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INSIDE

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Watch out for tough commercial payer audits

Learn from a Michigan agency's nightmare

Here is the kind of year that gives home care quality managers nightmares. Genesys Home Health and Hospice in Flint, MI, underwent a state Medicaid audit in the spring and was preparing for a fall survey by the Joint Commission on Accreditation of Healthcare Organizations. Then, Blue Cross Blue Shield of Michigan called to say its auditors would visit in July.

Genesys makes 110,000 visits a year; 10% are to Blue Cross patients. Blue Cross gave the agency two weeks notice before the week-long audit and requested a list of 95 charts from the past year to review, says **Nancy Griffiths**, RN, quality improvement medical records manager.

Four Blue Cross auditors combed through the charts to determine if each represented reasonable, necessary, and skilled care. They used the same criteria as Medicare.

"Each day we had a little exit interview, and they told us what they had found in the charts," Griffiths says. "At that point, we'd get out the medical record to look for any details that were missing." The auditors were particularly interested in the long-term cases, Griffiths notes.

The secrets are in the details

The experience showed managers that they needed to pay closer attention to homebound documentation, stressing with staff that each note has to show reasonable and necessary care.

"Our education coordinator did some research and came up with a sheet of phrases you could use to define homebound status," Griffiths explains. "She got those through team meetings and inservices, and passed them out to every discipline."

The Blue Cross audit was stressful and resulted in Blue Cross challenging payment for some cases. The agency is appealing. However, the audit did help prepare the agency for the Joint Commission survey and helped it earn accreditation with commendation.

Blue Cross Blue Shield of Michigan, serving 4.5 million members, made a decision last year to improve the clinical criteria program,

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including the audit and preapproval process, says **Thomas J. Ruane**, MD, associate medical director in Detroit.

Blue Cross has published a home care manual and Ruane is leading an effort to update the payer's home health care criteria.

"We're going to move from our own in-house written criteria to criteria provided by InterQual, a national provider of clinical utilization management criteria, located in Marlboro, MA," Ruane says. "We're going to get that criteria out to all of the home care agencies through the Michigan Home Health Association in Lansing."

As Genesys Home Health's experience illustrates, quality managers should be aware that an agency may be audited by private payers in addition to Medicare and Medicaid audits. While statistics are unavailable showing if private payer audits are rising, it's possible more agencies will face them as the home care industry increasingly turns to private payer business to supplement the declining revenues from Medicare under the interim payment system.

In any event, it's a good idea for agencies to prepare for such audits, experts say. "I think people just get lax and think if they didn't get audited or surveyed before, then everything they're doing is all right," says **Penny Rhein**, RNC, clinical operations chair for the Michigan Home Health Association. Rhein is also vice president of United Home Health Services in Canton, MI.

An insurance company might not have conducted regular audits because it was short-staffed. In other cases, a payer is purchased by another corporation and the new corporation believes in conducting regular audits. Whatever the reason, home care agencies that have been going about their business the same way for years might suddenly find themselves in the same position as Genesys.

Another explanation is that the commercial home care market, while still small, is growing. Ruane says Blue Cross in Michigan probably covers only about 5% of the state's home care patients, while Medicare may be covering more than 90%. However the company's cost for home care is rising.

"Even though we're not a major player by Medicare standards, the amount of money we have been paying has increased substantially and audits have occurred," Ruane explains. "And in audits, we've found situations where the home health care was inappropriate."

As a result, Blue Cross is putting some effort into being clear and consistent in its criteria for home care, he adds.

Follow Medicare COP with all cases

Rhein says home care agencies might have some trouble if they are handling their commercial cases differently from the way they handle Medicare cases because the commercial payers might expect them to follow the Medicare Conditions of Participation on all cases.

Michigan Blue Cross auditors, for example, use the homebound definition as Medicare describes it, and auditors look at charts to see if there are instances where the care was inappropriate, Ruane says.

"When it's uncertain whether home care would be covered, we want to have home care agencies contact us and discuss these issues and figure out whether any kind of case management program would be appropriate for the patient," he explains. "This way, the agency wouldn't end up two years later with $15,000 in charges that we don't think are appropriate."

