AMERICAN HEALTH CONSULTANTS®

HOMECARE Quality Management™

INSIDE

MAY 2001

VOL. 7, NO. 5 (pages 49-60)

Use care plan to stabilize anxiety in cardiac patients

Multidisciplinary approach, educational efforts key to OK agency's success

An Oklahoma agency has improved the stabilization of anxiety in its cardiac patients through a program of early assessment and intervention.

Grove-based TRINITY LifeCare, a business of INTEGRIS Grove General Hospital, launched the program four years ago in response to data gleaned from its participation in the Medicare Quality Assurance and Improvement Demonstration Project, says **Betty Reichert**, RN, performance improvement coordinator.

Reichert says analysis of the Outcome and Assessment Information Set (OASIS) surveys conducted by the agency as part of the demonstration outcome reports showed worse-than-normal responses on key questions relating to patients' reports of anxiety.

"[OASIS item] MO580 asks: 'When is the patient anxious?' MO600 [discusses] behavioral changes that might come into play, and MO620 [is] about the frequency of the different behaviors," she explains.

"When we got our outcome report, we were lower than the reference group, so we felt it was something we needed to look at."

Charting possible outcomes

Reichert says TRINITY LifeCare put together a multidisciplinary team to examine the issue further. The group did chart reviews, looking at both patients who met the expected outcome for stabilizing anxiety and those who didn't.

"I think we did 15 or 20 charts of both the ones who had met it and the ones who had not met the outcome," she says.

Those results helped the team focus in on cardiac patients, who appeared to be at higher risk for problems stabilizing anxiety. That's in keeping with research that shows anxiety to be a significant health risk for patients recovering from heart problems.

After extensive review, TRINITY LifeCare's team identified the problem it wanted to tackle, Reichert says: Staff were doing incomplete assessment and documentation of the causes of anxiety, and failing to apply interventions and goals that were directly targeted at the anxiety.

The team then formulated an action plan **(inserted in this issue)** that set up care behaviors expected of staff:

• **Evaluating and documenting the cause and level of anxiety being reported by the patient, as well as coping skills being used.** This would apply not only to anxiety identified during OASIS but also at any point during the course of care, Reichert says. The existing care plan would be amended to include assessment of mental status.

Developing an anxiety care plan

• **Addressing anxiety in the care planning process, whenever it was found to interfere with health.**

Reichert says TRINITY LifeCare developed its own standardized anxiety care plan, separate from the basic plan of care **(see plan, inserted in this issue)**. The form is in a checklist format, including a nursing diagnosis of the cause of the anxiety, the assessments performed, teaching conducted, and other interventions tried.

Although the focus of the program was on cardiac patients, the form is used whenever any patient reports a problem with anxiety, she says.

"It's also used with noncardiac patients — we encourage the staff to do that as well," she says. "Although we were seeing in outcomes that cardiac patients were at greater risk, there could be anxiety with any diagnosis for different reasons. The care plan was generic as far as anxiety, no matter what the diagnosis."

Interventions might include teaching the patient coping mechanisms such as relaxation exercises or positive thinking. Reichert says staff also could refer the patient to a professional such as a social worker, therapist, or clergy.

"We could get an MSW in there to help with counseling if there was depression because of a death in the family or something like that," she says.

• **Educating staff to suggest interventions to help patients stabilize or lessen anxiety.**

TRINITY LifeCare held an inservice for all staff on the subject, conducted by a mental health professional from a nearby hospital. Reichert says this was an important step to help staff deal with a condition that might be more difficult to interpret than the physical problems they were used to seeing.

"As this team was meeting, we began to see that anxiety is not something as easy to identify and to fix as a physical condition," she says. "It

CE questions

5. A good anxiety stabilization care plan would contain which of the following?
   A. A diagnosis of the cause of the anxiety.
   B. A recommendation that the patient ignore the anxiety.
   C. both of the above
   D. none of the above

6. What is a good reason for holding PPS inservices for contract therapists?
   A. Therapists sometimes have to handle the discharge OASIS, and without additional education they might overlook certain items.
   B. A quality manager will want to make certain staff nurses and contract therapists are handling documentation similarly.
   C. Medicare audits often focus on therapy services, so it's important to provide guidance to therapists, whether they are contractors or employees.
   D. All of the above are good reasons for holding PPS inservices for contract therapists.

7. Which of the following is *not* a good strategy for a smaller agency that is trying to remain solvent under PPS reimbursement?
   A. Market your business.
   B. Cut costs by providing only the barebones staff education.
   C. Know your medical supply costs.
   D. Fully monitor all activities.

8. The new Medicare homebound definition allows a patient to leave the home to receive what type of services at an adult day care center?
   A. medical
   B. therapeutic
   C. psychosocial
   D. all of the above

Source: TRINITY LifeCare, Grove, OK.

really made our team members and our staff think a little bit differently about things other than physical conditions that can create problems with people's health status."

