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OASIS data scanning technology: Is it right for your agency?

A look at scanning technology and what it can offer your agency

While the verdict is still out on when home health agencies must submit OASIS data to the Health Care Financing Administration (HCFA), there are some grim, inescapable realities: The time is coming, and it's bringing more work with it. No surprise then that agencies are searching for ways to ease this increased burden on their staff without breaking budgets already frayed by the interim payment system (IPS).

One possible source of help: HCFA is offering the data collection software program Home Assessment Validation ENtry (HAVEN). **(See box, p. 16.)** However, don't start celebrating yet, cautions **Robert W. Anderson**, CEO of Windham, NH-based Continuum Care Technologies Inc., a firm specializing in automated database collection for the health industry.

"It's a major fallacy to think that HAVEN will give you data reports and clean them up. It's just for data entry," he says. Whether it will ease any burdens is debatable.

One of the more obvious — and, at first glance, easier — means of collecting and submitting OASIS data is using scanning software and technology. Anderson notes at least one benefit is the perceived cost savings for agencies using scanning software.

"With less handwritten information to be entered, you can use a less-skilled person than you need for data entry. So once the clinician becomes accustomed to the forms, within three to four months a system could have paid for itself and then start pouring money back into the agency over time," he explains.

Scanning at work

Certainly the idea of running your aides' forms through a scanner and having the data magically appear in your computer, ready to be submitted, is appealing. But if you think that with a flick of a switch your problems will be solved, think again. In reality, getting the most out of scanning technology involves careful planning, training, and money. So before you rush to the nearest software vendor with an order in hand, take the time to investigate all your options, scanning and otherwise, before making what amounts to a costly decision. **(See list of vendors, p. 15.)**

Scanning software does what the name suggests. It scans information, then interprets and translates it before dumping it into a computer

file ready for further use. There are two basic varieties: image scanning and data scanning (with data, in this case, referring to written information that will need to be manipulated).

Image scanning has eliminated the need for publications to paste in photographs where needed. Just run the slide or picture through a flat-bed scanner or its equivalent, save the image as a file, and insert where needed. From there, if the graphic designer wishes, the image may undergo myriad changes to where the original image is no longer recognizable.

While the number of actions that can be performed on the image are countless, the one constant is that the image is considered a single entity. Portions of the picture may be lightened to make the background appear sunnier or a stray bit of lint removed from a lapel, but in either case the image is considered as one unit.

Points to consider

This one-for-all system is hardly useful when it comes to entering written data sets, portions of which may be needed in other programs or files. In such cases, scanning a form in the above-mentioned manner would prove a dismal utilitarian failure — you could see the form, lighten it, change its colors, and even cause it to appear as if it were melting, but you couldn't access the individual bits of written information and link it to other programs or files.

Instead, scanning written information requires an interactive system that allows the user to access certain portions of the data without interfering with or disrupting the original data set.

In this method of scanning, information can be collected in one of two ways, explains **Joe Cortese**, director of management information systems at Montefiore Medical Center Home Health in New York City.

"The first is an optical mark sense, like the SATs you took to get into college. You fill in a circle, and [the software] can sense if a mark is there or not and where it is. It doesn't require too much interpretation. The second is optical character recognition, where you have a box and the person is required to fill in a number or letter," he says.

Typically, explains Cortese, these scanners will "look like a little Photostat machine, where forms are self-fed into a data base via a built-in feeding mechanism."

When deciding upon a scanning system, several factors come into play: Price is one, and service is another. Cortese says that in his search for a scanning system he has come across prices ranging from $6,000 to $8,000 for just the software. Add in the cost of a scanner, which can run anywhere from $800 to twice that amount (Cortese suggests buying two to ensure a backup), and the cost of an up-to-date PC, which can run upward of $2,500.

"The whole package, just to get you started, can easily be a $12,000 investment, depending on the bells and whistles," says Cortese. "We're not even talking about having personnel to deal with errors and run reports or about clinicians' time."

Anderson suggests companies follow a few basic guidelines when deciding how much to invest.

"The cost of the software will be the same regardless of agency size," he says, "but the hardware is totally a function of agency size. For a small agency it makes no sense to spend a lot on a scanner. If you have about 250 patients and are using single-sided forms, you can get away with

How about something with a modem?

Confused about what's out there and what you need to successfully submit OASIS data? With this list of recommended hardware configurations and required software, the Health Care Financing Administration attempts to clear up some of the confusion.

