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HOMECARE Quality Management™

INSIDE

■ **Inserted in this issue:** Hiring requirements form

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American Health Consultants® is A Medical Economics Company

Agency creates a process for airtight documentation, billing

No more errors and delayed orders

It doesn't much matter if your Medicare billing and documentation mistakes were intentional or the result of shoddy workmanship. The federal government cares only that mistakes were made that could have cost the government some money. Since the federal government continues its crusade to crack down on fraud and abuse in home care agencies, it's a good idea to once again review your documentation and billing process.

A Kansas home care agency did exactly that after the director discovered that nurses and managers sometimes forgot to log in signed doctor's orders.

"We had a lot of new nurses. They weren't really aware of the big reasons we had everything signed and all the paperwork completed, so I looked at how we could become more compliant," says **Charlene Berges**, BSN, RN, director of Golden Belt Home Health and Hospice of St. Catherine Hospital in Garden City, KS. The agency makes about 1,200 to 1,500 visits per month.

"When there's a documentation problem, you can bring in a team for problem solving because employees feel like they know so much . . . like they're in on the planning process."

The agency educated its staff and began a lengthy education and training process for supervisors to emphasize that they need to be actively looking at notes and daily activity sheets.

"Then I looked at how to make my clinical coordinators more responsible for the day-to-day documentation," Berges says.

She suggested they have one clinical coordinator monitor all of the nonlicensed staff's daily activity sheets and notes, and the other coordinator would review the licensed staff's clinical activity sheets and notes.

After that process began, Berges decided to expand it and have the coordinators review all physician orders and Medicare 485s for accuracy against what was billed.

"We were finding things where maybe a fifth digit for coding was omitted, and this made a billing error," she explains.

Seeking errors

These are the kind of mistakes that can come back to haunt an agency, and so Berges and other managers worked hard to correct those and eliminate any future such errors. Within six months, they had achieved the mistake-proof documentation process they sought. "I feel a whole lot better if Medicare walks in for an audit right now," she says.

Here's how the agency, using clinical coordinators, developed its fraud-and-abuse-proof process:

• **Train clinical coordinators.** Previously, the coordinators were handling intake paperwork. They would check with support staff to make sure a visit was made before it was billed. But no one assessed the quality and quantity of those visits, Berges explains.

"When they were just doing intakes, they assigned the admissions and who was going to do it, but they didn't look at the recertifications and daily paperwork," she adds. "The nurses just sent them in. We had them typed up, and errors were caught after the fact."

Now, coordinators must look for billing errors, documentation omissions, late physician orders, and other items on each chart every day.

"If someone has overtime, they know why," Berges says. "They also make sure any admission we get for home health actually meets the standards the payer source demands, whether there is insurance, Medicare or private pay."

The clinical coordinators manage every documentation detail that relates to direct patient care. When the two coordinators get bogged down, Berges or a branch manager step in to help.

Berges says she and other managers are confident that when patients are discharged there are no longer any errors such as communication notes that aren't written. "Therefore, I know when we're billing Medicare it's for medical necessity, the patient has homebound status, and skilled care is needed."

• **Give clinical coordinators some help.** When the daily audits began, the clinical coordinators said they were overwhelmed because they were still doing the old audits, and it was difficult trying to catch up on those whole starting something new, Berges says.

"So we asked three or four of our older nurses who had quite a bit of home care experience, to do the post audits and the discharge audits," she adds. "We formed a committee to help with that."

The committee started the audits in February and was finished by May.

While the clinical coordinators monitor records each day, a special audit committee looks at discharge records, usually within 30 days of discharge. Also, the agency's occupational therapist, physical therapist, and other staff help with the quarterly audits.

"By the time we do quarterly audits and discharge audits, there's hardly anything that hasn't been corrected," Berges says.

• **Educate staff and change responsibilities.** The agency made sure everyone knew what would be expected of them with regard to documentation.