Commercial payer audits could serve as a wake-up call to home care agencies. For instance, agencies that have not been routinely audited in the past may be making mistakes that have never been caught, Rhein says. "Sometimes a good outcome of audits is that it checks your system and validates whether you're doing the procedure correctly."

However, there's no easy way to get through a 95-chart audit, she notes. "The advice I would give everyone is that you really need to know what your rules are and reference and review those on an annual basis to see what your own internal audit would find." ■

What can patient surveys really tell you? A lot

Target surveys to areas needing improvement

Suppose your agency's patient satisfaction survey results indicate that most patients rate the agency's quality of care as "excellent." Does this mean the quality manager can pack a bag and say the job's been done? Or does it mean the survey didn't ask the right questions? And how does one agency's "excellent" score compare with another agency's "excellent" score?

Those are the questions that can make quality managers' work a little tricky when they're trying to analyze satisfaction survey results.

So why bother with surveys at all? The answer: Quality managers will find the results of a patient satisfaction survey to be very useful, if they have made sure the survey is valid, reliable, and highlights areas the agency can target for quality improvement.

Home care agencies have a greater challenge than other types of organizations when it comes to interpreting client satisfaction surveys because the home care industry typically is rated high by its clients, says **Jan Brien**, MS, director of Parkside Associates in Park Ridge, IL. Parkside Associates, which specializes in patient, physician, and employee surveys that guide and evaluate quality improvement programs, has provided surveys and research services to more than 600 health care providers nationwide.

Patients rate agencies high

Parkside recently conducted a 183-agency patient satisfaction survey of 16,727 home care patients. Overall, 64% of the respondents said their home care experiences and quality of care were "excellent." Another 25% said their services were "very good;" About 9% said the services were "good," and only 2% called their home care services "poor" or "fair."

"Overall, we found that in general this industry is a very positive industry," Brien says.

However, the survey did highlight some areas that needed improvement. For instance, the survey found that patients expressed more satisfaction with the areas of care process than they did with the education process. Patients largely were satisfied with the amount of time a home care employee spent with them and whether the staff made them feel at ease or showed concern for them.

"We found that 98% of patients felt the home care staff were concerned about them as people," Brien says.

However, patients were a little less satisfied with how the staff involved them in the care-decision and goal-making process. They also expressed less satisfaction with how home care staff encouraged questions and explained medications and procedures.

"It's important to note that the care process and patient involvement are the two areas that have the most impact on how patients rate overall quality of their encounter," Brien says.

A home care agency that finds these types of discrepancies in a patient satisfaction survey could easily target patient education in a quality improvement project. But before a quality manager makes use of such information, the agency must have a reliable and valid survey.

"Not every survey will be effective for measuring quality improvement," Brien says. "You need to make sure you're working with a good questionnaire to begin with." This is not as easy as it sounds. She suggests quality managers these guidelines:

• **Make sure there's evidence for reliability and validity in the survey.**

Reliability and validity are related to what kind of scales are included on the survey. The survey questions should be able to cluster to form scales, and the scales should be reliable, Brien says.

"That means the items within the scales should have strong evidence of internal consistency, which is the appropriate statistical term for multi-item scales," she adds.

There have to be at least two items to make a scale. Often the more items that are included on a scale, the stronger the reliability. However, there are exceptions. One of the scales on Parkside Associates' home care survey has only two items, yet it is very reliable, Brien notes.

Parkside Associates' home care survey has four scales — the care process, patient involvement and education, orientation to home care, and perceived medical outcome.

While reliability pertains to how internally consistent the scale items are, validity is how well each of these scales predict overall quality of care since improving quality is the survey's goal.

Home care agencies could use a survey that already has validity and reliability built into it, or

they could create their own survey if they have access to someone with statistical knowledge, Brien suggests. "I have seen some independent surveys that are pretty good in terms of the way they are constructed."

• **Create an effective sampling method.**

The sampling method should be determined by an agency's plan for analyzing data. For example, if a multisite agency wants to look at client satisfaction in various sites, then the agency should stratify its sample by site.