Hardware recommendations:

- ✔ Pentium processor with Windows 95 or Windows NT operating systems.
- ✔ 32 megabytes of RAM and 2 gigabyte hard drive.
- ✔ CD-ROM and a 56-kbps modem.
- ✔ Internet access and Web browser software.
- ✔ Mouse and printer.

Software requirements:

- ✔ HAVEN, available via the Internet or on CD-ROM.
- ✔ Software that conforms to HCFA standard layout electronic record layout, edit specifications, and data dictionary and that includes OASIS data set. ■

Calling All Vendors

Here are some vendors offering scanning solutions for home health agencies in general and OASIS in particular:

☐ **AutoData Systems**
6111 Blue Circle Drive
Minnetonka, MN 55343
Telephone: (800) 662-2192
Fax: (612) 938-4693
Web site: www.autodata.com
Product: AutoData Pro
(not a stand-alone system,
but front-ended through vendors)

☐ **Continuum Care Technologies**
63 Range Road, Suite 202
Windham, NH 03087
Telephone: (800) 568-0351
Fax: (603) 894-6698
Web site: www.asma-homehealth.com
Product: Comprehensive Care Manager

☐ **Home Care Information Systems**
300 Broadacres Drive
Bloomfield, NJ 07003-2020
Telephone: (973) 338-2020
Fax: (973) 338-4946
Web site: www.hcis.com
Product: ASSESScan

☐ **ScanHealth**
4313 Haines Road
Duluth, MN 55811
Telephone: (800) 871-7310
Fax: (218) 529-2305
Web site: www.scanhealth.com
Product: ScanHealth Home-Solutions

a $600 scanner, which scans about 10 pages a minute and can hold 30 sheets of paper in the document feed. But if you have between 500 and 1,000 patients and are using two-sided forms, you'll need a $4,000 scanner."

With more patients, Anderson suggests investing in a $6,000 or $8,000 scanner. The first is capable of scanning 100 images a minute and can hold up to 300 sheets of paper in the document feeder, he says.

Error handling is another important consideration when selecting a scanning system, notes Cortese, because it's the nature of the beast for errors to crop up. Referring to the optical character recognition system, he says, "It has to think about it and make a judgment call: Is the number three a three or an eight? Here you'll have an error rate."

What the exact rate is depends on the method, he continues. "The success rate with the 'mark sense' is 99.5%, but when you start introducing character recognition with digits from zero to nine, you drop to a 95% success rate," he says. "If you add in the alphabet, it's down to an 85% success rate."

What happens when mistakes are found?

Before handing over a check, Cortese cautions shoppers to ask how a particular system will cope with mistakes. Consider this, he suggests: "If you were only supposed to mark one answer, but two are marked, then what happens? Will the software allow you to proceed with the batch and deal with errors later, or will it stop you dead in your tracks and ask the question then?"

Myra DiBlasio, BSN, RN, Rx clinical manager of Home Care Information Systems, in Bloomfield, NJ, explains that her company's system deals with errors as they arise. "Our software will ask questions about what needs to be verified to make the data clean. If someone has crossed out an answer and written in a new one, the software will stop and ask which is the correct answer. The clerical person, then, can fill in the correct, final answer."

When questions concerning handwriting occur, the system uses a handwriting recognition program. If there's a doubt as to a numeral or letter, such as is it a seven or a one, DiBlasio says "the computer will stop and ask for verification. The person then can look [on the original form] and tell and verify it in the computer."

As for forms, Anderson says agencies should insist upon software vendors providing updated forms, free of charge and within the timeliness that HCFA requires. Moreover, he says "agencies should always have control of the forms. They should always be yours, and even if you take the standard set, you should be able to make changes either internally [by the vendor] at no cost or send them and have the changes made cheaply and quickly."

Beware of systems that seem too good to be

To HAVEN or HAVEN not

When **Mark DeLauro**, RN, applications and case manager for Guthrie Home Health in Towanda, PA, began investigating OASIS scanning software options, he found many choices. But his agency eventually decided upon a Health Care Financing Administration (HCFA) offering, Home Assessment Validation ENtry (HAVEN).

"We decided not to go the scanning route, although we may in the future. From what we could ascertain in talking to people outside the industry and the vendor circle that's pushing the scanners, scanning is still too young and there are still some bugs that need to be worked out. We've heard warnings to the effect [HCFA] is developing the OASIS program too quickly, and there could be some bugs with that as well," he says.