"I've really held their feet to the fire and it's been kind of tedious," Berges admits. "But now when there's a documentation problem, you can bring in a team for problem solving because employees feel like they know so much and they feel like they're in on the planning process."

Employees must know how important it is that every action they take is documented, because otherwise Medicare could say they shouldn't be reimbursed for what they did.

"Documentation is the receipt for the care we give, and you get the payment from that receipt," Berges says.

• **Improve communication between nurses and clinical coordinators.** Nurses talk with clinical coordinators on a regular basis. Since the audit process has been made more efficient and focused, the coordinators actually have more time to spend with the staff.

So when a coordinator finds a problem with an employee's documentation, the coordinator can address it quickly and show the employee how to improve. Previously, nurses wouldn't hear about a mistake until sometimes several months after they had filled out that patient's paperwork.

"You have to talk to the person about it while it's fresh in their minds," Berges explains. "If you wait two to three months after the patient's discharged, employees won't remember the case."

Since part of the clinical coordinators' jobs is to do employee evaluations, they will sit down with nurses to write those evaluations together. "I

think these evaluations are much better. Nurses are getting evaluated for what they really do, and they're getting merit raises for what's really important," Berges says. ■

JCAHO survey can be good primer to clean house

Director views survey as a learning experience

Most home care quality managers aren't very happy if their agency receives any citations after an accreditation survey. It might surprise them, however, to learn that a Columbus, OH, home care director was pleased after her agency's initial survey, despite receiving a laundry list of citations.

But then most agencies have more than a month of service behind them when they're first surveyed. Community Home Health Services Inc. had been open for little more than the required 30 days when the agency was visited by a surveyor from the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL.

"We crammed three to five months worth of education in three weeks to prepare for the survey," says **Lisa Munnerlyn**, administrator for the agency, which opened in spring 1999.

When the Joint Commission surveyor came back with a lengthy list of problems the agency needed to correct, including one that required a response within 30 days, Munnerlyn wasn't surprised or distressed. After all, the surveyor was doing the small agency a big favor by helping managers find problems early on. Plus, the agency would have a chance to demonstrate how well it has improved documentation through a follow-up or focus survey in October 1999.

"Initially, the survey was looked at by some of our staff as, 'Oh gosh, this is terrible. We did these things wrong,'" Munnerlyn recalls. "But to me, it's a good thing."

The surveyor gave the agency some guidance, and the survey process gave the agency an opportunity to correct mistakes and try again. "I reassured staff that this is a learning process," she adds. "These are minor paperwork issues that clearly could be cleaned up and dealt with in a way that would not cause us to lose accreditation."

Whether a survey is an agency's first-ever accreditation survey or a triennial survey, quality managers certainly should view it as part of the staff's learning process, says **Donna Larkin**, a Joint Commission spokeswoman.

"The surveyors are there to work with an organization to improve the quality of care," Larkin says. "At any survey, the surveyors are asking questions about organizations so they can help the organization meet the quality standards we have for patient care."

A second chance

The Joint Commission decides when it is necessary to conduct a focus survey or when an agency should submit a written progress report. In Community Home Health Services' case, the surveyor thought it would be best to conduct a follow-up survey. Munnerlyn says she has welcomed the opportunity to have a second chance at the survey process: "This is what we consider the big survey."

Many of the citations were for documentation omissions or other small errors that were easily corrected, Munnerlyn says. A few have required the agency to create new forms and policies. Either way, she says it's important for the home care staff to focus on the positive aspects of the survey, such as the fact that a surveyor has helped them zero in on areas they need to improve. And since the agency is so new, they can use this kind of help to improve quality issues before they become firmly entrenched in habit and culture.

"The surveyor was pretty informative in assisting us in what we needed to do and in putting us on the path of righting the wrongs we had out there, and there weren't many," she adds.