Parkside Associates had the home care agencies in its study send out 300 customer satisfaction surveys. Their average rate of return was 53%.

The quality manager should look at the data and make sure the sample size is adequate for an analysis. Sample size adequacy is determined by the estimated number of errors. The larger the sampling size, the smaller the chance of error affecting the results. Brien says that a mailing of 300 surveys with a 53% response rate is large enough to yield a low level of error.

Quality managers can follow several strategies to make sure they have a high enough response rate, which typically would be in the 40% to 50% range. Assuming an agency mails its surveys, which is much less expensive than telephone surveys, here are some ways to increase the response rate:

❒ send out the survey within one week of a patient's discharge, then send a follow-up letter a week later;

❒ follow up nonresponders with a phone call;

❒ set up a system that prevents oversampling, which is when an agency sends out repeated surveys to the same patients.

Brien recommends they send a survey to a patient only once in a six-month period. "It might be difficult for home health agencies to track that, to pull the samples, but that really can affect the response rate," she adds.

• **Don't overanalyze the survey results.**

"When creating a report on the survey, only do the analysis you need," Brien says. "Sometimes people overanalyze the results when they should just get the key information, no more and no less, and it should be understandable, because understandable equals usable."

To integrate patient satisfaction results into a quality improvement or continuous quality improvement process, Brien suggests quality managers do the following:

❒ First, if the survey can identify a key aspect of service, then the results can truly identify an important customer requirement.

❒ Second, the agency should use the survey to monitor satisfaction levels over time to see if any changes need to be made, or to see if patient satisfaction has improved or declined as a result of new policies.

❒ Third, patient satisfaction surveys are a good way for an agency to evaluate the effectiveness of its quality improvement efforts or the value of new services.

❒ Fourth, some health care organizations use patient satisfaction survey results as a part of their employee compensation and incentive program. The better the surveys, the better rating the employee might receive on an annual review, or perhaps a whole department will receive some kind of financial reward if patient satisfaction measures improve.

"It's important to keep careful watch over the outcome of care that's provided to your patients because one outcome is their perception of the care," Brien says. "And if you're doing continuous quality improvement initiatives, then you want to measure the impact of your initiatives."

• **Follow basic QI principles to turn survey results into project.**

Brien says one home care agency cannot "photocopy" another agency's success story because quality improvement doesn't always work the same for different organizations. However, if a quality manager identifies a potential problem area based on customer satisfaction surveys, there are some basic steps the agency could take to solve the problem.

For example, Brien says, suppose patients expressed some dissatisfaction with the timeliness of visits. The first thing a quality manager might do is gain a better understanding of how late employees arrive at patients' homes.

"You want to collect baseline data, collecting information on the number of minutes past arrival time, and then do a flowchart of the process," she says.

Next, the quality manager will develop intervention strategies, which for one agency might mean a new scheduling system. Another agency might hire additional staff. A third agency might give staff better maps and directions to clients' homes.

After the agency makes changes, the quality manager again should measure the amount of time past scheduled appointment that employees arrive at patients' homes. If there has been some

SOURCE

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improvement, then the quality manager will look for an improvement in the customer satisfaction scores on that particular indicator. ■

Agency writes manual that fits like a glove

Manual helps agency sail through JCAHO survey

This is the sort of apocryphal tale that home care staff might share in the days of the dreaded anticipation of an accreditation survey.

A home care agency nurse was driving to a patient's home. An accreditation surveyor accompanied her. The pair drove by a dead animal in the road. Later the surveyor cited the agency because the nurse failed to pick up the carcass. The agency's outdated manual said that nurses on the road would pick up all road kill.

"This is just to show that what you have in your manual you better be able to say your agency follows," says **Katherine France**, RN, MN, executive director of the Visiting Nurses Association in New Orleans.

It's because of that type of experience, which happened to an agency France once worked for, that she now recommends agencies write their own manuals. "I looked at different manuals put out by several organizations, such as policy and procedure manuals for clinical staff to follow, and none fit our agency," France says. "We started from scratch and developed our own manual."