The agency's anxiety stabilization program has shown success every year since it was instituted in 1997, based on OASIS results from patients over time.

Whereas previously, TRINITY LifeCare had shown worse outcomes than the reference group, the agency's outcomes improved over time so that for the 1999-2000 year, its outcomes were significantly better than that of the reference group. **(See chart, above.)**

Reichert says that while the agency hasn't held subsequent inservices, the use of the care plan keeps the issue in the minds of staff members. In addition, when the agency gets a new outcome report, she publishes the information to remind staff of the importance of anxiety stabilization.

Her suggestions for agencies attempting to emulate TRINITY LifeCare's success:

Source

- **Betty Reichert**, Performance Improvement Coordinator, INTEGRIS TRINITY LifeCare, P.O. Box 450458, Grove, OK 74345-0458. Phone: (918) 786-4461, ext. 3803. Fax: (918) 787-3645. E-mail: reicbm@integris-health.com.

• **Make it multidisciplinary.** The original team who researched the issue and formulated the action plan included nurses, aides, and social workers.

"I think having a team with multiple disciplines is important because they bring in different views of the patient than nursing sometimes does," she says.

• **Develop a separate care plan for anxiety.** TRINITY LifeCare's checklist format makes it easy for a nurse to ask the necessary questions and find the appropriate interventions.

• **Don't just focus on what isn't working.** The team looked both at patients who did meet the outcome and those who didn't. That approach makes it easier not only to see what doesn't work, but also those interventions that do work — and to pinpoint staff who can help.

"This helps you identify a staff member who could help with inservicing, and I think that's an important thing to do — to draw on the resources you have within your agency. That's becoming more and more important with the cost factors in home health."

Provide staff with information

• **Tap local mental health resources.** Reichert says the two-hour inservice by the local mental health professional was a real benefit to staff who were grappling with the elusiveness of an anxiety diagnosis.

"The person we had was very dynamic and easygoing and answered a lot of questions," she says. "That was important because this was a very difficult subject to get our hands around as far as how we were going to improve this."

Reichert also recommended that the inservice be an interactive-type presentation, giving staff lots of opportunity to ask questions and pose problems to the speaker. ■

Educate contract workers to improve clinical quality

NY agency starts special inservices for therapists

Therapy is a major part of home care services, and yet many agencies must contract for part or all of their therapists. This may lead to problems with scheduling and with quality control of documentation.

The Visiting Nurse Association of Utica and Oneida County Inc. in Utica, NY, has begun a special inservice program for all therapists who contract with the agency.

Therapists meet quarterly at the agency, so it was a simple matter to add education to the meeting's agenda, says **Jeanne Gymburch**, SPHN, supervisor of special programs for the agency, which serves the Utica area of upstate New York.

Gymburch and the agency's quality improvement coordinator **Norma Swartout**, RN, were concerned about documentation of the higher-income episode payments that included physical therapy, occupational therapy, and speech therapy.

"We wanted to include education for therapists at their quarterly meetings," Gymburch says. "So we began with the September meeting, where we told them about the prospective payment system [PPS] and how it would begin in October."

Gymburch told therapists how it was important under PPS to focus on the skilled needs of the client and the client's homebound status.

Gymburch and Swartout wanted therapists to focus on making their documentation as complete as possible, Swartout says.

"It's important that the therapists' documentation is congruent with what the nurses are charting," Swartout adds. "We need to see the patient more holistically."

After that initial meeting with the therapists, the agency conducted a quality improvement (QI) study, Gymburch says.

The QI study looked at the therapists' October notes to assess two main points:

1. Did the therapist document homebound status correctly?

2. Did the therapist's notes reflect progress toward a goal?

"If the surveyor or payer pulled that note, would it stand alone as meeting those two requirements of homebound status and have a skilled need and illustrate which goals we're working toward achieving?" Gymburch asks.

Gymburch, Swartout, and a local college student participating in leadership training together conducted the study. They took a roster of active therapy cases, randomly choosing every fifth case to review. A total of 11 charts were reviewed, including 16 therapy cases, since some clients had more than one therapy discipline in the home at the same time.

Study examined various QI indicators

"Besides the homebound and progress-toward-goals, we also looked to make sure therapy order was on the [Medicare] 485, and looked for evidence of patient care conferencing between the therapist and the nursing supervisor," Gymburch says.

A supervisor would take the therapist's order received from the physician and document this on a load form that is sent to data entry for producing the Medicare 485 form.

The last indicator checked during the QI study was whether the client signed the service verification form, Gymburch notes.

"We've had that form with the nursing department for probably a year and a half, and we've always had it with home health aides," she explains. "We initiated it as a good thing for the client to sign as a way of documenting the visit."

The therapists had been lax on having these forms signed, so it was included as an indicator.