Munnerlyn describes some of the agency's survey problems and how these were corrected:

1. Organization leadership compliance problems: The standard cited was LD.5: Organization leadership complies with applicable law and regulation. This Type 1 recommendation cited five problems, which the agency needed to correct and document on a progress report within 30 days. These errors and corrective measures were:

- **No evidence that employees were offered hepatitis vaccinations within 10 days of employment:** Managers were supposed to ask employees to obtain a hepatitis B vaccine within 10 days of being hired. If an employee declined to do so, this should be noted in the files. "But we didn't have documentation of whether two employees had declined or accepted the vaccination," Munnerlyn says.

First, Munnerlyn called an emergency management meeting with the human resource director and the director of nursing. The three managers decided the simplest solution would be to fire the two employees and rehire them, then offer them the opportunity to be vaccinated for hepatitis B. The employees lost no benefits or seniority by the action, and this brought the agency up to requirements.

Also, managers now have employees sign a hepatitis B vaccine acceptance / declination form that says, in part, "I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to myself." Then the employee checks the decline or accept box.

• **Material safety data sheets identifying substances hazardous to employees were not on file as required by the Occupational Safety and Health Administration (OSHA):** Managers filled out material safety data sheets for all office hazardous substances, including copier / fax / printer toner, cleaning solvents, and others. The forms also contain information about possible hazardous substances that home care staff might encounter in client's homes. These forms are kept in a central location in the office and are accessible to all staff.

• **Employee health files were not kept separate from personnel files as required by the American Disabilities Act:** Health files now are kept in a locked room of the office with only one key that is held by the administrator, meeting ADA requirements.

• **The organization did not verify the licensure of direct and contracted employees:** The surveyor found four employment files for which there was no evidence that a written or verbal follow up was conducted on potential employee's references, job history, educational background, and licenses and certifications. The managers created a job qualification form that the human resource director fills out for each potential employee. The form serves as a screening tool, and is used to document training and other background information. **(See hiring requirements form, inserted in this issue.)**

• **Employees with potential for exposure to hazardous waste were not provided with personal protective equipment, except for gloves:** The agency now provides those employees with personal protective equipment, including latex gloves, protective goggles, vinyl aprons, and face masks. A documentation tool has been designed to give evidence that this equipment is available to the nursing and care staff. The tool, "Protective Equipment," reads: "I, [employee's name], have been orientated on the proper usage of the following protective equipment, and have received the equipment for my personal use whenever necessary during the hours that I am on duty as a home care person for Community Home Health Services Inc. Items given: goggles, apron, gloves (latex), mask."

2. Human resource problems: The surveyor said there was no documentation that the agency had a competency assessment program.

"Since the survey, we have devised a competency test for all field staff," Munnerlyn says.

The agency uses both contract workers and employees; now the written portion of the competency assessment is given when people apply for contract work or a job. This way, it's already on hand if they are suddenly needed to work during a particularly busy week, she adds.

Also, the competency assessment helps the agency gauge potential workers' strong and weak points.

The skilled assessment involves hands-on testing with a Hoyer lift and transfers. The hands-on assessments are scheduled once potential workers meet the other criteria.

Then, all who have passed the competency assessment tests are placed in a holding pool of available workers.

Another human resources problem involved job descriptions and qualifications for all staff. The surveyor said they needed to include job qualification guidelines for potential contract workers, as well. They wrote qualification descriptions for therapists, social workers, and nutritionists, even though the agency does not employee those disciplines.

"Now, the people we contract with have to meet our qualifications," Munnerlyn says.

3. Ethical issues in marketing: The agency's marketing brochure stated that the agency could provide therapy services. The surveyor said that was not accurate because those services could only be provided by firms that contract with the agency. "She said we were misrepresenting our services; so we redesigned our brochure to show what our services are, and deleted mention of physical therapy or occupational therapy," Munnerlyn says.

4. Document patient rights discussions: The

surveyor found two active patient medical records that had no documentation that the patient rights were reviewed with the patient and family. The agency's managers quickly corrected that omission through staff and management education. Now, the director of nursing and any registered nurse who conducts an initial assessment are required to bring a Patient Bill of Rights form to the patient's home on the first visit.