Staff at the Visiting Nurses Association, which has 2,500 visits per month, spent a year working on the manual. **(See sample page from manual, inserted in this issue.)** The effort paid off. The agency underwent its first survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation for Healthcare Organizations in late summer 1998, and the agency received accreditation with commendation.

One key to the agency's survey success was that managers made sure the staff knew the new manual inside-out by holding numerous inservices and regularly asking them questions, says **Maria Des Bordes**, RN, director of nursing. "We went through the manual — page by page, standard by standard — because the Joint Commission covers everything."

France and Des Bordes outlined the process the agency used to create the manual and prepare for the Joint Commission survey as follows:

1. Include Joint Commission and government regulations in manual.

Agencies should make sure their manuals contain all of the accrediting organization's requirements, as well as Medicare, and state guidelines. France found that the most effective way to do this was to have staff read the Joint Commission manual, using it as the framework. After managers wrote the manual, it was reviewed by the agency's quality assurance and education staff, as well as by Des Bordes and France.

"Nothing was printed until it was approved by all of these people," France says. Some agencies might choose to hire a consultant to help write the manual, although the New Orleans agency did not, she notes.

"We did hire a consultant to come in and do a mock survey. She went out with our staff and made a couple of recommendations," France says. "When she returned, she said, 'You will be accredited with commendation; you're doing everything you need to do, so don't change.'"

2. Give clinical staff some say over proposed requirements.

The proposed manual also had to be approved by the clinical staff, since these were the people who would be required to follow the rules.

A consultant or manager might suggest the agency include a guideline that seems like an important standard, although it's unrealistic.

For instance, it could be a rule that the agency will call a patient twice before making a visit. However, employees perhaps have never made those two calls, and they may be unwilling to start the practice. In that scenario, France says, managers should leave that suggested guideline out of the manual. The Joint Commission will not be impressed that an agency has some very strict guidelines in its manual unless all employees follow those guidelines religiously, she notes.

"If the clinical staff says a requirement is impossible and they can't do it, then don't print it in the manual," France advises. "Don't go into overkill."

Another example of an unrealistic guideline is requiring nurses to wash their nursing bags every

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night. "That's not necessary," France says. "It has to be kept clean absolutely, but you don't have to take it apart every night. . . . We asked for everyone's point of view, and we saved a lot of money by doing the manual together."

Managers also drilled staff, by asking them questions that could be answered with the manual. "If you can't locate things in the manual, then it looks like you've never opened it before, and it's just sitting in a corner," Des Bordes says.

By the week of the survey, the staff knew the manual so well that if a surveyor had asked to see a particular policy in it, any employee could have flipped to that exact page, France says.

3. Make it easy for surveyors to find necessary details about the agency.

The New Orleans Visiting Nurses Association impressed the surveyor by giving her a 16-page booklet that included the agency's mission statement, its history, its philosophy, and the board members' names and phone numbers.

"We also gave her graphs of the outcomes of the goals we had set and our objectives for patient goals," France says. "If we said a stage three decubitus ulcer would heal in X amount of time, we showed her a graph of whether we were successful in that or not."

The booklet also listed the background of key personnel, including their years of service in home care. **(See sample items from booklet, inserted in this issue.)**

"We also gave the surveyor a case history of the patient she was going to visit, with a little background on the patient that she could read if she wanted to," France says. "We didn't use names, only the patient's initials." The surveyor said the background information made her job very easy, she adds.

However, this didn't excuse staff from having to study and learn what they needed to about their cases. Managers made sure nurses knew every significant detail about their patients and about what the aides were doing for a particular case, Des Bordes says.

"The nurses' notes had to make sense and stand on their own, with all orders dated correctly," Des Bordes adds. "We called physicians to make sure they were getting everything in on time, and we checked documentation to make sure it didn't need to be corrected."

4. Post information that staff doesn't need to memorize.

Visiting Nurses Association managers gathered the agency's organizational chart, department goals, personnel information, and disaster plans and posted these guidelines in frames on the walls.