"We looked at HAVEN initially and although we heard warnings about it we decided to look at it again. We chose to go with it because it will get us through the interim. We want time to see whether we want a stand-alone system or one to integrate into the system we already have. We're looking at changing our computer system anyway, and with $13,000 price tag [for a scanning solution], we decided to wait and see how others make out before we do anything."

Continuum Care Technologies' CEO **Robert W. Anderson** understands DeLauro's point but feels that to put off climbing aboard the scanning bandwagon could prove to be a costly mistake in the long run.

"I think it's a valid point to hold off, but not because OASIS isn't jelled yet. If I was a director, I would ask myself if I understand the value of the data. If I do, I would [get a scanning solution] today. If I was only trying to stay compliant then I'd wait, because look what happened with surety bonds," he says.

"But it's a recipe for failure as a business. . . . If you're looking at IPS and trying to be successful in the future with the data you can get from OASIS and operations care maps, you can really drive costs down and quality up. If you're truly thinking about the future and being aggressive in the marketplace, then I'd do it." ■

true. **Mark DeLauro**, RN, applications and case manager for Guthrie Home Health, of Towanda, PA, came across a seemingly great deal that only required his nurses to fill in the OASIS data forms by hand. "For $995 a year, they would send you a master copy of each OASIS form and your printing shop prints them up," he says. "Then you fax the completed forms back to them and they submit the data for you. The only problem was that whenever I called for more information I couldn't even pin them down on their fax number."

Trained and true

Don't forget to look into training programs, notes DiBlasio, when considering a software package. Her company offers education on ORYX and OASIS compliance, as well as use of the scanning software. "We offer more education about performance measures . . . and how to use them as something valuable to the agency, so it goes beyond just the technical aspect," says DiBlasio.

Anderson says his firm spends more time training users in the basics of Windows and the OASIS process since often someone in billing does the scanning. "If we have an administrative person who understands word processing, then the training needed is minimal to run the software," he adds.

Duluth, MN-based ScanHealth doesn't expect training will be necessary, says **Michelle Wiklund**, vice president of marketing. "Users will receive a complete user guide, and because our system is so intuitive, we don't anticipate the need for training."

System integration should also be considered. DiBlasio's firm only sells its scanning solution to pre-existing clients.

"If you're buying an add-on system that doesn't interface, you'll be adding a lot of extra data that you don't need," she says. On the other hand, an integrated system incorporates data from different files so when printed, the first few pages of a client's chart are already filled with the demographics.

ScanHealth's Home-Solutions system doesn't require agencies to use its other systems to be integrated. "We can be the front end to a back-end system," says Wiklund, "so if the file structures are matched, you can readily import and export data."

Error rates, to be sure, are part of the drawbacks of scanning technology as is its relative newness to the health care scene, she notes. "With scanning solutions, you need to be aware that it's

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relatively new on the playing field, so there's no track record. It's not an automatic win-win deal."

DiBlasio agrees, up to a point, adding that scanning technology is "fairly new to home care but not to the general public. There are a lot of other places where scanning has been used for years, but we're just now taking the technology to home care where it's needed."

She agrees that scanning technology may not be right for everyone, with agency size being a key factor in determining whether the investment will pay off. "The regulations are going to say that information needs to be in the computer system and locked within seven days. It sounds easy to get the information in, but remember that also includes follow-ups and discharges.

"Since you can't predict how many you will have in a given day, to do manual entry is a little risky. Moreover, state training specifies that this is one of the big things they will be looking at: Did [the agency] get data in within seven days? With scanning solutions, you can get it in a day because it's a matter of sticking [the form] into a scanner, and it's in. It can be verified in the system, and once verified, it's locked and no one can touch that information," DiBlasio adds.

The purchase of scanning software and the related equipment is not something an agency should rush into, if at all. What is right for the large, urban, hospital-affiliated home health agency may not be right for the smaller agency linked to a small, rural hospital. Whether to take the scanning route is a decision only you can make. **(See related story, p. 16.)**

"It's not such a mature technology that it's always right enough to make it worth the while," Cortese says. "There are the costs of technology, technical supervisors, and maintenance. They all must be weighed against the cost of not using it to see if it will be worth it." ■

Self-justification for small agencies — part 3

Facts go a long way in proving an agency's merit

When it comes to securing a future for your agency within your hospital's health care continuum, agency size doesn't count. Planning does. Whether you have 20 nurses or 200, when going before the hospital administration it's important to have a clear idea of what your agency does for the hospital and readily available facts to back you up.