"The director of nursing reviews that with the client, and then there's a checkbox to mark to let us know the information has been reviewed," Munnerlyn explains. "The patient signs it, and a copy is put in the case folder." ■

Stop the bugs! Learn more about the *real* Y2K problem

(Editor's note: This story is part of an occasional series on what home care agencies are doing to control and prevent infections, particularly in light of the drug-resistant strains spreading through hospitals and elsewhere. Look in the December issue for information on a long-term infection control project conducted by a Missouri home care agency.)

Control infections through finding trends, problems

Kansas agency proves it has good infection control

As home health care approaches the 21st century, there is a disturbing trend of antibiotic-resistant bacteria spreading through hospital settings that makes it especially important that quality managers focus on preventing and controlling infections.

By now, most home care nurses have heard of the more common drug-resistant bacteria, including methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE). MRSA is a major problem in nearly all major medical centers, and VRE infections have increased rapidly in the 1990s, climbing twentyfold in the first few years of the decade. Also, penicillin-resistant *S. pneumoniae,* which accounted for 6.6% of total *S. pneumoniae* strains in the United States in 1992, now accounts for more than 40% of the total strains. Naturally, this problem has spread from hospitals to the communities, and ultimately to the home.

This is why some home care agencies are making infection control projects a top quality improvement priority in recent years.

For example, Susan B. Allen Memorial Hospital Home Health in El Dorado, KS, decided to track every infection treated or noticed among the agency's patients, beginning in January 1998.

"We were looking to see if we committed any cross-contaminations or certain trends of infections in one type of patient or coming from one type of facility," says **Martha McCabe**, administrator of the home health department for the hospital-based agency that serves two counties in south-central Kansas, near Wichita.

"We identified two trends in our infection data," she adds. "The majority of our staph or MRSA infections were coming directly out of the hospital into the home, and we narrowed these down to two particular hospitals."

One hospital accounted for all of the MRSA infections. These patients were still on antibiotic treatment when the home care agency admitted them.

"By the time we discharged all of these patients, their cultures and tests were coming back as negative," she adds.

Ruling out trends

The second trend McCabe noticed was that the majority of urinary tract infection (UTI) cases involved patients who had catheters, sometimes for more than a year. These patients often were the multiple sclerosis patients, who were chair-bound or bed-bound, and always were on a round of antibiotics. "Their UTIs always were recurring, and that is something we found not to be uncommon with those patients," she says.

Finally, the agency's thorough data-collection process helped managers rule out another potential trend: The agency had no instances of cross-contamination while caring for patients.

"We found out that for infections, our outcomes were good," McCabe says.

Here's a snapshot look at how the agency conducted the quality improvement data collection project:

• **The agency maintains a log book for infections.** Nurses made entries after obtaining patients' culture results or when a patient began taking an

antibiotic. The entries included the date, type of infection, patient's identification, and antibiotic prescribed.

"We'd go back on a monthly basis and review all the newly entered infections to see if they were resolved in 30 days, and whether they were kept track of when resolved, and when they occurred," McCabe explains.

• **McCabe conducts a sample chart review each month.** She assesses whether nurses have entered the required infection information on the patient's chart. This includes the antibiotic prescribed; onset of infection; category, such as upper respiratory or UTI; the treatment; medication order's starting date; lab results, and discharge date.

"I look to see if the information has been entered in the infection category, and I also look at the lab results and medication list," she says.

• **Nurses are responsible for continually following up on cases and leaving no blank spaces in the logs and charts.**

For example, the agency had a case of a draining wound. The nurse called the physician and requested that a culture be conducted, McCabe says. The nurse logged in the infection, but left the box for medication blank because the antibiotic hadn't been ordered. The log is considered incomplete until the nurse returns to fill in the name of the antibiotic, McCabe says.