"I did that because I didn't want anyone to rely on their memory if they got a little nervous," France says. "It was okay if a surveyor said, 'Tell me a goal for your department,' and someone could say, 'Well they're right here on the wall,' and then read them off."

The surveyor was impressed with this, she adds.

The wall charts included details, such as what home care staff would do to assist patients during a disaster, according to whether the patient was a level one, level two, or level three risk. The level three pertains to patients who might need the greatest amount of assistance.

Another example might be if the surveyor asks an employee how many therapists the agency employs. All the employee has to say is, "We have all the therapists posted right there," France adds.

"We made it as easy as possible for the questions we thought she would ask," France says.

5. Challenge a survey citation when you have a good case.

"You can prove your case to the Joint Commission if they question you about something, and if you know your agency is right on a certain policy," France says.

The agency had one small problem pertaining to physician orders. Occasionally, a home care visit was missed, and the surveyor couldn't find evidence of verbal physician orders acknowledging the missed visits. The surveyor said this was an error.

France disagreed. Louisiana home care rules allow agencies to skip obtaining a verbal order from the physician for a missed visit as long as the agency communicated the missed visit to the physician and documented that communication in the conference note. "You don't have to get the physician to sign it," she adds. "You have to

communicate it and document that you communicated it."

France proved the agency's case by quickly calling the director of the state's home care division and asking the director to sign a letter explaining the policy, which was just as she recalled.

"The surveyor would have cited us for that, so you shouldn't be afraid to defend your case," France adds. "You need to be strong enough to say, 'I'm right, and I can prove it, and this is what I'm going to do.'" ■

Does your PI program need a makeover?

You could be collecting more data than you need

When consultant **Martha George**, of Healthcare Accreditation Consultants in Spring Hill, TN, sees clients and attends conferences, she is often questioned about how home care agencies can incorporate OASIS data collection into the requirements of ORYX and the performance improvement section of the Oakbrook Terrace, IL-based Joint Commission standards manual.

The questions have left George surprised. "It's just not as simple as they make it out," she says. "There are specific requirements in the manual on topics you have to look at, as well as complying with OASIS and ORYX."

Don't let things slide until an inspection

The upshot is that many agencies are beginning to collect more data than they need, says George, "or worse yet, too little. Many agencies may not know how to proceed with modifying their performance improvement (PI) programs, so they leave it the same and hope that it flies. Then they find out during inspection they have made a major error.

Since all of the standards in the PI section of the manual are now "A" standards, it is easier for agencies to get caught in the Type I trap with possible focus survey implications."

As a result, George has developed a PI makeover she recently began implementing with some of her clients. She agreed to share it with our readers. In future months, *Homecare Quality Management* will look at the impact the PI revamp has had at some of the agencies with which George works.

She outlines the makeover process as follows:

- **Step 1: Evaluate what you have.**

The first step, says George, is to take an annual look at the PI program you have in place and answer four questions:

1. Was it effective?
2. What areas were not effective?
3. What data did you collect that produced useful information?
4. What data did you collect just because you had to?

"If you monitored incident reporting and found that rather than meeting the 2% goal you set, you have hit 10%, then you know you want to get that down," she explains. "As you modify your processes and procedures, you should see a trend downwards. If you don't, then your program isn't effective."

What are you doing with all your data?

Remember, she adds, PI is a concept that agencies have to learn over time. "It is not quality assurance, and it is not just stuff you collect. You have to do something with the data. Often, agencies will find that they collected more information than they needed to, and more information than they could possibly act on," says George.

- **Step 2: Evaluate what you need.**

This step involves not only determining what data you must collect to meet regulatory requirements, says George, but also figuring out what data to collect to help you meet your agency's priorities, goals, and mission. You should also keep in mind what resources you have available to collect, process, and act on the data collected.

For example, if your agency's mission statement says that you will meet the home health needs of your community in a cost-effective manner and still provide quality care, then you will want to collect data on issues as diverse as infection rates and patient satisfaction.

