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HOMECARE
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## INSIDE



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American Health Consultants® is A Medical Economics Company

# Case managers increase productivity and efficiency

*Arkansas agency has holistic approach to care*

An Arkansas home care agency director noticed many patients had a longer-than-necessary length of stay, partially due to problems with continuity in care.

"You could read the nursing notes and see that the patient was not getting a coordinated effort of care," says **Rhonda Riley**, RN, agency director of White River Medical Center Progressive Home Care, in Batesville, AR, a hospital-based agency with 40,000 yearly patient visits, serving north-central Arkansas through three offices.

Nurses made their own schedules. Referrals were given to whomever wanted another patient. In addition, nurses handled the scheduling of home health aides.

This system created too many inefficiencies, Riley says. For example, one nurse might drive from one end of the county to another within a day. Also, patients often had several different nurses within a week of receiving home care services.

### *Getting with the program*

Riley and other managers decided to revamp the entire system, beginning with scheduling changes. They chose to use a case management model, with case managers coordinating care for all nurses.

The case management program worked. Between 1997 — when the program began — and January 1999, the program produced the following positive outcomes:

- Productivity increased. The amount of time spent on each visit decreased from two hours and 10 minutes per patient, which includes office paperwork time, to one hour.
- It's now easier for the agency to reach physicians and gain their trust because the case managers are the only ones who call them.
- Length of stay decreased from about 71 visits per patient to 45 visits.
- Change helped the agency prepare for the interim payment system (IPS).
- Agency received high scores after a survey by the Oakbrook

Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

• Lowered staff mileage because scheduling is currently centralized.

### *Case managers are integral*

It works because the agency's four case managers serve as the central nervous system, directing care from a central location. They know what is happening with each case; therefore, coordinating care much more efficiently.

"The case manager is pulling out the clinical pathways each nurse needs," Riley says. "She's pulling all this together, and the nurse is focusing on direct patient care."

Here is how the agency developed the program and achieved the positive outcomes:

**1. Choose case managers.**

Case managers have few patient duties, only making patient visits on rare occasions. Their main jobs include organizing and supervising.

Riley chose staff nurses who had good organizational skills, some of whom had been in supervisory positions before. "They had a good understanding of rules and regulations; they had a vision of what we were trying to achieve by coordination of care, cost effectiveness, and better care for our patients," she says.

The main office has two case managers, and the branch managers in the two branch offices also serve as case managers.

**2. Cut paperwork for field nurses.**

This helped to create staff buy-in. Before, field nurses spent a lot of their time in the office, handling paperwork. Now, there are fewer people in the office, and field nurses have less documentation to complete.

"The field nurses loved it. They got to spend more time and more concerted effort on the care of their patients," Riley says. "Productivity increased because nurses spend a longer time in patients' homes, but less time in the office."

**3. Create routines for case managers.**

The case managers took over scheduling and the monthly task of checking billing against nursing notes.

Each month, case managers set up a patient list according to orders for the patient. As notes come in, the case manager reviews those that are completed and signed by the nurse, therapist, and aide. Each visit is highlighted as completed.

This makes monitoring frequencies and coordinating billing at the end of the month both efficient and easy. It also helps the agency verify there are no bills for visits, unless the notes have been turned in and the patient signed them. All notes are checked against the itineraries.

When new referrals are made, they are recorded and distributed to a case manager. The case manager assigns the admit visit to a nurse. The nurse completes the visit and reports to the case manager. The nurse and case manager discuss the plan of care and initiate care pathways. They also establish field charts and make referrals to other disciplines as necessary.

Also, case managers keep a notebook of Medicare 485 forms, new orders for each patient, and a case conference form. This keeps necessary information readily available for staff and physicians. **(See case conference progress note, p. 19.)**

Case managers have taken over the important task of contacting physicians and coordinating care with them. "There are some times when a nurse is in the home and needs to make that physician call immediately; otherwise, nurses can wait to come back into the office and talk to the case manager," Riley says.

This way, case managers have regular contact with physicians and office nurses all the time, and it's easier to build a relationship. "Doctors trust them because they have one person to talk to; that's another reason for increased productivity," Riley says.

When a physician returns a call to the agency, he or she is no longer told, "I don't know the answer to that, because the nurse isn't here right now." Instead, the case managers are always there to accept calls from physicians.

**4. Divide case manager territory geographically.**

It's easier to use geographical areas because this ensures greater efficiency in scheduling patient visits, and it's simpler, Riley says. When the agency receives a patient referral in Case Manager A's territory, then Case Manager A takes over the care of the patient and assigns nurses to the case.