A target of 75% accuracy was set for the quality improvement study indicators, and the study found that three of the five goals met that target with 81% or greater compliance, Gymburch says.

The successful indicators were the orders on the Medicare 485 which had an 81% compliance rate; the evidence of communication between the therapist and supervisor had a 94% compliance rate; and progress made toward goals was documented on each note in 84% of the cases.

The areas that needed improvement included documentation of homebound status, which had only 69% compliance, and the signing of the service verification form, which had 38% compliance.

Sources

- **Jeanne Gymburch**, SPHN, Supervisor of Special Programs, and **Norma Swartout**, RN, Quality Improvement Coordinator, Visiting Nurse Association of Utica and Oneida County Inc., 2608 Genesee St., Utica, NY 13502-6003. Telephone: (315) 735-8521.

However, the last indicator had too small of a sample to be a fair representation of how well therapists were doing with having the service verification forms signed, Gymburch says.

"They keep the service verification form in their possession until they discharge the client, so we had a low number of charts that fell into that category; it was not a good representative sample," Gymburch adds. "We are focusing on that again in our next study, which will have a larger sample."

Improvement gained through inservices

After evaluating the results, the QI team decided the study demonstrated an opportunity for improvement that could be addressed through an inservice with therapists and a follow-up study.

In the meantime, the agency was sent some Medicare 488 forms, which are Medicare audit requests. Just as Gymburch had expected, these all focused on therapy.

At the next quarterly meeting with therapists, Gymburch asked them to attend either a noon meeting or a 4 p.m. meeting on a separate day. Both meetings were held during the middle of the week in February 2001.

Gymburch told therapists the agency had conducted a study and showed them the results. She said there would be a 100% note review as a follow-up study.

Therapists were given a packet of information and were told about various policies of which they might be unaware. For example, whether an episode is a start-of-care, recertification, or discharge, its documentation has to be "locked" into the computer within seven days, Gymburch explains.

"We talked to the therapists about the discharge and the therapy role and what a therapist has to do if therapy is the last skilled discipline on the case," she says.

When therapists are the ones completing the discharge Outcome and Assessment Information Set (OASIS) form, they have to document evidence of a drug regimen review at all OASIS time points, including the start of care, resumption of care, recertification, and discharge.

"So if therapy was the last skilled discipline, the therapist would be responsible for submitting to the office a drug list for nursing review," Gymburch adds.

The inservice lasted one hour, and the packet of information, which included copies of the discharge OASIS, the comprehensive discharge form, and the recertification form, reinforced the lecture.

About 40 therapists attended the two meetings, and those who were unable to attend had individual training sessions, Gymburch says.

The agency has received some positive feedback about the inservice from the therapists who attended, Swartout says. "I think it definitely assisted us in making the paperwork more complete."

During the week after the inservices, Gymburch and Swartout began the 100% chart review. It's a time-consuming process, using about 15 hours per week between them, but it is necessary, Gymburch says.

The chart review will continue indefinitely as the agency waits for a response to their answers to the Medicare audit requests. "If Medicare doesn't like what they read or if they deny what you do with the skill, they can deny the whole episode," Gymburch says.

After the study is completed, based on the current 100% chart review, the agency will share the results with therapists and then decide on the next QI strategy. "Well, make decisions after we have the results," Gymburch says. ■

QI medicine may cure documentation woes

MI agency creates 'Education at a Glance'

The staff at Oakwood Home Care Services in Allen Park, MI, continued to have difficulty in completing their Outcome and Assessment Information Set (OASIS) forms accurately even after multiple inservices, so managers devised a brief, attention-grabbing educational device that would provide weekly updates, reminders, and lessons.

"It seemed like what the staff needed was a follow-up, so we decided to give them a quick little education sheet that they could read at a glance, and that's why we named it 'Education at a Glance,'" says **Joyce Berry**, RN, MS, BSN, manager of regulatory compliance and accreditation for the large suburban agency, which serves three counties in southeastern Michigan near Detroit. The agency had more than 6,300 unduplicated admissions last year and provides more than 50,000 visits a year.

Starting in August 2000, Berry and other managers created one-page educational sheets on bright orange paper. They gave the staff purple folders in which to store the sheets so that they would have them readily available if there was a question about OASIS or documentation that they needed to have answered, Berry says.

Each sheet took one small piece of a particular question or problem. For example, the Dec. 21, 2000, Education at a Glance focuses on the OASIS question M0032, and a Nov. 29, 2000, sheet is about how to use a discharge OASIS assessment form. **(See samples of Education at a Glance sheets, p. 55.)**

"Instead of looking at a four- or five-page handout, they were given the information in little segments, one segment at a time," Berry explains.