M. Darlene Hall, RN, executive director of Topeka, KS-based Stormont-Vail Home Health and Hospice, heads up a small hospital-based home health agency and oversees the operation of about 50 nurses in four branches in the northern part of the state. Her philosophy throughout her 14 years in home care is to seize every opportunity to boast about her agency.

Hall, who reports to the hospital's vice president, says she is fortunate in having a home-health-friendly hospital administration. Still, she believes that communication has been and will continue to be essential to an ongoing, positive working relationship.

"When I'm in a meeting with directors or the administration, I never miss a chance to mention something we've done that's quite good," she says. "I'm on the national board of directors for the National Home Care Association, and I make it a point of sharing updates with my vice president, too."

It's not just the hospital's senior management that receives her attention. Hall also makes it a point to keep the physicians informed of agency doings and speaks regularly at doctors' meetings. She says that too many physicians are poorly informed about what home health has to offer and what their responsibilities are regarding

patient referrals. To counter their misconceptions, she prefers meeting one-on-one with physicians interested in home care.

"I talk to the doctors at their meetings but I've found they're not very responsive in groups," she says. "I go ahead and put up information in the lounges on what their responsibilities are, and with the ones who are more interested, I make an appointment to visit them in their offices and talk with them individually."

Hall supplements her talks with information, making sure that doctors and the members of the administration receive updated copies of her agency's publications. She also passes out a laminated list of doctor's responsibilities in referring patients to home care. "I don't kid myself. Probably a lot of these are filed in the circular file, but at least I try," she says.

Teamwork promotes value

Teamwork within her agency is another factor Hall says has been instrumental in proving the value of home care. "We have a lot of camaraderie and a lot of pride in the service we provide. I think this pours over to the administration, and they recognize that home care is a good thing."

Much of this sense of pride can be attributed to the compartmentalization that Hall has instituted within her agency. "I have people who are experts in a particular area," she says, mentioning that her staff include a diabetic nurse, a social worker, a psychiatric nurse, and an infusion therapist — all of whom are certified. "The team approach is a good one because it translates into the fact that even though everyone has to be competent in all areas before they're allowed to do anything, that people interested in a particular area will do a better job at it."

Making sure her agency is an integral and valuable part of the hospital's health care continuum extends beyond the hospital for Hall, and she takes every opportunity to speak to "groups like the auxiliary groups, retired state and city employees. It's important to educate people on what your abilities are."

She also charges agency directors with keeping hospital administration abreast of legislative issues related to home health. "[Agency directors] need to keep current. They need to be involved with their state organization so they know exactly what's going on. I subscribe to home health newsletters from the surrounding states. I've found that to be very informative as to what might be headed our way," she explains.

Hard data are also instrumental in convincing hospital administrators, typically concerned with the bottom line, that your agency is critical to the community's quality of health care. **Jo Burdick**, RN, MSN, executive director of MeritCare Home Care, in Fargo, ND, believes patient satisfaction goes a long way toward promoting a health care agency to its own hospital. But backing up that with statistical data is better still.

Do a study, she suggests, and use specific examples "to show how you can be valuable. Our system, for example, requires anyone who is ventilator-dependent to go into intermediate ICU if they are admitted. Previously, my agency had been caring for that patient at home for another specific thing and whereas we were doing it for $300 a day, the charges were $1,800 a day in ICU."

Her approach is to update her immediate boss monthly: "It behooves the director to have as much information as possible together. We have a good track record, and I like to point that out that we have 15% more referrals every year and while physicians are still referring to us, we had fewer visits this year than last. We want to make [hospital administrators] see that we are preparing for a managed care environment."

OASIS data collection, Burdick believes, will be valuable in the long run for compiling the statistics she likes to show hospital administration. Saying that home care really hasn't had a tool to compile this type data, Burdick notes that OASIS "will be a good way for any agency to put together outcome criteria for the hospital and to say this is how we do what we do and how we save you money. You really want them to see that we'll go out and solve problems for [them]."

Information from OASIS collection can be used in a report similar to Hall's compilation. About a year ago, Hall began the lengthy process of gathering information, 100 pages in all, "defining home care, our structural basis, and what areas of expertise and what teams we have so the administrators know what we're capable of doing. We want them to know what we're about."