So far, the nurses have been doing a very good job keeping track of ongoing cases of infection, she adds.

• **Nurses no longer have to write down entries on the log book, once the agency had the resources to start an electronic log.** The agency uses a software program that enables nurses to enter infection information while still in the home. The software, created by Patient Care Technologies of Atlanta, is installed in nurses' portable computers.

The software makes it easy for nurses to update the record anytime during the care process. "Nurses can chart multiple infections and infection sites on the computer," McCabe says. "Then, every month, I go into a menu that is available through this system, and have it compile all the infections for a given period of time."

The software will compile the infections in any way that McCabe desires. For instance, she might desire to see all the infections that occurred on a particular site or of a particular type.

Also, McCabe can assign risk levels to patients by pulling information on nutritional status, infection history, and safety issues.

"The system allows you to draw a list of people who have certain risk factors," she notes. "It allows us to pull a list of people who are at a high risk and make sure they are evaluated." ■

IPS causes reduction in care, fewer resources

Study highlights system's problems

A new study's findings about the impact the interim payment system (IPS) show that most home care agencies have altered their case mix and practice patterns to conform utilization to reimbursement. That has resulted in reduced care for diabetics and other patients who have chronic, long-term health care needs.

The study, "An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care," presents a stark glimpse of the consequences of the Balanced Budget Act of 1997.

The results, please

George Washington University of Washington, DC, conducted the study of 28 home care agencies in nine states — California, Florida, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, Pennsylvania, and Texas. Each agency answered 60 questions regarding data from 1994, 1996, and 1998 about their types of patients admitted to care, patient mix over time, patterns of referrals and discharges, clinical practice patterns, and changes in demand for alternative services and financing.

The participating agencies included nine freestanding, for-profit agencies; 11 freestanding nonprofit agencies; and eight hospital-based or affiliated agencies.

Here are some of the study's findings:

• **Southern agencies were more likely to reduce the level of services, since they apparently had a case mix with more chronic illnesses and were less able to change that.**

• **Agencies in other regions often relied on screening admission of patients and altering market patterns to control case mix of patients, and would reduce the number of visits.**

• **Complex diabetics were significantly affected by both exclusions from care and**

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reductions in the level of services.

• Patients with predictably low costs appeared to experience improved access to care, regardless of amount of time in care.

• Most agencies said the financial pressure to limit services has created greater fragmentation of care between different types of providers.

• The number of Medicare patients admitted to the study agencies as a percentage of all patients has declined 21% since 1996, and Medicare 1998 revenues have declined by 25% from 1994 levels.

• Some agencies said IPS has triggered some efficiencies and quality enhancements, including more case management, higher levels of nursing supervision, more goal and outcomes orientation with patients, reduction of administrative costs, and teaching patients greater independence.

• Nearly all of the agencies studied said they have cut staff, resulting in a 23% reduction in skilled nursing staff since 1994.

(Editor's note: For a summary of the report and more information about IPS, see the National Association for Home Care's Web site at: www.nahc.org/NAHC/NewsInfo/99nr/gwrpt.html.) ■

HF study readies agency for PPS, capitation

As VNS of New York, the largest freestanding, nonprofit home care agency in the United States, looked toward the future in 1997, management saw several things of importance.

First was the move toward capitated contracts that would leave the agency at risk for patients who were rehospitalized or whose care otherwise departed from accepted norms. The other issue staring the agency in the face were the interim and prospective payment systems that would require the agency to do more and better while reducing utilization.

Ultimately, when the agency paired up with Lenox Hill Hospital in New York City for a joint disease management (DM) study in 1997, it seemed an opportune time to put together programs that would address those issues, says **Maureen Dailey**, RN, MSN, CETN, director of the Centers of Excellence and Disease Management for the 1,500-nurse agency. The result was a DM program piloted from a joint United Hospital-funded study for heart failure (HF). Among the positive results: reduced rehospitalization rates, improved patient satisfaction, and the integration of available state of the art technology at VNS and the hospital. There is also some anecdotal evidence that nurse and physician satisfaction has improved.