"This system cuts down on mileage travel

*(Continued on page 20)*

**SOURCES**

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PROGRESSIVE HOME CARE

## Case Conference Progress Note

Name:_____ MR#:_____ SOC:_____

Goals:

1. _____
2. _____
3. _____
4. _____

Homebound Status (Functional Limitations):_____

_____

New Problems/Goals

1. _____
2. _____

| Date | Contact/Discipline | Communication/Conference | Initial |
|---|---|---|---|
| | | | |
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Progress Toward Goals:

1. _____
2. _____
3. _____
4. _____

Signature_____ Date_____

PROGRESSIVE HOME CARE *Work Scheduler*

Date Jan 3-9, 1999

| Name | Sunday 1/3 | | Monday 1/4 | | Tuesday 1/5 | | Wednesday 1/6 | | Thursday 1/7 | | Friday 1/8 | | Saturday 1/9 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO | FROM | TO |
| RN | | | 1st visit 5 | | | | | | | | | | | |
| RN | | | | | | | | | | | | | | |
| LPN | | | | | | | | | | | | | | |
| CNA | | | | | | | | | | | | | | |
| PT | | | | | | | | | | | | | | |
| OT | | | | | | | | | | | | | | |
| ST | | | | | | | | | | | | | | |
| MSW | | | | | | | | | | | | | | |

Source: White River Medical Center Progressive Home Care, Batesville, AR.

because it is centralized, and everybody knows what everybody else is doing," Riley explains.

The system works well, says **Brenda Rutherford**, RN, a main office case manager.

"I manage patients in the north and west end; and the other case manager has the south and east," Rutherford explains. "I know a lot about her patients and where they live and vice versa; by looking at the board, I can see how to schedule somebody if I want to schedule one of her patients."

The case managers keep track of the schedule on an 11-inch by 17-inch work scheduler sheet that has columns for names, day of week, and time beginning and ending. **(See sample scheduler sheet, above.)**

**5. Hold regular case conferences.**

The agency holds case conferences every two or four weeks, depending on individual cases. The list is posted in advance, and the case conference form is kept with the managers at all times. Significant information regarding patients also is logged on the form.

Case conferences include discussions of completed patient goals, informing physicians of any changes and other information. Present staff members sign the case conference form and place it in the chart as part of the permanent record.

**6. Have case managers meet regularly with nurses.**

Case managers speak with nurses before an intake visit to give them specific details about the case and a general guideline of what frequency they should have, Rutherford says. "We go over the diagnosis and what some of these care paths recommend for frequency and duration," Rutherford says. "When nurses come back from the visit, they report to us."

Case managers hold one-on-one meetings in the morning when nurses come into the office to pick up their schedule.

"Sometimes we even have a line, and I've threatened to put up a number box," she says. "In the morning, we put out fires and get nurses out in the field, and we go through the day with some incoming questions from them," she adds. At the end of the day, case managers meet again with a nurse if the nurse has seen anything unusual in a case. ■

# Specialists increase managed care revenues

*A little knowledge goes a long way*

Whether your agency is small or large, chances are you're being referred more patients from managed care companies.

Some agencies view managed care patients as more trouble than they're worth because of increased documentation and hassles often associated with managed care organizations (MCOs). However, other agencies view these cases as opportunities for potential revenue sources.

## Divide and conquer

Two experts say the best way for home care agencies to handle MCOs is to designate one employee as a managed care specialist or case management coordinator. This model relies on having one person develop rapport with MCOs and learn their lingo.

"I think even a small agency could and should do it by having someone, such as a supervisor, designated to do it," says **Brenda A. Trask**, RN, MSN, site visitor for the Community Health Accreditation Program, in New York City. Trask has spoken nationally on patient care in the new millennium, and formerly was the director of clinical operations for Inova VNA Home Health, in Springfield, VA.

Managed care specialists are the liaison between the staff and the managed care companies. Their role is to make sure communication flows smoothly and nurses and therapists know exactly what MCOs expect. Also, they explain to MCO case managers why a particular patient needs extra nursing or therapist visits.

Inova VNA Home Health began a managed care program in August 1997, eventually employing three managed care specialists. By 1998, the agency began to experience some positive outcomes, Trask says. For example, payers began to reimburse the agency a little faster, and there were fewer complaints from both payers and physicians.

"Mainly, we noticed our authorizations went through more smoothly, and there were fewer discrepancies on the billing side," Trask says. "We had fewer complaints from physicians because they were getting the services they ordered, and the managed care specialists were able to talk with physicians about different ways to get things done."

The program, which Inova VNA expanded since Trask left, will soon have nine case manager coordinators, who will handle all reimbursement issues except for regular Medicare cases, says **Eileen L. Dohmann**, MBA, RNC, executive director of Inova VNA Home Health, which has 270,000 visits a year with four offices that serve metropolitan Washington, DC, metropolitan Maryland, and northern Virginia.

## Agencies need MCO revenues

Dohmann says it's no longer an issue of whether the agency can afford to create these specialty positions: "You can't afford *not* to do it."

Previously, Inova simply had each nurse deal with the MCOs that covered their particular patients. "On any given day, we could have 20 nurses calling managed care organizations," Dohmann says.

This created a lot of headaches. For example, a nurse might forget to obtain authorization for visits, and reimbursement was denied. In other cases, nurses might obtain authorization, but forget to tell the billing department that the visits were approved. In still other cases, the agency might have negotiated a certain rate with a MCO, but no one told the billing department what that rate was supposed to be.

Managed care specialists or case management coordinators handle all of the communication components; therefore eliminating most of these problems.

"It's a coordination piece that is so difficult, and it's very timely and expensive," Dohmann says. "But if you don't [create those positions], you are effectively saying you don't want that managed care business."

Inova has seen a steady increase of its managed care business since beginning the program. However, Trask says that trend was market driven and has only highlighted the need for managed care specialists. "The timing was right, and we were trying really hard to keep our focus on good patient care. As a result, it turned out to be good business," Trask explains.