With the finished data in hand, Hall made up a number of spiral-bound notebooks and dispensed them to each of the hospital's vice presidents as well as the board of directors, which she explains, as a medical center board knows very little about home care. This handbook is treated as a living document and periodic updates are sent out. To date, it has been a "great tool for

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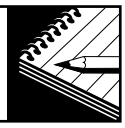
people who are needing to know a little about us and what we do. It's been very good in giving people that understanding."

Whatever an agency's method, both Hall and Burdick believe that once hospital administrators understand home care's function, it will maintain a hospital-affiliated agency.

"If the hospital has a true understanding of continuum care and is committed to it, then it only makes sense to have your own agency," Burdick says. "It's a system of thinking whereby if the agency's patients do well, then the hospitals do as well." ■

GUEST COLUMN



The survival of home care in the new millennium

Can it continue, and even flourish?

By **Cathy Frasca**, RN, BSN, FACHCA
Vice President, Home Health Services
South Hills Health System
Homestead, PA

Over 10 years ago, an article titled "Home care grows in spite of pitfalls" appeared in *Modern Healthcare*. This, I fear, is to be our destiny.

In my more than 30 years in this industry, I have learned that the changes and challenges confronted by others in the health care industry pale in comparison to what we in home care face. It seems that as soon as we overcome one obstacle, a greater one looms on the horizon. The interim payment system (IPS), OASIS, ORYX, prorating, Wedge audits, surety bonds, sequential billing, per-visit and per-beneficiary limits, the list goes on. No wonder we in the industry have the perception that our government is trying to put us all out of business. Are we paranoid or is there some basis to this belief?

When I started in home care I found the Health Care Financing Administration (HCFA) to be supportive and helpful as both an advisor and consultant. There seemed to be a sincere willingness on its part to come to a mutual understanding of and assist in the implementation of home care regulations. We had a mutual respect for each other, one that was cemented by a common goal, to deliver quality patient care.

That all changed, however, as reports of fraud and abuse inflicted a blight on our industry. Certainly those who abuse the system are an embarrassment to us all, scarlet letters that I believe will be erased over time. But seemingly overnight, fairly or unfairly, almost every home care provider was perceived as dishonest. It's been this notion, together with the government's attempt at balancing the federal budget, that has resulted in what appears to be an all-out war against our industry.

Even though fraudulent providers were few in numbers, they managed to steal a significant amount from the Medicare home health program, a fact that was widely covered by the media. Perhaps this media attention explains why even though similar violations had been discovered within the nursing home industry, HCFA's response to the home care industry was far more severe: HCFA chose to treat every provider as suspect and to over-regulate and under-reimburse the industry to the point where it's impossible for agencies to survive. The result is that already more than 1,000 home health agencies nationwide have been forced to close their doors, while many more have had to reduce their services and costs to the point where patient care may be jeopardized.

Looking back, the battle really began with the Staggers lawsuit against HCFA. While the National Association of Home Care (NAHC) not only won its case but also recovered all its court costs in the process, it doesn't appear that HCFA learned anything from the ordeal. Instead, HCFA retaliated against the home care industry by unilaterally changing home care's Medicare reimbursement from an aggregate to per-discipline basis.

The results of this throughout the industry were devastating. Many highly qualified, experienced,

and capable administrators were either demoted or terminated when negative variances in their agencies' bottom lines were taken as a sign of poor performance rather than what they were — an unprecedented, inappropriate, and unpredictable action by HCFA. Not long after, when HCFA was forced to reverse its decision, the administrators' replacements were then hailed for "turning the bottom line around."

Acting responsibly

Just who should be held responsible for the flagrant examples of abuse and the significant losses that resulted within Medicare's home care program? Should only the providers who are now being penalized be made accountable, or should HCFA, which had the responsibility of overseeing the program, share in the blame?

Consider that several years ago HCFA designated regional fiscal intermediaries (FIs) for the expressed purpose of ensuring Medicare's home care regulations and reimbursement policies would be applied consistently and appropriately. Had HCFA and the FIs been doing their jobs, I don't believe such a nationwide, widespread disparity in home care reimbursement could have occurred. How else to explain, other than with a lapse on the part of HCFA and its FIs, that in some states there are an average of 20 to 40 visits per admission, per patient, while in other states, agencies report hundreds of visits per admission for similar diagnoses?