Electronic intervention

As an example of how well the program can work, Dailey points to an 86-year-old man with HF and a new diagnosis for pulmonary fibrosis, and new to home oxygen use. He lived alone and had been rehospitalized six times over a two-year period — at a cost of about $5,500 per hospitalization. Dailey says the patient often failed to monitor his weight daily and fell out of the weight parameters set by his physician — sometimes precipitated by eating high-sodium foods.

Under the new program, he was put on electronic monitoring through which his daily weight check and other vital statistics were automatically sent to the VNS office. Through biofeedback, education, and coaching by his home care nurse, he began to understand the link between his weight and related changes in his cardiac health status, and the need to intervene before the need for hospitalization arose.

If the patient failed to complete a weight check or if his weight went up too much, he was phoned by a nurse and encouraged to take

action. At one point, after aide visits stopped, he put on five pounds.

"As it turned out, the patient ordered in high-sodium, prepared kosher food when the home health aide was discontinued," says Dailey. "During holiday periods, he also ate high-sodium foods. The physician was notified, his medications adjusted, and a nurse went in and educated him about the salt content of prepared kosher foods he was ordering into the home."

The nurse taught him about "programmed cheating" for occasional times the patient knew in advance that his salt intake would increase. She told him that if he knew there was a situation where he might stray from his prescribed regimen, he should call his physician and negotiate some extra diuretics. "Assessing individual patient preferences and cultural influences is important to include in the nursing assessment," says Dailey, noting that the VNS' culturally sensitive and literacy-appropriate patient Heart Failure Self-Care Guide was used in the study across the continuum of care.

"The monitor gave us real time clinical data so that early and effective intervention could prevent avoidable rehospitalizations until the patient was independent in effective self care. That patient hasn't been back in the hospital for almost two years," she says.

Using technology to improve outcomes

The program starts in the hospital, where HF patients must achieve specific outcomes in order to move through various phases of the program. The focus is on wellness, not days spent in the hospital. A nurse case manager follows the patients throughout their stay at Lenox Hill, coordinating care and intervening when the need arises. They also ensure that home care is available when necessary after discharge, working with the VNS home health intake coordinator (HHIC).

Once in the home care program, patients are started on a comprehensive care management program that includes monitoring daily weights and blood pressure. For high-risk patients, such as those who have a history of more than one rehospitalization in the last year, a telehealth monitor is provided for the patient. It monitors weight, blood pressure, pulse, and blood oxygen levels, transmitting them to a central station.

Dailey says the monitoring is important during the first week or two following discharge for high-risk patients, augmenting clinical data assessed on home visits. "The transition zone from acute care to home care can be a vulnerable time for rehospitalization," she says. Patients being weaned off of home care are also monitored electronically when they are otherwise identified as high-risk patients. Not only does this automatically alert staff to any problems early, but patients like the 86-year-old man can receive positive reinforcement of desired behavior via biofeedback.

The HHIC's electronically transmitted a heart failure protocol in the patient plan of care to the home care nurse. The protocol cues the nurse to use patient self-care guides and best practice tools in care management. The protocol includes key clinical information communicated from the patient's acute care stay. The cardiopulmonary clinical nurse specialist from VNS educated the home care staff about best practices and the heart failure pathway. The HHICs were also coached about what vital information to include in the protocol section — such as weight and blood pressure parameters, the ejection faction, and the New York Heart Association functional classification.

A VNS clinical specialist is available to consult on particularly complex cases, and because of the electronic components of the program, the notes from that specialist are electronically available to any nurse caring for that patient via the electronic record.

The outcomes from the program were strong: Along with a reduction in 30- and 90-day readmission rates to 20% compared with a national average for Medicare patients of 50%, 86% of the patients that were part of the program were put on ACE Inhibitors, compared to a national average of just 40%. Dailey says those patients with more than one previous rehospitalization fared even better, with a reduction of 50% in readmission rates.