At first, the staff received the educational sheets twice a week, but that soon proved to be too time-consuming for managers and staff, so it became a weekly tradition in which the staff would find the sheets in their mailboxes on Fridays. On the same day, a compliance specialist at the agency will read a summary of the educational sheet into a voice mail message that is sent to all employees.

Education tips were played on voice mail

"If people feel like they're too busy to read it, maybe they'll listen to it on voice mail," Berry says.

The staff had positive feedback for the Education at a Glance initially, and managers noticed some improvement in documentation. However, some problems persisted, so managers had to move to the next phase of quality improvement.

One of the more persistent problems involved how the staff filled out the verification of change orders.

"At the top of the form, they have to write down the order date, and sometimes they didn't fill that in at all," Berry says. "We have to enter that information into the computer, and the person doing the order entry had no idea what to enter."

Nurses also sometimes forgot to put down a physician's phone number at the bottom of the form. Since the phone number was how the agency's computer identified each physician, this also proved a major problem. A third problem involved the presumption of care form. Nurses would carelessly write that the care was resumed for nine weeks even when there wasn't that much time remaining in the episode of care, Berry says.

"Before the prospective payment system [PPS], we weren't resuming care; but now with Medicare patients, we have to keep them within the same 60-day episode and it doesn't matter how many times they went into the hospital," Berry explains. "If they keep coming back to you, your payment is for the whole 60 days, unless there's a significant change in their condition, such as a patient originally diagnosed with pneumonia returns to home care after having a stroke."

To solve the problem of documentation mistakes, mostly due to sloppiness, managers decided to follow up the educational sheets with supervisor auditing and oversight, Berry says.

The responsibility for entering data from the presumption of care and recertification forms was given to the team leaders. This has a twofold benefit: First, the managers are in a better position to determine what some of the missing data might be because they know these cases and, secondly, they now can see exactly what the problems are with their own team's documentation and so they can easily fix the problem by having meetings with them, Berry says.

"Team leaders meet with their staff all the time, and they have closer access to them than we do, so it works better," she says. "Team leaders would say, 'yes,' that it's taking them time to do this, but at least it's putting the problem back where it's occurring, and we're no longer asking a clerical person to try to guess or make determinations or track down a clinical person to find out the correct answer."

Although the most recent change to using team leaders was too recent to measure outcomes, Berry says it likely will show improvements in documentation, whereas the educational sheets weren't enough.

"We had educated the staff all we could educate them, and we realized that the Education at a Glance was not causing enough of a change in their behavior with regards to the change in orders, so it was a performance issue," Berry adds. "We put the correction back with the people who actually monitored their performance."

Berry's department had been auditing admission assessment documentation and then contacting individual nurses when errors were found. This did not seem to result in the necessary behavioral changes, so her department handed over the monitoring and auditing tasks to the nurse managers.

"This way, they look at all admissions, and if

(Continued on page 56)

Michigan agency creates 'Education at a Glance'

Oakwood Home Care Services of Allen Park, MI, decided to give staff some quick reminders about documentation and Medicare assessment.

Each week, one-page educational sheets called "Education at a Glance" are sent to the staff and repeated in voice mail messages. Oakwood Home Care Services shares with *Homecare Quality Management* these three examples of the educational sheets:

1. Regulatory Compliance and Accreditation

Memo #16, November 29, 2000

DISCHARGE OASIS ASSESSMENTS

• Use this form when:

— your patient gets transferred to an inpatient facility without agency discharge (THIS OPTION IS FOR STRAIGHT MEDICARE PATIENTS ONLY).

Selection #6 on M0100 of the discharge OASIS form.

— your patient gets transferred to an inpatient facility with agency discharge.

Selection #7 on M0100 of the discharge OASIS form.

— your patient dies at home. Selection #8 on M0100 of the discharge OASIS form.

— your patient is discharged from agency. Selection #9 on M0100 of the discharge OASIS form.

— your patient gets discharged from agency — no visits after start of care. Selection #10 on M0100 of the discharge OASIS form.

• Use the discharge summary (the one that goes to the doctor) when:

Your patient is discharged from the agency. (Selection #7, #8, #9, or #10 on M0100 of the discharge OASIS form.)

• Do not use the discharge summary (the one that goes to the doctor) when:

— your straight Medicare patient gets transferred to an inpatient facility without agency discharge. Selection #6 on M0100 of the discharge OASIS form.

REMEMBER THESE GUIDELINES BEFORE DISCHARGING

☐ Conference with all disciplines involved in the case.

☐ Check the patient's insurance.

☐ Straight Medicare patients are not discharged when transferred to an inpatient facility within a current cert period.

☐ Check M0100. Read all the selections before you mark one. Mark only one.

☐ Fill in the discharge summary only when the patient is actually discharged from the agency.

2. Regulatory Compliance and Accreditation

December 21, 2000; Memo #17

Have you ever noticed OASIS question M0032? Can you remember what it asks for?

You aren't alone. Most people can't.