Dohmann says the increased managed care business has helped the agency survive during Medicare's implementation of the interim payment system. She says the coordinators could become experts on handling the prospective

payment system when it is implemented.

"More of our referrals will be handled by those people who are very focused on how to maximize service for the patient and maximize reimbursement for the agency, while always maintaining that services provided are appropriate to the patient's need," Dohmann adds.

## Step up to the plate

Trask offers these guidelines to developing a managed care specialist program:

**1. Focus on improving communications.**

It's easier for payers and home care agencies if they are talking with the same person each time a case is discussed. "We started with the idea that this was a communication role, and it'd be easier for the payers if they were talking to the same person each time — if the same person was keeping track of things," Trask says. "We knew we had a communication problem, and we were making sure that patients were getting services and were satisfied."

Payers also had a communications problem with physicians, who were frustrated because they could not understand why they were not receiving authorization for their orders, Trask recalls.

She suggests agencies select managed care specialists by looking for nurses who have good communication and strong organizational skills.

**2. Describe managed care specialists' duties.**

The managed care specialist duties include:

- maintain continuity of care by making sure the staff uses the appropriate agency and community resources in planning care;
- coordinate authorization and communication between the payer and clinical teams;
- facilitate the agency's compliance with external and internal clinical policies and company contracts;
- act as a resource to professional and paraprofessional staff;
- maintain the chronological documentation of these coordinated efforts in the patient's history file.

The managed care specialist also oversees the cost-effective purchase of patient supplies and ensures that the agency uses the vendors that have a contract with any particular MCO.

**3. Select quality monitoring areas for managed care.**

Quality managers and managed care specialists monitor the following areas:

- number of retro-authorizations, successful and denied;
- number of authorizations vs. number of visits not made;
- number of recalls to clinical staff to obtain additional information to get authorizations;
- delays in authorizations greater than 48 hours;
- unbilled revenue;
- bad debt — visits made without authorization split out from Medicare.

The managed care specialist or quality manager can create a simple authorization tracking tool that includes six columns consisting of these categories: Patient name; patient ID number; payer; number of visits authorized; authorization period, and dates of visits.

Trask also suggests agencies create managed care reports for nurses and therapists. These reports explain exactly what the nurses and therapists need to report to the managed care specialist and when they should make verbal reports. **(See description of nursing and therapy reports, p. 23.)**

**4. Have managed care specialists educate staff on MCOs.**

Agencies should hold an inservice on the managed care specialists' role and how staff could most effectively communicate with them.

The managed care specialists also could be involved in giving staff regular education and updates. It also might be helpful if the managed care specialist distributed a list of documentation tips for staff. Trask offers this example:

**Fee Agreement**

- *View ALL insurance cards.* Document all ID numbers for all insurance on forms.
- Document agency charges.
- Document patient portion/co-pay amount; this information can be found on the referral.

**Admission**

- All managed care Medicaid or Medicare patients require full assessment.
- Project the frequency and duration for the full nine weeks. Your discharge plan may be shorter.
- Document short-term goals with time frames.

**Clinical Progress Note**

- Each week document:

— homebound status
— wound measurements
— patient/caregiver ability to learn, willingness,

or availability to provide care

• Document coordination of care, including the managed care specialist.

**Discharge Summary**

• Reason for discharge cannot be *"no further insurance authorization."*

**Interim Physician Orders**

• Authorization does not equal a physician's order!

• Obtain a physician order for all changes in the plan of care:

— frequency
— added discipline
— treatments
— medication changes.

"It takes teaching and mentoring, but once the nurses are exposed to the process a couple of times, teaching won't be as necessary," Trask says. ■

# Check out guides to nursing, rehab reports

**Brenda A. Trask**, RN, MSN, a site visitor for the Community Health Accreditation Program (CHAP) in New York, offers these guidelines for developing reports for a home care agency's managed care specialist to use when dealing with managed care organizations (MCOs):

• **Nursing Report for the Managed Care Specialist (MCS)**

A. Initial and subsequent contacts with the MCS will be verbal reports. On occasion, reports may require a faxed copy of the nursing note to the insurance company. If required, the MCS will notify the case manager.

***The following information is needed in the verbal report:***

1. Last and first name and spelling, along with patient ID.
2. Specific number of visits for the next two-week period.
3. The clinical assessment, to include all vital signs, blood glucose readings, leg / abdominal measurements if applicable, and knowledge deficits.
4. Wound care descriptions to include:
a. measurements, L x W x D with undermining (if applicable), depth, and location of undermining
b. color of wound
c. drainage color and amount
d. location(s) of wound; if multiple wounds, be consistent with location and descriptions with each report
5. Wound care procedure.
6. Is a patient caregiver available to be taught and willing to assume responsibility for the wound care?
7. Will an ET (enterostomal therapist) nurse evaluate and suggest alternative procedures?
8. Homebound status.
9. Last or next physician appointment date.
10. If the purpose of the visit is to draw labs, report the results of the lab draw and any medication changes affected by the lab results.
11. If a home health aide is providing service, is that service to continue and why? What is the frequency of the visits for the next two weeks?
12. Will a nutritionist be utilized?