These inequities should have been uncovered years ago and immediately corrected. While many home care providers, including my own agency, have reported fraud and abuse throughout the years, our complaints fell on deaf ears. Perhaps if early intervention had taken place, the huge scandals that have tainted our industry could have been averted. But now, with the home care IPS as proposed by HCFA, significant inconsistencies among home care providers will continue to be perpetuated.

As a result, regions such as western Pennsylvania, which has the highest percentage of elderly residents of any place in the country and thus the greatest need for an appropriate level of home care reimbursement, is being penalized. As a region, it has one of the lowest utilization rates (the number of visits per admission) in the nation, yet it will receive one of the lowest reimbursement ceilings. Meanwhile, states with higher, more costly utilization rates will be rewarded with higher reimbursement ceilings.

Over the course of my career, I have met many highly qualified and caring individuals at HCFA, but lately, as a provider, I have found the organization to be more of a hindrance than an asset to our industry.

In still another example of HCFA run amok, after more than 30 years of achieving outstanding ratings from licensures, certification, and accreditation surveys our agency received a compliance audit in August 1998, and even though I had heard Wedge-audit horror stories from colleagues, the full impact of the lack of a democratic process didn't hit me until I was directly involved.

Now I fully realize the necessity of monitoring the appropriateness of care, and I am also aware that there's a difference between isolated human errors and flagrant abuses of the Medicare home care reimbursement system, but what shocked me most were the tactics applied to the audit process. For example, should a provider decide to appeal a denial, the agency could then be hit with a 100% review of claims, which until completed would mean suspension of the agency's payments. When the government threatens to cut your funding while it reviews each and every one of your claims, it certainly counts as a significant disincentive to challenging the government even if you as a provider know you're in the right.

I wonder sometimes if HCFA realizes that Medicare is an entitlement program and should be made readily accessible to those who qualify. Perhaps the acronym HCFA would be more appropriate if it stood for Hold Cash Flow Arbitrarily. I am not alone in this belief. Congressman William Coyne (D-PA), and senators Arlen Specter (R-PA) and Rick Santorum (R-PA), among others, attested that HCFA has strayed too far from its original imperative — to provide needed health care services in an appropriate, cost-effective setting.

The intent of Congress was and still is to provide Medicare reimbursement for home care services to those who are essentially homebound and require intermittent skilled care. "Bedfast or house-bound" was not Congress's intent, nor were patients, who with assistance are able to leave their homes, meant to be denied reimbursement.

For the first time in the history of the home health industry, we have significant bipartisan support, and when Congress adjourned last October, a majority of key legislators had either sponsored or cosponsored an IPS reform bill. Perhaps that sent a strong message to the president and HCFA that the intent of Congress will be

fulfilled by those who will be held accountable.

HCFA claims it needs to cut costs in home care because industry expenditures are increasing beyond belief. But do administrators in HCFA understand institutional care is far more costly than its home care cousin. Are they aware that significant reductions in acute care length of stay and reimbursement have resulted in patients leaving the hospital before they are ready, and, accordingly, these same people require more follow-up care at home?

Even so, the home environment, coupled with family support systems, are the most cost-effective means of delivering many health care services. However, if Medicare reimbursement continues to be slashed these programs will be unable to continue. It's becoming increasingly important that home care focuses its efforts on public education and sending a strong message that we, our patients, and their families — all members of the voting public — can effect change through the legislative process and turn this situation around. After all, the government is currently revamping the IRS. Why shouldn't HCFA be next?

I have always fought for what I believe, and now as I near retirement, I am vowing to work with any organization that will fight for the survival of home care. I have every confidence that the right things will be done for the right reasons. We have a duty to ensure that our patients have ready access to quality home care services. We must see to it that Medicare funds are used appropriately, and we must do all of this in a cost-effective manner.

In the future, home care will focus increasingly on providing a full spectrum of integrated home health and in-home support services. Medicare and non-Medicare providers will partner to offer patients ready access to one-stop shopping — a complete package of quality, cost-effective home care, hospice, and support in-home services.

No doubt we have our work cut out for us, and perhaps there is no better place to start than by convincing our legislators to reform or at least place a moratorium on IPS. After all, you can't provide access to quality home care if you're out of business. Together with our legislators, the president, and HCFA, we will turn this disaster around.