OASIS question M0032 asks for the resumption date. If your patient has not been resumed this question must be answered "N/A." Remember the rule, "answer every OASIS question unless it is part of a skip pattern?" A date would only be marked for a straight Medicare patient that has been resumed following an inpatient stay. Once a patient has been resumed, this date should be reflected on every following OASIS assessment in the episode of care.

For example:

• Ima Hhrg's start of care date is 11-23-2000.

• She was hospitalized on 11-30-2000. (Of course, we filled out a transfer to an inpatient facility without discharge OASIS.)

• Ms. Hhrg came out of the hospital and was resumed on 12-5-2000. (A ROC OASIS is required.)

• She had to go back into the hospital on 12-12-2000. (On that transfer to an inpatient facility OASIS form, M0032 would show 12-5-2000).

• When Ms. Hhrg was discharged from the hospital and resumed by her home care nurse on 12-15-2000 (again, a ROC OASIS is required), her new resumption date would be 12-15-2000.

• On her discharge OASIS, question M0032 would read 12-15-2000. (The start of care date M0030 remains unchanged throughout the entire episode of care.)

3. Regulatory Compliance and Accreditation

January 11, 2001, Memo #20

Do you know why OASIS questions M0190, M0210, and M0230/M0240 (on the admit) all ask for a medical diagnosis?

Well . . .

M0190 asks for the inpatient diagnosis; "The condition treated during an inpatient facility stay within the last 14 days."

M0210 asks for the "medical diagnosis for conditions requiring changed medical treatment regimen."

M0230/M0240 asks for the home care diagnosis. This is the reason we are providing home care.

Do you know where on the OASIS to write the diagnosis codes found on the insurance verification

(Continued next page)

form? (The insurance verification form comes with the CPC when you receive the admit pack.)

Well . . .

They go under question M0190! Intake codes the inpatient diagnosis only. Remember that M0190, M0210, and M0230 can be all the same, or all different! We all know that sometimes the reason the patient was hospitalized is not necessarily the reason they need home care. Remember IMA Hhrg?

The point?

The diagnosis codes found on the insurance verification form are for the inpatient diagnosis. The home care diagnosis may be totally different! ■

something is not done correctly, they can deal with the staff," Berry says. "It makes it a lot more effective if the person monitoring your performance knows what your problem is, and employees respond more to their managers."

M0150 question caused many problems

Some of the biggest documentation problems on the OASIS form have involved the M0150 question, which asks for the patient's insurance. Nurses were failing to indicate that the insurance was Medicare if it was a Medicare HMO, and this type of omission results in inaccurate data being sent to the state office that handles Medicare data, Berry says.

The problem was that staff didn't understand that they had to indicate both that it was Medicare reimbursement and that it was Medicare HMO reimbursement on the form, Berry explains.

The same problem cropped up later when patients were discharged to another facility because the discharge form also required that information, and staff would either forget or mark it incorrectly.

Since the managers began to review these forms and monitoring nurses' documentation, those types of problems have improved, Berry says.

"The managers resented the extra work at first, but I think they found it enlightening. They have met with staff on a one-on-one basis to correct problems," she adds. ■

Source

- **Joyce Berry**, RN, BSN, MS, Manager, Regulatory Compliance and Accreditation, Oakwood Home Care Services, 1633 Fairlane Circle, Suite 100, Allen Park, NY 48101. Telephone: (800) 757-7711.

Medicare homebound definition gets broader

Home health patients could benefit from change

A recent change in the definition of patients who can receive Medicare home health benefits will allow homebound patients to leave the house to receive services in adult day care centers.

The change, passed by Congress in December as part of a Medicare / Medicaid bill, is unlikely to unleash a flood of new home health patients.

Most patients who would be affected had previously been forgoing care at the day centers rather than give up home health benefits. But supporters say the new definition will provide therapeutic benefits for home health patients, ease the burden on their caregivers, and give agencies greater flexibility in providing services.

"We believe that adult day services can really complement Medicare home health and provide a lot of relief for families," says **Howard Bedlin**, vice president for public policy and advocacy for the National Council on the Aging.

But he and others involved in the push to change the definition say they expect use of the new homebound rules to take place slowly, as the Health Care Financing Administration (HCFA) and fiscal intermediaries work out what exactly will be allowed.

Day care provides benefits

The definition, set out by HCFA in a program memorandum in February, states:

"The absence of an individual from home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or

accredited to furnish adult day-care services in the state, shall not disqualify an individual from being considered to be confined to his home."

William Dombi, Esq., vice president for law at the National Association for Home Care (NAHC), says he expects home care providers to use the new definition "cautiously," but that it is expected to lead to an expansion of services.

"The Congressional Budget Office says it's going to cost money to do this change, so that translates to an expected expansion," Dombi says. "In the early stages, I would suspect that the impact would be limited because the home care providers are going to be cautiously approaching this expansion."

