvement committee, which identified a team to lead the initiative. The team included the director of clinical services, the medical records supervisor, and the billing supervisor — a multidisciplinary approach that Baby calls the key to the agency's success.

"Your first gut reaction if you have an AR problem is to say, 'Well it's the billing department's fault they can't get the bills out,'" she says. "But we know that's very superficial, and if you look at the entire process, there's a lot that has to be done by the clinical staff.

"What we did through this team was to sit down and open up communication between the two groups [to] develop a better understanding of why information is needed, and more importantly, the role that everybody plays in successfully getting a bill out."

Baby says the lead team recognized early that it couldn't carry out the entire initiative on its own, so it formed eight subteams, each of which was responsible for researching a particular area and coming up with recommendations.

The team, with the assistance of HomeReach's in-house performance improvement staff, used diagrams to sketch out the billing process from start to finish. Baby says they found three major areas that they believed would be critical to improving performance in AR days:

1. Enhancing the management information system. Baby says HomeReach has been using a Delta information system for the past three years, but hadn't used all of the functions of the system that were available.

In particular, nurses were doing all their clinical documentation on laptop computers, but were entering billing information manually through the agency's billing department.

Baby says the addition of the Delta Charge

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entry system allowed nurses to verify visits electronically for the purpose of billing. Inservicing helped explain the new procedure to them.

HomeReach took other steps to allow automation to help smooth the billing path. Fund transfers and remittances now come to the agency electronically through the fiscal intermediary. And staff now have electronic signature capability instead of having to come to the office to sign their paperwork.

In fact, Baby says, the entire medical record — or as much of it as possible — now is stored electronically. "The only material that we file in the medical record now is something that needs an original signature or the patient's signature," she says.

2. Reviewing end-of-month activities. The agency set up a schedule of what processes needed to be completed by the end of each month, as well as who was responsible for each process. "We reduced the total days it took to close the month from an average of 76 to 108 days all the way down to 58 to 82 days — by about 24%," Baby says.

Those changes didn't just affect billing staff. The team changed the process by which unverified visits or visit errors were tracked and resolved.

"Previously, the billing supervisor was responsible for trying to figure out what happened to all those visits and what the errors were," she says. "We ended up with a backlog."

Under the new system, the billing supervisor goes to the clinical manager of the team member in question. The manager is responsible for researching the problem and reporting back to billing promptly. "By doing that, the clinical managers have become more aware of what were some of the recurring problems," Baby says. "They could stop them or work with that clinician on correcting them."

3. Developing a tracking system for physicians' orders. HomeReach uses a Delta mechanism for tracking physicians orders, but also has devised a Microsoft Excel spreadsheet program to help with the task.

Baby says the program does a better job of identifying when the agency sends out a plan of treatment and which physicians don't return them promptly. The medical records staff now follow up, working with the physician offices to reduce those days. The average time of receipt of signed physician orders decreased from 33.7 days to 22.4 days.

Throughout the process, the subgroups exploring various issues had the authority to make changes in the system as they saw fit. The lead team served as a coordinator of the subgroups,

CE objectives

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rather than the final authority. "We knew that the people in each of those [subgroups] were really the experts because they were the ones who were dealing with the problems and issues day to day," Baby says.

"We gave each team broad authority to make the changes that they needed, within the scope of keeping it all coordinated with the larger team," she says. "The larger team just had to make sure that a change from one recommendation wasn't going to have a negative impact on another one or that it was doable."

If a change didn't work, it could be rescinded. Baby says that too often in an organization, people don't believe that their suggestions are heard or that they have the power to make a difference. "You know how that can happen," she says. "They'll say, 'They told me I could change it, but I was second-guessed.' We never really got into that. We empowered them to make the changes they saw necessary."

As a result, she says, people got excited in seeing the success of their own ideas. Baby estimates that by counting team members, trainers, and others, the initiative involved the total participation of about 160 people.

Some lessons learned from this initiative that Baby now applies to other PI efforts include:

• **Early identification of communications issues.** The teams were all set up with both clinical and billing staff to ensure that communication was in place from the outset. The process has led to an enhanced understanding of each department's role in the total success of the agency.

"In the past, if somebody in the billing department went to a clinical manager to try to work out a billing problem, the clinical manager got defensive," Baby says. "Now, they all have a better understanding of each other's role. I have a better understanding of who I'm passing information on to, what they're doing with it, and why they want it in the format they want it in."

• **Effective display of data analysis.** The agency used two- by three-foot laminated storyboards to keep the staff up to date on the progress of each of the teams.

"One thing we found out is that people don't read memos," she says. "Your visiting staff are out in the field with laptops, so they're not in the office every day. On the other hand, you want them to feel like they're part of the organization and you want them to participate."

When visiting the office, nurses now can glance at the storyboards and get the information they need in a few minutes. The PI department made the boards visually appealing by using color and graphics. "We use storyboards for every one of our PI initiatives now," Baby says.

Baby says HomeReach officials were pleased and surprised by the JCAHO honor. In fact, she says, they didn't make the submission for the Codman award with any expectation of winning, but rather as a learning experience.