B. Reviews should be phoned to the MCS two days before the present authorization period expires.

C. If the total number of visits approved is not used within the allotted period, call the MCS to have the authorization period extended. Include the number of visits used versus the number authorized for that period with your request.

D. Notify the MCS with date of discharge and total number of visits used.

E. If a service is added, please call the MCS to confirm the benefit and obtain authorization. Give the reason for the need for the added service.

• **Rehab Report for the Managed Care Specialist**

A. Initial contact with the team MCS after patient evaluation is completed requires a fax of the evaluation, using the correctly completed cover sheet. A verbal "heads up" voice mail should be left for the MCS; include any extenuating circumstances.

***Subsequent requests are to include the following in a verbal report:***

1. Last and first name, spelling, and patient ID number.
2. Specific number of visits for the next two-week period.
3. Present distance the patient can ambulate with / without an assistive device.
4. Present muscle strength in affected area(s).

**SOURCES**

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**Brenda A. Trask**, RN, MSN, Site Visitor, Community Health Accreditation Program Inc., 350 Hudson St., New York, NY 10014. Telephone: (800) 669-1656.

5. Present range of motion in affected area(s).

6. Steps inside/outside of the house, presence of hand rails.

7. Goals over the next two weeks.

8. Homebound status.

9. Last or next physician appointment time.

10. If a home health aide is providing services, is that service to continue and why? What is the frequency of visits?

B. Reviews should be phoned to the MCS two days before the present authorization period expires.

C. If the total number of visits approved is not used within the allotted period, call the MCS to have the authorization period extended. Be sure and include the number of visits used vs. the number authorized for that period with your request.

D. Notify the MCS with date of discharge and total number of visits used.

E. If a service is added, please call the MCS to confirm the benefit and obtain authorization. Give the reason for the need for the added service. ■

# Care continuity boosts patient satisfaction

*Where patients are concerned, less may be more*

It became clear to quality managers at Melrose-Wakefield Home Health Care in Saugus, MA, that patients were not satisfied with the agency's nursing continuity of care. Patients indicated too many nurses were visiting them, and didn't like the frequent changes.

The agency's patient satisfaction surveys shows the overall satisfaction was about 85%; but the question about continuity of care resulted in only a 68% satisfaction rating, says **Patricia L. Finocchiaro**, RN, MS, clinical director of the agency, which is part of the Hallmark Health System, a four-hospital system in Malden, MA. The agency has about 115,000 visits a year.

The agency formed a team using the quality improvement process called FOCUS-PDCA, devised by Health Corporation of America in Nashville, TN. FOCUS-PDCA stands for the following:

- **F**ind a process to improve.
- **O**rganize a team.
- **C**larify current knowledge of the process.
- **U**nderstand the causes of process variation.
- **S**elect the process improvement.
- **P**lan to implement improvement.
- **D**ata collection and analysis.
- **C**heck data for process improvement.
- **A**ct to hold, gain, and continue improvement.

## *Improve patient satisfaction*

The results have been encouraging, Finocchiaro says. Nursing care continuity rose from a baseline of 60%, to as high as 85% after major changes were implemented. Some of the initial changes were revised, and the latest continuity of care rate hovered in the 78% range.

Using FOCUS-PDCA as a framework, Finocchiaro describes how the agency improved its patient satisfaction levels:

**1. Find a process to improve:** The agency selected nursing continuity because of its direct relationship to improved patient satisfaction and because continuity is addressed in the home care accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

Department managers were also concerned that variations and inconsistencies in nursing practice could harm patient outcomes, Finocchiaro says.

**2. Organize a team:** The team consisted of Finocchiaro, two clinical nursing supervisors, an education coordinator, a clinical information system coordinator, and the director of quality improvement, who also served as the team's advisor. "We chose those members because they were familiar with the operations and the current system of scheduling that we used," Finocchiaro says.

The team was supposed to be temporary, created solely to work on this particular problem and disband when the process was completed. "We would, however, meet periodically to review the process improvement cycle," she says.

**3. Clarify current knowledge of the process:**

The team gathered information to develop a best practice standard for continuity.

First, they had to collect data to establish the agency's current rate of nursing continuity. They used a tool that asked nurses why they did not see their primary patient on a particular day.

The nurse-driven variables included vacation time, personal time, and sick time.

Supervisors conducted one-on-one interviews with five nurses, following them over a one-month period, and keeping track of each time they missed seeing one of their patients, Finocchiaro says.

The team tallied the results, looking for trends in the top reasons selected.

They found:

• a nurse-driven variable of nurses scheduling their own days off;

• a patient-driven variable of patients needing a visit at a certain time of the day, and the nurse couldn't make the visit at that time.

The results surprised team members. Nurses were able to plan their own schedules, and might arrange days off to have less impact on patients, Finocchiaro says.

## *Formula for success*

The team also determined the agency's current rate of continuity by using a simple formula: Continuity = Number of primary patients seen by primary nurse (in one quarter) divided by the total number of patients on the primary nurses' caseload (in one quarter).

The overall rate of continuity for nurses in the agency was calculated to be 60% based on that formula. The team looked for guidelines or benchmark data about continuity of care.

"We felt instinctively that we could improve the process of continuity, and thus the associated rate," Finocchiaro says.