NAHC joined with the National Council on the Aging in working for the change. Also lobbying for the expanded definition was the Alzheimer's Association, which is "very pleased" with the outcome, says **Bonnie Hogue**, director of federal and state policy.

Hogue says under the previous definition, patients with Alzheimer's disease who received care at adult day centers were unable to qualify for Medicare home health services. Because home care is more expensive than adult day care, most patients chose to forego the day center visits in order to continue receiving home health care.

According to the Alzheimer's Association, adult day care can help Alzheimer's patients with exercise and movement activities and personal interaction, and can help reduce caregiver burden.

Hogue notes that patients with Alzheimer's disease often have comorbid conditions, such as cancer or heart disease, which require hospitalization and subsequent home health care.

She says when some of those patients have had to give up the adult day care, they began to decline more rapidly than they might have otherwise.

"For people with Alzheimer's disease, that component of dementia treatment within adult day care can often be a very critical component of their care," she says. "We heard of cases where people who had left the hospital didn't get back to adult day care and eventually ended up in a nursing home because of the decline."

Bedlin says he believes allowing home health patients to also receive services at adult day centers could result in patients being able to live at home longer.

Another benefit of the expanded definition could be more efficient delivery of services by home health agencies, Dombi says.

"We're looking at it as an opportunity for both the patient and the home care provider to try to create some cost-effectiveness in delivery of services as well as convenience for the patient," he says.

For example, he says, diabetic patients could receive insulin injections at the day care center, or someone needing personal exercise assistance could receive it there. For some agencies, providing care directly at the centers would reduce costs.

However, Dombi says, those visits wouldn't be counted by HCFA as qualifying skilled visits for coverage purposes. They couldn't be counted when determining low-utilization payment adjustments and outlier payments.

Sources

- **Howard Bedlin**, Vice President for Public Policy and Advocacy, National Council on the Aging, 409 Third St. S.W., Washington DC 20024. Phone: (202) 479-6685. Fax: (202) 479-0735. Web: www.ncoa.org.
- **William Dombi**, Esq., Vice President for Law, National Association for Home Care, 228 Seventh St. S.E., Washington, DC 20003. Phone: (202) 547-7424. Web: www.nahc.org.
- **Bonnie Hogue**, Director of Federal and State Policy, Alzheimer's Association, 1319 F St. N.W., Suite 710, Washington, DC 20004. Phone: (202) 393-7737. Fax: (202) 393-2109. E-mail: bonnie.hogue@alz.org.

Working out details

Dombi says NAHC representatives have been meeting with HCFA officials to determine the full scope of what will be allowed under the adult day care definition. Allowed activities would have to meet the therapeutic and psychosocial requirements in the definition.

"One question that's come to us from Congress is, "Does psychosocial include going to a center to play bingo?" The answer is, it really depends on the patient," Dombi says. "In some cases, absolutely yes. Alzheimer's patients will gain a lot from that kind of integrative activity with others. And many other homebound patients would as well."

Bedlin says he expects there will be concern among agencies over how the fiscal intermediaries would review claims from patients attending adult day care. As a result, claims using the new definition could start slowly.

"I do think it will take several months, but I expect by the end of this year, we'll have some

clarity, and home health agencies will be comfortable knowing that they can submit a claim for payment when a person is going to adult day services — and get it covered."

And the definition could get even looser, if various movements now under way pan out. Bedlin says a coalition of disability rights groups has asked for an even broader homebound definition and further legislation on the issue could be introduced this year. ■

Expert shows small agencies how to succeed

Keep up quality under many constraints

Home care agencies that handle between 200 and 1,000 episodes a year may have a variety of quality issues that arise because of tight financial constraints. Coping with these concerns can be challenging.

This is particularly true in the southwestern part of the United States where the majority of home health agencies are small, says **Vern Peterschmidt**, president of Peterschmidt and Associates in Albuquerque, NM. Last September, Peterschmidt discussed the financial challenges of managing a small home care agency at the 19th Annual Meeting & HOMECAREExpo, sponsored by the Washington, DC-based National Association for Home Care, which was held in New Orleans.

"The majority of home health agencies in the Southwest are very small in nature, with fewer than 1,000 episodes per year," Peterschmidt says.

Small agencies often are located in rural areas, and in the Southwest, these agencies may be isolated geographically from other health care organizations, which may present staffing and other challenges.

"You don't have people to bounce off your ideas," Peterschmidt explains. "It may be that few people in your agency understand the prospective payment system [PPS] as well as it should be understood."

Also, nurses in small agencies have to care for a broad range of patients, and that can cause PPS reimbursement problems because if they don't understand PPS adequately, then they may not understand how they are being paid for each of these patients, he adds.

Another common problem is that quality assurance standards in smaller agencies might be less stringent than with larger organizations, Peterschmidt says.