Now the big challenge is adapting the successful program to meet the needs of the outpatient prospective payment system (PPS). The end-of-month activities, for example, will have to be revised to work within the new episodes of care. Staff had to be taught the importance of a successful Outcome and Assessment Information Set assessment and accurate coding.

But Baby isn't worried about the effects of PPS. "It wasn't like we planned [this initiative] not anticipating there would be a change on Oct. 1," she says. "Our challenge now is to maintain our low days in AR through PPS. That's our new goal." ■

Treatment Protocol

Protocol for the Home Treatment of Proximal Deep-Vein Thrombosis with Subcutaneous Low-Molecular Weight Heparin

A. Day One

1. Medications:
    1. Start the patient on Lovenox (enoxaparin sodium) 1 mg/kg SQ BID or Lovenox 1.5 mg/kg SQ QD, plus warfarin 5 mg PO QD. Note that starting dose may be lower in elderly patients or patients with hepatic disease.
    2. Educate patient and family members about supportive care responsibilities, indications, administration, side effects, and drug/food interactions that are associated with the prescribed medications.
    3. Instruct patient to visit laboratory to obtain aPTT, PT/INR, and CBC with platelet count if warranted, or arrange for home-based testing.
2. Patient activity:
    1. Elevation of the affected extremity may be beneficial.
    2. Local heat may improve microcirculation.
    3. Perform range-of-motion or recommended exercises.
    4. Limit physical activity if painful.

B. Day Two

1. Medications:
    1. Continue medications.
    2. Perform a brief physical exam and assess for bleeding complications.
    3. Reinforce correct Lovenox administration technique, and medication compliance.

C. Days Three through Seven

1. Medications:
    1. Continue medications.
    2. Obtain PT/INR and adjust warfarin dose as necessary to achieve an INR between 2 and 3.
    3. Continue patient or caregiver education regarding the indications, administration, side effects, and drug/food interactions that are associated with medications.
    4. Instruct patient to visit laboratory to obtain aPTT, PT/INR, and CBC with platelet count if warranted, or continue home-based testing.

Source: American Academy of Home Care Physicians, Edgewood, MD.

Shore Home Care • Home Health/Hospice
Patient Satisfaction Survey • PI Action Plan

On June 19, 2000, Shore Home Care assembled a multidisciplinary Performance Improvement team to develop an action plan to address Press Ganey (PG) results. The team met twice weekly until the plan was in place. The SHS Process Improvement model was implemented. The team prioritized its opportunities for improvement by using the priority index and correlation coefficient correlation results. The top ten indicators were categorized into similar groups and then an action plan focused upon 1) clinical process changes, 2) staff education, 3) office processes, and 4) communication. The table below summarizes that plan.

Plan/Do

Indicator	Clinical Process Changes	Staff Education	Office Processes	Communication
Family informed re: tx **Family involved in Plan**	- Redesign the orientation process - Educate the patient/family on an ongoing basis regarding each aspect of their Bill of Rights - Instruct staff to call sickest patients each day to check status and educate patient about an after-hour plan	- Educate staff on the Policy & Procedures for Admission to Services		- Develop and circulate monthly flyers r/t the Bill of Rights - Expand use of patient calendar to include POC
Ease of schedule change **Ease of scheduling visits**	- Develop staffing expectations for per diem staff - Assess productivity expectations/under utilization - Schedule 1-2 prn staff each day to pick up unanticipated visits	- Staff education on organizational skills	- Integrate therapy scheduling into SHC scheduling - Assess how staffing affects scheduling processes/under utilization	- Continued SHC representation at Rehab meetings - Re-educate/enforce staff compliance; re: submitting daily itinerary and of calling patients before visiting
Aides' concern for privacy **Aides' sensitivity to inconvenience**	- Evaluate current agency supervisory standards for all field staff with a goal to raise standards for direct supervision	- Education to all staff in Sensitivity Training		
Handling emergencies	- Develop protocols/standards for on call responses			
Billing questions			- Develop an information sheet r/t cost of SHC services	- Inform HCI of PG results - Clarify who is responsible for billing questions
Dealing with Problems/Complaints		- Staff education on patient Bill of Rights - Customer Relations Inservice	- Develop flowchart for the Receptionist for any complaints received	- Color code teams - Patient Folder to include complaint process
Recommend to others	- Staff to educate patients on PG survey process	- Educate all staff on question content of the PG survey	- Include a copy of the PG survey in each patient Information Packet - Initiate Phone Satisfaction Surveys with 1-2 weeks for all patients; focused towards our top 10 opportunities for improvement	- Redesign Patient Folder

Ongoing meetings will select champions for the focus groups, determine a timeline, and implement the Action Plan.

Check:
1. Clinical record audits r/t documentation for including the patient/family in the Plan.
2. Internal satisfaction results
   - Audit on call logs for timeliness and appropriateness of responses
   - Audit phone satisfaction results
   - Audit compliance of new standards for field supervisions

Act:
Re-evaluate and revise the plan over time based on "Check" findings.

Source: Shore Home Care, Easton, MD.