"If you start getting complaints in patient satisfaction that indicate areas where you are not meeting your mission, you want to look at that and what you can do to fix it." Likewise, if you set an agency priority to increase referral sources by 10%, one area you should monitor, says George, will be who refers patients to you.

As you conduct this part of the evaluation, George says, remember the reasons for collecting

1999 Performance Improvement Program

Monitoring Activity/Performance Measure

Antibiotic Therapy Interruptions

- **FOCUS:** Monitor all instances of interruption in antibiotic therapy
- **INDICATORS (NUMERATOR):** Total number of interruptions in antibiotic therapy categorized by type of therapy, reason for interruption, and length of interruption
- **DENOMINATOR:** Total number of patients with antibiotic therapy during the designated reporting period
- **EXCLUSIONS:** None
- **THRESHOLD:** 95% of all antibiotic therapy will not result in interruption
- **COMPONENTS:** Components of care monitored by this indicator include:

1. Assessment of agency's ability to properly monitor patient's therapy.
2. Appropriateness of therapy to facilitate desirable outcome.
3. Assessment of company's ability to accept patients for therapy.

- **DIMENSIONS:** Efficacy, continuity, and efficiency
- **DATA SOURCE:** Antibiotic therapy interruption log, nurses' notes
- **PURPOSE:** The intent of this activity is to evaluate the components of care listed above by monitoring the company's ability to assess and monitor the patient towards minimizing potential therapy interruptions. The frequency of interruptions can also be reduced by assuring the appropriateness of drug therapy and proper monitoring. Therapy interruptions can cause dissatisfaction in the services being provided by the company, as well as prolong the need for treatment which could adversely affect the well-being of the patient and overall effectiveness of the therapy.
- **FREQUENCY:** Daily monitoring with log sheet review monthly and formal quarterly report
- **TYPES TO BE MONITORED:** Patients receiving administration of antibiotic therapy by all routes
- **METHOD OF REVIEW:** Staff will document all therapy interruptions along with type of therapy and reason for interruption on the appropriate form and/or log sheet. Interventions will be taken immediately as appropriate. On a monthly basis, the director of nursing will evaluate all log sheets, identify any trends, and take appropriate measures to correct any identified problem areas. A quarterly report will be prepared by the director of nursing and presented to the PI Committee during the regularly scheduled quarterly meeting.

The quarterly report shall include the following:

1. How many patients were on antibiotic therapy during the quarter, categorized by route and type of therapy.
2. How many patients experienced therapy interruption, categorized by the reason for interruption and how long.
3. The interruption-to-therapy ratio.
4. Department evaluation and analysis in narrative form.
5. Appropriate graph and other statistical analysis.

The PI Committee will evaluate the report and make any recommendations necessary to assure that the actions taken were effective.

Source: Healthcare Accreditation Consultants, Spring Hill, TN.

data, she suggests. Those are:

❒ to monitor a process' stability;
❒ to identify opportunities for improvement;
❒ to identify changes that lead to improvement; to sustain improvement.

Some areas which she says should be considered are:

❒ safety in the home environment;
❒ employee safety;
❒ quality control;
❒ utilization review;
❒ staff opinions and needs;
❒ outcomes of processes or services;
❒ patient demographics and diagnoses;
❒ financial data;
❒ infection control;
❒ patient perception of care;
❒ employee competence;
❒ sentinel events and / or incident reports.

"You always want to monitor areas that could cause harm to a patient closely," she says, "Other areas, like staff opinions or patient satisfaction, can be looked at less intensively. Those things don't change a lot."