"We're concerned about documentation problems that a small agency might have," Peterschmidt says. "They might not be using clinical pathways; they might have a problem obtaining specialists, like wound care specialists."

Smaller agencies also often have more difficulty with maintaining adequate staffing, and clients may perceive them to be less stable than a larger agency, he adds.

Peterschmidt offers these strategies for a smaller agency to better handle their financial and other concerns:

1. Learn about outsourcing.

"Smaller agencies might not know about the opportunities provided by outsourcing," Peterschmidt says. "They need someone at the director's level to bounce ideas off."

So it's important to consider outsourcing as an option when it's difficult to find full-time staff. Also, smaller home care agencies could improve their knowledge base by hiring consultants. Agency directors might look for nursing specialists and consulting RNs who could fill in staffing gaps and educate the agency's management and staff.

"You'll pay the price to bring these people in, but I think the reward you'll receive and the satisfaction of having things done correctly is worth the price," Peterschmidt says.

Smaller agencies obviously may outsource and contract with other companies to provide therapy services.

Outsourcing also might help a smaller agency even in administrative areas, such as payroll, budgeting, and accounting. "All of those things

COMING IN FUTURE MONTHS

- Federal ergonomic rules: What's required now?
- Verbal orders: Ensuring accuracy
- Need qualified nurses? You might need to search across the Pacific
- Staffing problems are long-term challenge for agencies

could be assisted by having some of those tasks outsourced, or by hiring consultants or part-time people," Peterschmidt says. "It's not appropriate any longer to have full-time positions if they're not necessary because you have to control your costs."

The bottom line is that smaller agencies have to operate as efficiently as larger agencies, although they may not have the personnel in order to do the necessary functions of budgeting and revenue projections, he adds.

2. Stress staff education.

With PPS guiding many decisions home care agencies make, it's very important to have a well-educated staff, which means ensuring employees understand the reimbursement standards and the importance of precise and accurate documentation, Peterschmidt says.

"Everyone needs to understand this new system and understand about how the payment side of the business works," he explains.

Since it's difficult for smaller agencies to take staff time for inservices or to hire educators, they could supplement in-house education by using educational opportunities, which often are inexpensive, provided by state and national home care associations.

"I find that a lot of small agencies say, 'I cannot afford to belong to the state association or the national association,' and I say, 'You can't afford *not* to belong, because they give you educational opportunities at reasonable price levels.'"

Also, through home care associations, administrators of small agencies will learn from their peers about what is happening and changing in their industry.

3. Fully monitor all activities.

Every agency, whether large or small, needs to monitor all clinical activities through reporting mechanisms that include the monitoring of utilization levels, outcomes, documentation, and how these are tied to billing.

Agencies also need to have a billing system that provides clinical reports and financial reports so that someone reviewing billing can easily see what type of patients are being served, how many visits are incurred in various diagnostic categories, and what the outcomes are, Peterschmidt says.

"One good thing is that most billing systems will fit any size of agency," Peterschmidt says. "Many billing systems have great reporting systems connected with them, but agencies do not understand the management reports that come out of that, so they don't use them."

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. ■

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

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $319. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies. $191 per year; 10 or more additional copies, $128 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $53 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Contributing Editors: **Melinda Young, Suzanne Koziatek**.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Executive Editor: **Jim Stommen**, (404) 262-5402, (jim.stommen@ahcpub.com).
Editor: **Holland Johnson**, (404) 262-5540, (holland.johnson@ahcpub.com).
Production Editor: **Nancy McCreary**.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Editorial Questions

For questions or comments, call **Holland Johnson** at (404) 262-5540

Source

- **Vern Peterschmidt**, President, Peterschmidt and Associates, 6220 San Mateo Blvd. N.E., Suite 200, Albuquerque, NM 87109. Telephone: (505) 858-0708.

4. Know your medical supply costs.

Another problem area for smaller agencies involves monitoring medical supplies. Since medical supplies are now part of the Medicare reimbursement, agencies need to know their medical supply costs per episode.

This requires agencies to monitor their medical supply items and the costs of those items used by Medicare reimbursement. They'll also need to monitor the utilization of medical supplies, track the costs individually, and distinguish between routine and nonroutine medical supplies.

Smaller agencies could reduce supply costs by belonging to an association that has group-purchasing agreements with various vendors, and this information could be obtained from a state home care association.

"If you have wound care patients, they incur a lot of wound care supply costs, and those could be at such a level that they cause an agency to have major financial losses," Peterschmidt offers as an example. "So you may not be able to afford to serve all kinds of patients, and it's OK to not serve all types of patients; because if you cannot afford to give certain patients the care they need, then you cannot afford to serve them, and it'd be appropriate to take those patients on."

Treat agency as small business

5. Make quality improvement cost-effective.

Look for products that will assist a quality manager in establishing standards for patient care, Peterschmidt advises.