They found a study conducted in 1996 by the Home and Health Care Association of Massachusetts, the industry's statewide education and lobbying group. The study examined continuity of care in 17 Massachusetts home health agencies. It reveals that the average rate of continuity was 77%.

"We chose to use 77% as the standard with which we would compare our own performance," Finocchiaro says.

**4. Understand the causes of process variation:** Team members brainstormed factors that could impact continuity. They listed their ideas on a flip chart, and organized them into three categories on a cause and effect diagram:

• **Nurse-driven:** Vacation, sick time, and personal time.

• **Administrative-driven:** Staff meetings, caseload assignment, other mandatory team participation, and other meetings.

• **Patient-driven:** Patient scheduling needs (if a patient requires an early morning visit for insulin administration, for example); patient condition change requiring an unscheduled visit; fluctuation in patient census leading to too many patients for one nurse to see, or too few patients requiring nurses to take patients from other nurses to meet productivity expectations.

**5. Select the process improvement:** The team decided to target only continuous improvement activities related to patient satisfaction and nursing continuity. They chose not to evaluate the effect of poor continuity on clinical health outcomes because that would change the focus of their improvement efforts, Finocchiaro says.

**6. Plan the improvement:** "We decided the only way we could impact some of these variables was to look at a different approach to nursing care," Finocchiaro says. "Unless nurses work seven days a week, there's always going to be some break in continuity."

The team looked at the option of using primary nursing teams, instead of its traditional primary nurse approach in which a primary nurse is responsible for a particular number of patients. In the new approach, two or three team nurses would follow the same patients. That way, the patient would consistently have the same nurses providing care.

Other options the team discussed include having nurses work 10-hour days and every other weekend, or hiring only full time staff nurses.

**7. Data collection and analysis:** Clinical supervisors reviewed patient caseloads of five nurses over a one month period, and the team analyzed this information.

"The outcome indicators, patient satisfaction, and continuity rate were identified as our key quality characteristics because of their importance to our customers, and we could accurately measure them for improvement," Finocchiaro says.

The team anticipated that patient continuity would increase and patients would be happier if the agency switched to the primary team approach, she adds.

**8. Check data for process improvement:** "We

## SOURCE

**Patricia L. Finocchiaro**, RN, MS, Clinical Director, Melrose-Wakefield Home Health Care, 1715 Broadway, Saugus, MA 01906. Telephone: (781) 979-

took two staff nurses who had joined our quality improvement focus team, and asked them to schedule their patients for the next month as a team rather than as individuals," she says. "We asked them to cover each other's weekdays and weekends off, then we gave them a smaller, manageable caseload of patients."

The two nurses tried this model for one month. Their patient continuity, measured together as a team, was 85%. They were considered to have achieved continuity if either one of them had seen a patient within their joint caseload.

"It brought us up to what we thought was our goal, but it was still not a reality; it was just a predictor model," Finocchiaro says.

**9. Act to hold, gain, and continue improvement:** The next step was to discuss the model's results and changing the staff's structure with the staff. "We had to deal with a lot of staff anxiety about how that would impact their ability to practice independently," she says.

Then managers developed nursing teams, matching nurses to others with complementary skills and expertise. Nurses seemed willing to try the teams, although later nursing buy-in would prove to be a problem.

They gave nurses a month to discuss the changes with patients. "Staff nurses suggested that we include the patients in the education process," Finocchiaro says. "If patients knew from the beginning of their home care experience that they would be followed by a team of nurses, they would have different expectations of what constituted continuity."

Once the entire nursing staff began to use the team model, quality managers measured the continuity rate on a quarterly basis to make sure they held their gains in continuity.

The patient satisfaction survey is only sent out annually, so the process improvement team had to find other ways to measure patient satisfaction in the interim. For example, they conducted telephone surveys on a regular basis. The telephone surveys indicated patients were becoming more satisfied with nursing continuity.

"We monitored the scheduling. We had a scheduler involved, so she knew who the teams were and how to refine schedules," Finocchiaro says. "We also posted the continuity rates monthly in a graph, so staff could see how they were doing."

The agency achieved the desired outcomes, with continuity rates of 84.1%, 81%, and 81% in consecutive months following the change.

"But there was another glitch here," Finocchiaro notes. "The staff didn't like it, and they were very unhappy with the change." After trying the team process for three months, managers met again with nurses and asked them how they could revise it to meet their needs.

### *You've got voice mail*

The nurses said they were unhappy with the phone message system used, for instance. When the teams were enacted, each team of nurses was given one voice mail number. This was supposed to improve communication between team members, but nurses said it was hampering their patient care by making them spend more time taking messages.

The agency again gave each nurse a separate voice mail number.

Some nurses also said they preferred to work independently; they could not adjust to working in teams. "We met with the QI director again and talked about the staff needing time to get through these things," she explains. "We looked at revising the primary team approach, instead using a primary pod approach."

Patients would be assigned to individual nurses instead of two-person teams. Only each nurse would work within a nursing pod, meaning more than two nurses would handle patients' care. A pod might consist of three nurses and a float nurse. If none of the three nurses could be available to visit a particular patient, then the float nurse would visit. The pod would see the patient weekdays and on weekends.

Nurses appeared to like the change. Finocchiaro believes they even began to make greater efforts to see their own patients more often because the whole process made them aware of continuity issues.