VNS found some other benefits to the program too. For instance, Dailey says that ejection faction is not the most significant predictor of rehospitalization among all populations. "That was interesting. That was good information for us, and we have to be aware that we may not be able to generalize to all patients what we learn in a particular study. Each population must be stratified according to significant risk factors for that population."

Dailey also says that VNS was able to capitalize on other opportunities for improving care management by taking what they learned in this study and applying it in other situations. For example, all HHICs in every hospital are entering

SOURCE

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specific heart failure information into the patient record to improve communication of key clinical information across the continuum of care.

Expanding success

While the program originally started only with Lenox Hill patients, its success has led VNS to expand the program to all of its hospital referral sources. "All our nurses have been educated to this now," Dailey says. "All HHICs have been educated to the key information that is needed in the plan of care specific to heart failure. We have demonstrated that this information is important to quality of care."

The success across regions and teams is still being studied and the model perfected, she adds, but so far, patient satisfaction rates are high; staff has verbalized satisfaction with the integration of best practices for heart failure; and rehospitalization rates are down for HF throughout the agency.

"You can conceptualize disease management as having four pillars," Dailey says. First, there is there is population stratification that helps identify who in the HF population needs management. Second, there are clear guidelines on the disease — in this case, from the Agency for Health Care Policy and Research. Thirdly, there is aggressive early management that allows an agency to respond quickly to changes in the patient's clinical status on a multidisciplinary basis. And lastly, there is outcomes tracking, which looks at clinical quality, satisfaction (patient, physician, and nurse), patient quality of life, and cost.

"Through this program, we gained experience in these four pillars," says Dailey. "We were also able to see not just how it affected our cost, but how we could use information on cost across the continuum of care to help us build a cost effectiveness model across the continuum of care. As we move to capitated contracts, this will help. We can go to our payers and say that spending more money on a comprehensive disease management program involves more outpatient costs. But overall costs are down when avoidable rehospitalizations are prevented."

Dailey emphasizes that HF rehospitalizations aren't just a cost indicator, but a key clinical quality indicator, since research has demonstrated that HF patients have significant morbidity and mortality with rehospitalizations.

She says that if you can align your incentives with those of other providers, you are doing everyone — including patients — a favor.

"We have a close relationship with Lenox Hill due to our joint venture in home care and providing outsourced cases management services to the hospital for acute care in 1999. Through that close relationship, we can easily replicate the model we tested in the UHF study. In addition, we are taking what we have learned and working collaboratively on continuum care pathways with other acute care customers," she says. "The more we can collaborate with other care partners, the better care outcomes will be for all our patients."

Effective DM programs will ensure home care agencies' success in the future, Dailey says. "We have many customers; through this model for high-volume high-cost diagnosis like HF, we will partner with referring customers to improve the continuum of care. Disease management is an excellent model to take exquisite care of whole populations of patients one person at a time. You can't just have good case management. Seamless integrated care is the new standard." ■

Playing for the same team

Ramona VNA and Hospice in Hemet, CA, had a typical home care agency structure: Case managers oversee a group of patients and reported to a nurse manager. "But with OASIS, we knew that to meet timeliness and performance improvement requirements, we would have to change things," says **Marilyn Stoner**, RN, MSN, vice president of the full-service agency. The result was an experiment in teaming staff that she describes as "wildly successful."

Among the benefits: home health aide supervisory visits, which were at 85% or 90% before the change are at 100% now in both the agency's offices. There has also been a reduction in the number of different staff members seeing each patient, which has had a positive impact on patient satisfaction scores.

Employee satisfaction is also up, says Stoner, and staff members find it easier to talk to a team

leader than find time with a manager. "Our office is large, and 12 people can't talk at once to one manager. It also helps in cases when you introduce some procedural change, like OASIS. Now, we have a larger supply of people who know what has to be done than under the old system of case managers."