Smaller agencies might not have enough patient volume to establish their own clinical pathways, so they should try to find programs that will assist them in establishing quality standards.

"A larger agency might use its own utilization experience to establish standards," Peterschmidt explains. "But a smaller agency can use clinical pathways because it's a guide to achieving their outcomes."

6. Market your business.

"I have a concern that small home care agencies do not look at themselves as a small business, although small agencies can make a profit," Peterschmidt says. "That involves protecting your referral source and expanding your referral source, and the only way you can do that is to market your services."

Marketing will help an agency keep its physician referrals and it will help an agency expand and grow.

Small agencies, again, may need to hire a consultant to assist them with marketing strategies.

7. Develop good cash-flow projections.

Cash-flow problems can be particularly drastic in small agencies because they can live or die by the next payroll, Peterschmidt notes. "So they need to have good cash-flow projections and have a good lending source."

After the interim payment system (IPS) was implemented, many small agencies closed because they didn't understand the concept of IPS and how that was different from a cost-based system, Peterschmidt says.

"I really felt like if they had the knowledge, they would have stayed open and would have planned for the changes," he adds. "The cost-based system encourages agencies not to manage their own business, but PPS is the final step in saying, 'Now, we're here, and you have to operate as a small business.'" ■

ANXIETY CARE PLAN

CLIENT_____ DATE_____

NURSING DIAGNOSIS: Potential/actual **ANXIETY**; related to ... (Mark appropriate box)

- ❒ **Ineffective coping skills**
- ❒ **Disturbance in self-esteem**
- ❒ **Change in health status**
- ❒ **Loss of spouse**
- ❒ **Altered thought process**
- ❒ **Significant loss**
- ❒ **Altered comfort level**
- ❒ **Spiritual distress**
- ❒ **Impaired communication**
- ❒ **Social isolation/withdrawal**
- ❒ **Impaired physical mobility**
- ❒ **Financial hardship**
- ❒ **Other:**_____

GOAL:
- ❒ **Client will demonstrate problem-solving skills by** _____.
- ❒ **Client will demonstrate a lower level of anxiety by maximum independent functioning within confines of diagnosis.**
- ❒ **Client will be able to identify triggers for and symptoms of anxiety and healthy alternative ways to deal with it.**
- ❒ **Other:**_____

RN Signature_____ Met Goals_____ Cont. Plan_____ Revised Plan_____

NURSING ORDERS

Check only interventions that apply to goal achievement

Assessment of
- ___ Appropriate coping skills.
- ___ Home environment to provide a calm and comfortable/safe atmosphere.
- ___ Client's verbal and non-verbal cues and participate in active listening.
- ___ S/S of anxiety.
- ___ Interaction/side effects of anxiety related medications.
- ___ Physical response to anxiety.
- ___ Client's perception of the threat of the situation.
- ___ Happenings, thoughts and feelings preceding the anxiety.
- ___ Physiological/social needs and stressors.
- ___ Other (specify)_____.

TEACHING/INSTRUCTION

Check only instructions that apply to goal achievement (Client or Caregiver)

Instruct in
- ___ Alternative coping mechanisms.
- ___ Relaxation techniques and exercises and encourage daily exercises.
- ___ Positive thinking and avenues to express feelings.
- ___ Benefits of providing a calm and comfortable environment.
- ___ Medications related to anxiety disorder.
- ___ Pain/symptom control measures (specify)_____.
- ___ Safety measures related to (specify)_____.
- ___ S/S of anxiety.
- ___ Other (specify)_____.

INTERVENTIONS

Check only interventions that apply to goal achievement

- ___ Discuss the client's behaviors in a constructive manner with him/her and encourage positive behaviors.
- ___ Encourage client to express self in an appropriate manner and to explore the threat and/or fear of conflict.
- ___ Refer to MSW, MD, therapist, clergy as needed.

3/21/97

TRINITY LifeCare Action Plan

Stabilization of Anxiety in Cardiac Clients

Identified Problem:

Incomplete assessment and documentation of etiology of anxiety with specific interventions and goals directly related to the anxiety state.

Care Behaviors or Processes Selected as Best Practices

1. Whenever anxiety is identified during course of care, the level of anxiety, etiology and coping skills will be evaluated and documented.
2. Anxiety will be addressed in care planning process when it interferes with health status.
3. Staff will be educated to specific interventions appropriate to stabilize/lessen anxiety that interferes with health status.

Actions:

1. Revise existing care plan to include assessment of mental status.
2. Develop standardized anxiety care plan with protocol/guidelines to follow to identify etiology and coping
3. Presentation to staff for recognition of anxiety and etiology with specific intervention and documentation approaches.
4. In-service staff on revised and new standardized care plans.

Source of both charts: TRINITY LifeCare, Grove, OK.