The quality team learned that they could have avoided some of the buy-in problems over the change if they had involved front-line nurses in the beginning of the process. "By engaging the staff at the front end of the total quality management process, the team could have benefited from their input and elicited their support," Finocchiaro says.

The agency continues to monitor the continuity on a monthly basis, and a recent measurement indicates that the continuity rate still is slightly above its 77% initial goal. The 1998 patient satisfaction rates are not yet available. ■

# Wound program saves money, improves care

*QI program scores marketing victory for NJ agency*

Does the following list of woes sound hauntingly familiar? Managed care organizations demand hard data on outcomes. The prospective payment system promises to punish agencies carrying too many chronic cases requiring many visits. Patients increasingly demand more control over their care.

One agency found an opportunity to address each of these common home care issues with one dream-come-true program.

Bayada Nurses Home Health Specialists, of Morristown, NJ, found a wound care program that uses a more structured protocol and zinc-based wound care system to improve wound closure outcomes.

A pilot study resulted in savings of more than $3,000 per patient and wounds that closed 52% faster. Along with those results, the patients in the study — some of whom had unhealed wounds for more than two years — took more control of their own care and improved their quality of life. The agency was rewarded for its improved care by getting all of the wound care patients from one of its biggest contracts, Horizon Blue Cross / Blue Shield of New Jersey in Newark. **(See chart, p. 28 for more data.)**

Bayada, which has 26 offices in seven states, faced the same problems with wound patients as other home care agencies.

"These patients tend to be older patients with a very slow healing process who are often plagued with comorbidities, such as diabetes or congestive heart failure," says **Donna Angelini**, RN, clinical coordinator for the agency. "We had patients who had been homebound for two years because of chronic draining craters," she says. "Our goal is to either heal these wounds, or at least make family members capable of caring for the patients independently."

When Princeton, NJ-based Derma Sciences approached Bayada to pilot its Optimum Outcomes Wound Management System, the idea was appealing.

"We are always looking for new programs to improve care and provide value to payers," says Angelini.

Bayada went to one of its largest payers, Horizon Blue Cross / Blue Shield, and asked if its patients could participate in the study. The payer agreed. Derma Sciences brought in its own ET (enterostomal therapist or wound care specialist) to present an inservice to Angelini and six nursing supervisors.

Along with information on the Derma Sciences products, the company presented an in-depth wound care protocol that Angelini says impressed her.

"They had things written out for every kind of wound and every disease process," she says. "It was written in a fashion that anyone could understand. Family members, after instruction, could use these sheets as a reference and be able to provide the care."

Three offices were chosen to pilot the program. Patients were randomly chosen. There was no opportunity to select only those patients with fresh surgical wounds, or without comorbidities.

Indeed, Angelini jokes that Horizon seemed to present Bayada with only the worst cases. When a patient was admitted, he or she was evaluated. Angelini then called the patient's physician to explain the study and ask if the patient could participate. "About 80% of the doctors were receptive to it," she says. "Those who weren't were wound care specialists with their own centers and protocols."

## Dramatic results

The study included 20 patients with 25 wound sites. Those sites include Stage 2, 3, and 4 decubitus ulcers, dehiscence, stasis ulcers, ischemic ulcers, and surgical wound sites.

The physician and the home health nurse determined whether wounds were healing using a 14-point assessment tool. Patients were initially treated with the traditional treatment regimen. If

### SOURCE

**Donna Angelini**, RN, Clinical Coordinator, Bayada Nurses Home Health Specialists, 20 Community Place, Morristown, NJ 07960. Telephone: (973) 538-

## Key Pharmaco-economic Data Optimum Outcomes Program

| | Prior Treatment Regime (n=25) | Optimum Outcomes Program (n=21) | Comparative Results |
|---|---|---|---|
| **Clinical Components** | | | |
| Wounds Healed | 4 (16%) | 14 (66%) | 410% increase |
| Average Time to Wound Closure | 61 days | 29 days | 52% decrease |
| **Economic Components** | | | |
| Average Cost per Healed Wound | $5,500 | $1,825 | 67% decrease |
| Average Visits Per Healed Wound | 68 | 25 | 63% decrease |

*Source:* Bayada Nurses Home Health Specialists, Morristown, NJ.

the wound did not heal, the wound treatment was changed from the current treatment to the Derma Sciences system.

### *Elements for success*

The Optimum Outcomes Wound Management System uses proprietary wound healing products containing zinc, vitamin B6, magnesium, vitamin A, and other elements that are carefully PH balanced. The system also includes:

- care plans and protocols for wound management that are wound specific;
- wound care education for nursing staff;
- wound care consultants for nursing staff support;
- data collection mechanism.

"The data collection tool collects clinical and economic information so the customer has a basis for comparison between their traditional wound care and our system," notes **Richard Mink**, MBA, vice president and chief operating officer of Derma Sciences. "The management system itself costs nothing. Customers agree to buy our products and we provide the training, the protocols, and the data collection mechanism."

The results for specific patients varied, but Angelini says some of the stories are amazing. She recalls one woman who had been hospitalized for a wound 12 times in eight months. When she wasn't in the hospital, she was homebound. After entering the program, she had no hospitalizations and was able to leave home for the first time.