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Clinical pathways offer better outcomes

Process is difficult and time-consuming

With their system contribution under fire, hospital home health agencies are now struggling for ways to get their wagons in a circle and prove their worth. Developing clinical pathways that help reduce the length of, or totally avoid, hospitalizations is an excellent way to justify one's existence, according to providers.

While designing pathways in collaboration with your affiliated hospital may ultimately save your hide, it may cause bumps and bruises along the way, sources warn. The combination of involving and scheduling many already overcommitted players, gaining consensus on treatment protocols and establishing patient control and hand-off points can take months or even years.

"It's a complex, difficult process. It's not as easy as people think," says **Cynthia Runner-Heidt**, RN, MSN, administrator of patient care services at Lehigh Valley Hospital in Allentown, PA. "It may be easier in a smaller hospital with fewer players."

"The time varies. It depends on the number of places on the continuum, the number of people involved, the volume of patients. Some [can be finished] in six months; others take years," adds **Greg Solecki**, vice president of home health care at Henry Ford Health System in Detroit.

The challenge starts with determining which pathways to develop. As a general rule, high volume, length of stay, or cost diagnoses offer the most hospital cost savings, home care value and patient benefit opportunities. Exceptions, however, abound.

Some of the most common hospitalization-related diagnoses do not easily lend themselves to pathway development, states **Rita Bendekovits**, RN, MSN, ONC, CRRN, rehabilitation clinical specialist with Lehigh Valley Home Care. For example, stroke patients have widely varied complications, with possible physiatrist, neurologist, or family practitioner physician management. Standardizing treatment with so many variables and care directors is more difficult.

Although the idea for total joint replacement, one of Lehigh Valley's first clinical pathways, originally came from a performance improvement study evaluating cost savings and therapy increase

opportunities, the diagnosis lends itself to pathway development, according to Bendekovits. "It's an elective surgery, it's consistent with complications and post-op procedures, and though it's multidisciplinary, with only orthopedic surgeon physician management, it's easier to get standardized discharge orders from physicians."

Clinical pathways that conserve the most hospital resources also offer home care the greatest opportunities, but providers may have to lower their sites, at least initially. Hospital-based professionals may understand little of home care's capabilities, so winning converts with small successes may be necessary to advance the overall program. "We've worked on quite a few with not a lot of patients, but if you maintain a positive approach, people will see you as a willing collaborator and call you back to the table," Solecki reports.

In addition to working on pathways involving few patients or resources, you can also gain support by taking key hospital players on home visits, Solecki advises. "It's hard to look beyond your place on the continuum," but a personal experience may help train hospital eyes on home care, he notes.

Hospital-to-home care pathways that involve many departments may have a multidisciplinary steering committee to guide the process. The appropriate home care representatives depend on the scope of the project and your institution's politics, Solecki advises. He often attends at the start of pathway development to "talk up home care," but leaves the details to "people who own the process, know the best about the process and well-represent the home health agency — maybe a manager or clinical specialist," he says.

The real fun of clinical pathway development begins after you've selected a disease target, sources report. To eventually develop standardized protocols, affected hospital and home care departments should each separately identify current practices, Bendekovits says.

❒ **Outline home care practices.**

In home care, staff from each discipline involved should meet alone to develop a consensus treatment. This is no simple matter, even for conditions with common curative interventions, such as joint replacement, Bendekovits notes.

"There is not a consistent approach in home care. It is an independent practice no matter what you do. It is very hard for anyone to sit down and identify [what they do] in any visit. Once you can accomplish that, the rest is easier," she explains.

"The flowcharting is very long and time-consuming, but it helps identify [the care components]," Solecki agrees.

Expect resistance initially. Wary field staff may first ask, "How can you tell us what to do?" Bendekovits reports. However, once participants understand that "writing down what [they] do doesn't mean you're taking away [their] independence," the discussion moves on. As individuals begin describing their normal practice, differences quickly become apparent.

"After sitting down and hearing [each other's interventions], you hear a lot of, 'Do you really do that? I don't usually do that,'" she says.

❒ **Conduct chart audits.**

Chart audits highlighting different approaches, as well as sometimes poorly articulated progress notes, help focus the discussion, according to Bendekovits. Conducting the initial data gathering chart audits for Lehigh Valley's total joint replacement pathway, she discovered "it was hard to pull out what they did. They wrote these long narratives, and I would ask myself, 'What are they doing?'"