Choose two areas from among these that your agency has an issue with for close scrutiny. "Most agencies know their problem areas," says George. "And remember when you are choosing your

1999 PERFORMANCE IMPROVEMENT SCHEDULE

Monitor	Frequency Reviewed	Formal Report
Utilization Review	Quarterly	Quarterly
Personnel Turnover Ratios	Quarterly	Annually
Work-related Accidents/Injuries	Quarterly	Annually
Incident Occurrences	Quarterly	Biannually
Patient Satisfaction	Ongoing	Annually
Physician Satisfaction	Ongoing	Annually
Infection Control	Ongoing	Biannually
Medication Use	Ongoing	Quarterly
Staff Competency & Education	Quarterly	Annually
Safety	Quarterly	Annually
Financial Data	Quarterly	Quarterly
Patient Demographics	Quarterly	Quarterly
Priorities for Improvement	Quarterly	Quarterly

The Performance Improvement Committee shall meet quarterly to discuss the status of monitoring activities and present data results, Those issues that do not require a quarterly report will be discussed to assure that the processes remain stable. If a process is determined to be unpredictable, then the reporting frequency shall become more intensive with a focus on corrective measure to regain stability.

Source: Healthcare Accreditation Consultants, Spring Hill, TN.

areas that ORYX is coming in. Don't choose two areas that are not part of OASIS and your ORYX system. That's just making work for yourself."

• **Step 3: Develop your performance measure.**

You need to develop a tool that provides an indication of your performance in relation to a specified outcome or process. That tool will always answer who, what, where, when, why, and how. "The tool should ask: Who is involved in the data collection process? What data will be collected? Where the data can be found?" **(For a sample tool, see chart, p. 52.)**

The "when" means determining if you need to look at this data quarterly, monthly, or even more often. "If the process has been performing well and is stable, you can slack off a little in the monitoring," says George.

For example, patient perception of care typically performs well in most agencies. "You can continue to monitor on an ongoing basis, but you don't necessarily have to prepare charts or graphs and full statistical analysis on this quarterly. Maybe you should prepare a full report annually."

You also have to answer why you are collecting the data and how it will work.

"Determine components and dimensions of performance," says George. With the perception of care issue, for example, you might be looking at timeliness and continuity. The components of that process could be to evaluate the home health aide staff to determine if they arrive within five minutes of the scheduled time, whether the aides call the patient prior to the visit, and how many different aides provided care to a patient in a given month.

• **Step 4: Create a calendar.**

The next step is to put together a PI calendar. List all of your activities and determine when you will review your performance measures, when you collect data, when you analyze that data and when you will discuss the PI measures.

You should meet to discuss how the collection is going, adds George, and whether anyone involved in that process needs help. You should also figure out how often and how you will present the data.

These meetings should include a general discussion of the program, as well as whether a particular PI measurement is still in line with your priorities as an agency and if it is bringing you nearer to your goals. **(For an example of one agency's PI calendar, see box, above.)**

• **Step 5: Implementation.**

Educate your staff on changes to your PI program, and include the performance measures and

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goals in your discussion. Then start collecting data. George advises that you include as many staff members as possible in data collection and analysis activities.

"This helps you get more perspectives, gives staff ownership, and facilitates more discussion," she says. "In the old form, a PI coordinator developed the program, collected the data, and analyzed that data. But the commission wants a lot of people involved in this process. And it works better. There is no overwhelming of the PI coordinator, and you get the point of view of people who are actually working on this."

Give surveyors what they want

The whole PI program can be put into a notebook. Include the plan, your agency's mission statement, your committee members, your calendar, and any tools you create. Next, put in four quarterly separators. All graphs, data, and meeting minutes for each quarter should be filed in this folder, says George. "Surveyors love this."

Once you have implemented your program, don't leave it to languish, but evaluate it every quarter or reporting period to see if the measures you implemented were successful. Always involve staff in any changes or modifications to the program. You might want to post data results on a board in the agency break room so that all of them can review it, she adds.

Lastly, don't overdo it. "Pull your OASIS data into your PI program," says George. "The same with ORYX once it's implemented. Don't go crazy monitoring issues, though. You cannot effectively monitor everything. Choose your priorities." ■

Community program helps patients, agencies

Award winner takes pressure off home care

Hearing about Middletown (OH) Regional Hospital's case management program two years ago raised some concerns for area home care agencies. Agencies feared either the program could take patients from the agencies, or there would be new administrative duties attached to patients referred to those agencies. But for the agencies involved, the program has been nothing but a plus.