There were patients who hadn't seen a change in their wounds for months, but saw improvement within a week of starting the program. Angelini says nurses would call her, amazed at the progress.

The faster healing and decreased visits initially meant less money for Bayada. However, there was a reward. Horizon, which previously referred its wound care patients to about six different agencies, started sending all such patients to Bayada for treatment.

"We lost income on the number of visits, but we gained referrals," says Angelini. Other payers are also starting to jump on the Optimum Outcomes bandwagon.

There were some associated costs to the program. Bayada paid market rates for the Derma Sciences products and there was increased paperwork.

"There is a weekly wound assessment sheet to be filled out, and a wound measurement to do every week," Angelini says. "I had to keep tabs on all these wounds and compile the data. While we aren't tracking the data anymore, we still fill out the form. In fact, we have started using the form for all of our wound care patients, whether they are part of this program or not." There was also time spent on in-services to train staff.

However, any grumbling by the nurses was quieted as they saw the results of the new protocols. Angelini says it reinforced her belief that any wound care protocol is better than the older treatments, such as flushing with peroxide, some physicians still prescribe.

"I think that the more education people receive, the faster wounds will heal," she says. "A lot of physicians and surgeons don't know about new modalities. This is an opportunity to educate them about something new. Anything is better than peroxide irrigation."

Along with the better care, faster healing, and increased referrals, Angelini thinks there has been another benefit to the program.

"I think that agencies have to develop special programs to stay marketable and relevant. This does that for us," she says. "Payers want pathways. They want programs for wound care, diabetes, or asthma. If you want to be successful, you have to have protocols and ways to measure outcomes. Everything is going that way; if you don't do it, you will be left behind." ■

# Electronic signatures save time and money

*Agency program gets thumbs up from surveyors*

When Home Care of Southern Ohio in Portsmouth decided to jump on the technology bandwagon in 1993 and computerize documentation, administrator **Karen L. Marshall**, MS, RN, already had it in her head that eventually, her staff would use an electronic signature program. The program she started last spring keeps nurses in the field instead of the office doing paperwork. This not only saves time and money, but means patients get increased and improved care.

Since implementation, she has had the program validated by both Medicare and Joint Commission surveyors, who approved of the policies and procedures Marshall put in place to ensure document security and patient privacy.

Although Marshall didn't do a prior study on how much time her staff spent in the office going through their mailboxes, printing and signing paperwork, she estimates there is about an hour per clinician saved through the new process.

"If I were starting over again, I would do a pre-implementation study so that I could see exactly what the savings were," she says.

Whenever technology replaces traditional paperwork, there are legal concerns to be addressed. For instance, how would an electronic signature be verified? How are privacy issues addressed?

Marshall dealt with these issues by providing each clinician with a unique identifier that is a combination of the name, operator number, and a clinician-chosen password. Aside from the clinician, only the computer operations specialist has access to these identifiers.

"Even I, the administrator, don't know them," explains Marshall. The identifier list is kept in a secure, locked site.

Each nurse also signs a Computer Access Confidentiality Agreement. **(See sample agreement, p. 30.)** Key policies outlined include:

- Nurses will only use their own identifier.
- If the identifier is jeopardized in any way, the computer operations specialist must be notified immediately and a new password chosen.
- If nurses allow anyone else to use their password, corrective action — up to and including dismissal — will be taken.
- A saved note is akin to adding a signature, and the document is locked.
- If a correction or change needs to be made, the clinician must create an addendum.
- The electronic signature consists of the name, patient number, and date at the bottom of the note.
- If you are working in the office on a server, you must log out before walking away from the computer.

### *No costs, no resistance*

Another concern as the century draws to a close is whether the system is year 2000 (Y2K) compliant. However, Marshall made sure all computer systems were Y2K compatible before implementing the system.

"Our clinical system has always been Y2K compliant from development. We also have assurances from our other system vendors that their products are in compliance," says Marshall.

Just in case, there are quarterly tests to determine if the agency can reconstruct electronic

*(Continued on page 31)*

## *COMING IN FUTURE MONTHS*

- ■ Create peer review process
- ■ Make best use of OASIS data
- ■ Improve staff compliance process
- ■ Pathway improves CHF outcomes
- ■ PI project decreases supply costs

# Sample Computer Access Confidentiality Agreement

I, _____, have been assigned username/operator number _____ and have chosen the password of _____ for the purposes of Electronic Signature.

1. The username/operator number and password serve as an unique identifier and will not be shared with anyone.

2. I understand that my username/operator number and password are my electronic signature and are intended to have the same legal effect as my handwritten signature or initials.

3. I am responsible for all entries and orders, information and data which I enter into the information system under my username/operator number and password.

4. At no time will I allow anyone to make entries in the Clinical Link automated clinical record using my username/operator number and password.

5. I acknowledge the following:

   A. If at any time I think that my password and username/operator number have been jeopardized, the Computer Operations Specialist (or designee) and my immediate supervisor shall be immediately notified and I will give the Computer Operations Specialist a new password.

   B. I understand that if, at any time, I allow my username/operator number and password to be used by another person, corrective action will be taken, up to and including dismissal.
   **Exception:** When the username/operator number and password are needed by the Computer Operations Specialist or designee to investigate a computer malfunction.