Balance democratic processes with forward momentum when setting focus group sizes. Lehigh Valley used two experienced therapists to distill a laundry list of joint replacement interventions into a concise activities flow chart, Bendekovits reports. Using employees rather than independent contractors may also help.

"Employees have a more vested interest and are generally more positive than independent contractors. If you only have independent contractors you

COMING IN FUTURE MONTHS

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may have to involve nurses more," she notes.

Combine discipline-specific intervention sequences into an overall home care activity outline. With care management responsibilities, nurses should drive visit-by-visit goal identification and progress, Bendekovits advises.

❒ Collaborate with hospital staff.

As pathways help reduce hospital stays, the home care components should build on and smoothly transfer from hospital practice standards, according to Bendekovits. With their interventions outlined, home care staff should meet with hospital staff to review practices and develop consistent approaches.

Intervention outlines form the basis of care standards. Developing standards of care that are neither too rigid nor detailed is another challenge. "People want to include all nursing knowledge in the standards of care. [My advice is] don't ignore them, but put them someplace else," she says. For example, it would be inappropriate to spell out a neurovascular assessment in a standard of care because it is common nursing knowledge. Instead, include it in a separate education model, she advises.

❒ Obtain physician support.

Without physician support, hospital-to-home care clinical pathways simply don't work, sources advise. But it is one of the most challenging aspects of pathway development, and one that home care often has the least control over. Physicians in private practice may have little interest in or incentive to adopt standardized discharge orders. With recent re-engineering and cost-containment initiatives, however, employed physicians at academic medical centers may be more accustomed to care protocols. In either circumstance, sources advise using physician leaders and home care champions to influence peers.

In the case of Lehigh Valley's total joint replacement protocol, physician buy-in started with an individual meeting with the chief of orthopedics. Draft standards were subsequently distributed to and comments solicited from all orthopedists with staff privileges at the facility, according to Bendekovits.

❒ Develop documentation tools.

With care standards developed and physician support obtained, one of the last steps to clinical pathway development and implementation is designing documentation tools. It helps to format pathway tools like other care plans, according to Bendekovits. "We use a documentation tool and flow sheet, and our staff love it. It's so simple, and they were writing so much before. This looks like our other care plans; it has the same sequencing, same verbiage, and it works very well," she says.

❒ Measure outcomes.

Documenting the impact of clinical pathways is important, both to demonstrate positive patient outcomes and to substantiate cost savings and decreased hospitalization. "You have to collect data to demonstrate that you have value and share it with other collaborators. And you have to find out why if it doesn't demonstrate what you think it should," says Solecki.

At Lehigh Valley, the clinical pathway team is monitoring whether patients discharged directly from the hospital to home do as well under the new protocol as those who go first to a nearby rehabilitation facility, Bendekovits says. "I really do believe patients do very well at home, but you have to prove it."

❒ Keep communication lines open.

Establishing clinical pathways is only the start of an ongoing dialogue about care protocols and

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outcomes. Solecki explains that the Henry Ford Health System total joint team still meets monthly nine years after the pathway was first implemented. Members share data and work on further clinical outcome improvements.

❒ **Conduct ongoing education.**

Continuing education — with home care field staff, hospital discharge planners, and physician offices — also comes with the clinical pathway territory, according to Bendekovits. Enthusiastic field staff exert peer pressure on those who less diligently comply with the protocols. In the absence of capitated arrangements placing the facility at risk for longer hospitalizations, discharge planners may not promote home care as quickly or strongly.

Despite the challenges, clinical pathways are here to stay. They are a key ingredient in the success of hospital based agencies, sources report. ■

NEWS BRIEF

JCAHO accredits Kaiser Permanente

All 16 of Kaiser Permanente's northern California hospitals have received continuing, three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

JCAHO singled out Santa Clara Medical Center's perinatal services, Sacramento and South Sacramento Medical Centers' stroke pathways services, the critical cares services at Walnut Creek Medical Center, and preventative medicine programs, in general, including pediatric asthma prevention, immunization, and mammography screening programs. ■

CE objectives

After reading this issue of *Hospital Home Health*, CE participants will be able to:

1. Identify the types of OASIS scanning software solutions.
2. Describe HAVEN's basic capabilities.
3. Explain two ways in which small agencies can show their value to hospital administration.
4. Discuss the Health Care Financing Administration's level of Y2K compliance. ■