Although Stoner hasn't measured this yet, she also believes that physician satisfaction has improved from the program. "Rather than getting several calls with questions from several different people here, the team leader can make one call and get all the questions answered," she says. And if there is a problem with a particular patient, there is a point person to go to who knows about the case. "Before, if there was a problem, I would get the call. Then I would have to research the issue, talk to various people, and then call the person back."

Finding an equation that works

"We tried a lot of things," Stoner says of her grand experiment. "We looked at different team sizes and whether they should be multidisciplinary or discipline specific. In the end, Ramona VNA opted for the latter, with teams of five to eight people working with about 60 patients.

Beginning late last year, the agency looked for nurses to volunteer as team leaders and create the program from scratch. Those team leaders simply started trying different things in a pilot project with no rules. If they tried a particular sized team and it didn't work, they changed it. If putting different disciplines together didn't work because there wasn't enough work for a social worker on any one group of patients, then that was scrapped. What evolved over two or three months was the teaming program that Ramona VNA has operated for some six months now.

"We had 400 patients in our Hemet office," explains Stoner. "When they knew what they wanted, we changed that office. Then we changed at our Sun City office, then with our intermittent care program, then with our hospice program."

The team leaders are treated and paid as clinical specialists. Indeed, one of the characteristics Stoner looked for in finding her team leaders were her clinical experts. "We also wanted the best documenters — those who had the highest regulatory compliance."

Stoner says she had no difficulty in getting the change accepted by her nurses and other staff. "People were anxious for change."

That's not to say that there weren't issues to be resolved. For instance, it was difficult for team leaders to decide where they wanted the lines of authority to stop, Stoner says. "As it is now, they don't discipline, they don't hire, they don't fire. Some agencies might want to include those things. But deciding what kind of job these people want or don't want is hard." There was also an issue in determining what issues were for the team leader to decide, and which should be brought to the attention of a manager. "It took us a short time to work out. It was an evolutionary process."

Stoner says that there is no reason to make all the changes all at once, that letting things grow can make a project turn out better than you anticipated. Among her other tips for making a team program work:

1. Centralize scheduling. This is a must, she says. "Scheduling is a complex term that needs to be broken down into its components." Team leaders start the process, while the schedulers write out the schedules and answer questions about who is seeing whom. They also manage the per diem staff as much as possible. "This has been an incredibly difficult part of the job."

2. Select a good team size. "We aim for 80 to 100 patients per team," says Stoner. Those patients are managed by five to eight nurses, physical therapists, LVNs (to provide wound care) and occasionally other rehabilitation specialists or social workers. "We have them, but not enough work to assign them to teams."

3. Maintain high productivity. The best way to do this is to facilitate communication, although this remains a challenge between disciplines.

4. Choose your team leaders. Stoner says all those involved in the pilot project volunteered,

SOURCE

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and all those who volunteered were among the strongest nursing staff at Ramona VNA. "They were enthusiastic to try this system."

Lastly, Stoner thinks everyone should read the book *A Simpler Way* by Margaret J. Wheatley and Myron Kellner-Rogers (Berret-Koehler Publishing, 1998; list price $19.95). "This should be our bible," says Stoner. The book begins by saying that we all want life to be "less arduous and more playful. We are all just killing ourselves from stress."

Rather than demanding that any change work right the first time and immediately, this book reinforces that "playing" with a theory and letting it

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evolve is a better way. "Organizations are living things. They evolve like species. If you pay attention to the innovation as it occurs, you get farther faster. That's what we did with this project."

Stoner says agencies that think their staff need more support to meet regulatory requirements might benefit from this team structure. "We don't want to baby-sit our staff or make them feel we don't trust them. But regulations are so complicated now. Team leaders provide a checkpoint for staff." ■

CE objectives

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

1. State three major drug-resistant strains of bacteria.
2. Implement a process to reduce documentation and billing errors.
3. Help prepare their agencies for PPS. ■