I have read the above information, understand it, and agree to act in accordance with it.

Signed: _____ Date: _____

Computer Operations Specialist or Designee: _____

| DATE | NEW PASSWORD | OPERATOR SIGNATURE | COMPUTER OPERATIONS SPECIALIST/DESIGNEE SIGNATURE |
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Revised: 9/98

*Source:* Home Care of Southern Ohio, Portsmouth, OH.

## Home Care of Southern Ohio Clinical Record Guidelines

**TITLE: AUTHENTICATION BY ELECTRONIC SIGNATURE**

**PURPOSE:** To permit the use of computer-generated electronic signatures and to ensure appropriately authenticated and dated electronic signatures via secured-computer entry. Electronic signature is intended to verify authorship and has the same legal effect as a handwritten signature or initials.

**STANDARD:** Patient heath care records generated in the Clinical Link automated documentation system are authenticated through use of a unique identifier and password of the primary author who has reviewed and approved the entry. The documents specifically effected as follows:

- SN, OT, PT, ST, and SW Daily Visit Notes
- Verbal Orders

**RESPONSIBLE STAFF MEMBERS:** Staff of Home Care of Southern Ohio with access to Clinical Link and the right to make entries in the clinical record as defined in the HCSO Structure Standards Manual, Governing Rules, Medical Records Management (Chapter X).

**SPECIAL DIRECTIONS:**
(1) Entries in the automated clinical record are made only by the individual using his/her username/operator number, unique password, and computer.
(2) Authentication of the electronic signature via a computer secure entry using a unique identifier composed of a username/operator number and password.
(3) The username/operator number is assigned by the Computer Operations Specialist.
(4) The password is chosen by the employee and is not divulged to anyone. If the employee, at any time believes that the security of his/her password has been jeopardized, the employee will immediately notify the Computer Operations Specialist for a new password and will assign a new Computer Access Confidentiality Agreement. The Computer Operations Specialist will assign a new password in the system.
(5) If, at any time, the employee allows his/her password to be used by another person, corrective action will be taken, up to and including dismissal.
(6) Prior to saving a clinical document, the employee reviews the note. Upon completion of the save command, the note is locked and cannot be altered.
- Changes or corrections to the note may be added to the addendum of the note.
- Verbal Orders are locked at the time of communication with the server and cannot be altered. Any changes, revisions, or corrections to the order must be made on a separate Verbal Order.

(7) The **Electronic Signature** is the **name, employee number,** and **date** at the bottom of the note.
(8) Each employee shall sign a Computer Access Confidentiality Agreement upon receiving his/her computer and at least annually thereafter. Computer Access Confidentiality Agreements are maintained in locked storage by the Computer Operations Specialist.
(9) Each employee will assure that the computer is at the "Clinical Link On Screen" before walking away from his/her computer.

(Revised 9/98)
*Source:* Home Care of Southern Ohio, Portsmouth, OH.

records in case of a system crash, and the old standby paper forms are kept on hand.

The agency had already computerized, so there were no hardware or software costs associated with the change. Indeed, the only cost was the one-day inservice to explain the policy, and the time Marshall spent developing some of the forms associated with the program.

### *Go with the flowchart*

Aside from the confidentiality agreement, she created a flowchart of the clinical record order and a grid to explain the disposition of specific forms. **(See sample forms, inserted in this issue.)**

"We did this to make it clear for us, for staff, and for surveyors whether we print and file a form, print it on demand or make it part of the paper record," she says. "It also tells whether something has to be signed or not, and whether it must be a handwritten signature or an electronic one."

The agency also uses clinical record guidelines that state the purpose, nature, directions, and responsible parties for each form. They were revised to include a statement on whether the form uses a written or electronic signature.

There were no complaints about the electronic signature program from the 200 staff at Home Care of Southern Ohio, says Marshall. "They saw it as a time saver, one and [for] all." **(See guidelines, above.)**

Medicare and Joint Commission surveyors

## SOURCE

**Karen L. Marshall**, MS, RN, C, Administrator, Home Care of Southern Ohio, 727 Eighth St., Portsmouth, OH, 45662. Telephone: (740) 354-8129.

also thought the idea was a good one. Since the program was implemented in March 1998, the agency has "sailed through" both surveys.

For other agencies considering a switch to electronic signatures, Marshall says it's vital to have all confidentiality agreements signed before implementation.

"That covers you legally," she explains. You should also make sure your office and medical records personnel are clear on which forms are electronic, which are paper, which need a written signature, and which can have an electronic signature.

### *Confidentiality yours*

Marshall didn't have a lawyer look at her policy or confidentiality agreement, but she says that other agencies may want to go that route. At the very least, she advises agencies research applicable state laws regarding electronic signatures and be familiar with the Medicare and Joint Commission rules, as well.

"Clinicians should also understand that when the form is saved, that is the final check," she warns. "Within the context of electronic signatures, when the clinician saves the form, they are, in essence, signing the form. Clinicians should not take this lightly." ■

# CE objectives

After reading this issue of *Homecare Quality Management*, CE participants will be able to:

1. Discuss how home care nurses should deal with managed care organizations.
2. Describe the FOCUS-PDCA quality improvement process.
3. Describe benefits of a wound management system.
4. Describe legal issues concerning use of electronic signatures. ■




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