Jayne Morgan, RN, acting supervisor and case manager at Dayton's Home Health Plus, says there is little additional work for her 18 nurses. In some cases, the case managers at the hospital have been able to actually alleviate some paperwork burden from her staff. The Middletown program, which was recently given a NOVA award by the Washington, DC-based American Hospital Association, is designed for patients with complex health issues who had been presenting repeatedly at urgent care or emergency facilities.

According to **Carol Turner**, FACHE, vice president of clinical and information services at the hospital, readmission rates were becoming a problem, too. As a result, 15 community leaders got together to create a case management program.

"This was a way for the community to work together to improve health status among our citizens," Turner says. "We worked with hospices, parish nurses, home care agencies, and other health care providers to make sure that patients could move through a seamless system."

The hospital wanted a "community-based case management program, but we wanted it to be management in all areas where patients receive care, not just one episode of care," she says.

The resulting program has serviced some 180 patients in the last two years. According to Morgan, the only additional work for her staff is

COMING IN FUTURE MONTHS

- Make data sing with efficiency
- Develop awesome competencies for staff
- Get a grip on ORYX
- Happy employees make happy customers
- How to measure whether patients dissatisfied with you or their employer

to make sure the case managers at the hospital get copies of lab reports, case conference notes, and intake forms for patients. "Most of our interaction is over the phone — case manager to case manager. They call us and tell us if there is a need, and our case manager contacts them if there are any issues," she says. **(For specifics on features and requirements, see box, below.)**

Features of & Requirements for Participation in Middletown Regional Hospital Case Management Program

Features:

- Participation does not require physician referrals.
- Participation is not dependent on Medicare guidelines.
- Program is free to patients.
- Patient agreement is required.
- Case managers are available 24 hours a day, seven days a week to patients.
- Case managers are able to refer to resources such as home care, hospice, nursing home placement, DME, support groups.
- Case managers act as patient advocates.
- Case managers promote appropriate use of resources.

Requirements:

- Patient must have a physician on staff at MRH.
- Patient must have a new diagnosis.
- Patient must suffer from a chronic illness resulting in more than four emergency room and/or inpatient admissions in six months.
- Patient must have a complicated medication regime requiring medication management skills.
- Patient must need disease management skills. For example, patient has difficulty with self management; insufficient family support; multiple physicians; only qualifies for home care for a short time; is not homebound.
- Patient must sign informed consent.

Source: Middletown (OH) Regional Hospital.

SOURCES

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Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

While the referrals have all been one way so far, Morgan says there is no reason why the home health agencies couldn't return the favor, referring patients who might benefit from case management to the hospital.

The impact on patients has been significant, she adds. One patient had a chronic foot ulcer. At one point, amputation was considered. After months of daily home care visits, he was healed. However, his mobility and motivation recently decreased, and at a monthly visit for a catheter change, Morgan's nursing staff found some suspicious areas on one of his legs.

"We thought he needed some extra visits," she explained. "We called the community case manager, and she called the insurance company. She acted as intermediary and got us the extra visits."

That action saved the agency time, brought it more business, and was beneficial to the patient as well.

Other agencies also are happy with the program. **Kelli Haberthier**, RNC, administrator at Cincinnati's Spectra Care likes the additional communication she gets about patients.

"If they go into the hospital, we know we'll get a call," she says. "I see it as us working together to benefit the patient."

Even when a patient has been discharged, Haberthier and her staff are informed about that patient's progress or setbacks. That way, if the patient returns to home care, there is more complete information on his or her condition.

"There really is no down side," Morgan says. "You are no longer solely responsible for the patient, but you have all these people involved in the care, all these people working together towards a common goal."

The only change Morgan would like to see is some standardized forms for reporting on patients which could be sent to the patient's primary care physician and included in the patient chart.

"I think if we had that, it would be a perfect program," she says. "If you have the chance to participate in something like this, or even to start planning a program like this in your community, I'd say go for it." ■

AHC offers health care Y2K reference resource

American Health Consultants has published the *Hospital Manager's Y2K Crisis Manual,* a compilation of resources for non-technical hospital managers. This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, potential fixes, and possible consequences, including:

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CE objectives

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

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