

# HOMECARE ADMINISTRATOR™

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**ROUTE:**

- Clinical Services
- Billing Manager
- Clinical Records Manager
- Marketing
- QI Coordinator
- Education Manager
- Human Resources
- Return to Administrator**

## Agency Competence: Clinical Records, Part III

**Beyond the continuing record review that occurs throughout an episode, an agency must conduct quarterly record reviews. Focus reviews based on quality indicators complete the picture.**

Over the past two months, *HOMECARE ADMINISTRATOR* has offered guidance on clinical record review as one aspect of competent agency management. Competent agency management encompasses all functions of those who are responsible for ensuring regulatory compliance while producing desired clinical and financial outcomes.

Clinical record review processes provide the structure for collecting and analyzing information about direct homecare services. With adequate data, agency staff has the basis for making decisions that will support ongoing improvement of care. Additionally, when analyzing the results of record review, it must be recognized that the documentation is indicative not only of clinician practice, but also of the agency's overall processes. The competence of the record review itself affects the ability of staff to make sound decisions about care and service delivery.

Previously in this series, the focus has been on general record review parameters and the continuing record review that is closely linked to the events that occur within an episode. Monitoring

an episode by reviewing the documentation associated with such events as admission, transfer, and verbal orders allows agency administration to proactively guide case management. Such monitoring takes on further significance when considering the potential payment reviews agencies face with routine intermediary audits and the implementation of audits by Recovery Audit Contractors.

The focus this month is on the quarterly record review mandated by the *Conditions of Participation* and on additional reviews that an agency chooses to conduct based on its performance improvement plan and quality indicators. Quarterly record review provides an agency with a standard, regularly scheduled assessment of its documentation and clinical service delivery processes, allowing comparison to past results and evaluation of actions taken to improve. The additional, or focus, reviews are methods for an agency to take a close look at specific quality indicators, determining why performance results may fall below the thresholds the agency has established. Together, these forms of record review offer a picture of agency services that can be instrumental in guiding future improvements.

**Understanding the quarterly review regulation**  
Standard (b) of the Medicare *Conditions of Participation* §484.52 includes quarterly record review as one component of agency evaluation. The regulation requires "at least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement."



To clarify the application of this standard, let's break it down into its main points:

- “At least quarterly”: The standard does not specify a singular meeting or that a group comes together to complete the quarterly record review. Designated reviewers may conduct the audits individually and at different times, as long as an appropriate sample of records is reviewed each quarter. The Interpretive Guidelines: Home Health Agencies (HHA), G250, describes this provision.
- “Appropriate health professionals”: The quarterly record review standard is sometimes confused with *Conditions of Participation* §484.16, which addresses the group of professional personnel that meets to advise the agency. Some agencies have used the advisory meeting as the setting for quarterly record review, expecting the advisors to also be skilled at record review. That is not necessary and may be detrimental to the quality of the record review. Choose reviewers who are interested and committed to conducting the review. It's often helpful to use your clinical staff for at least part of the review, as this broadens their awareness of documentation and processes. Orienting new reviewers to the process and expectations is critical to the success of record review.
- “Scope of the program”: Consider the services provided by the agency and ensure that reviewers are professionals who represent all services delivered. If specialty programs exist, ensure that appropriate professionals review records from those programs.
- “A sample of both active and closed clinical records ... furnishing services directly and under arrangement”: There is no specific requirement for the size of the sample, although it's appropriate to use standard sampling methods, such as 10 percent of the average census, selected using a random numbering pattern. All services must be eligible for sampling, including those provided “under arrangement” by contracted clinicians. Medicare surveyors may ask the agency to describe its method for selecting records for review.
- “Determine whether established policies are followed in furnishing services”: Quarterly record review is sometimes considered tedious because it tends to focus on the details associated with policies, such as appropriateness of admissions and care provided according to orders. For a meaningful review, ensure that the format of the review targets the most pertinent care delivery policies. Avoid duplicating the review of information that is

already available via automated methods, such as reports of physician order timeliness and admission time frames. For overall analysis, automated reports may be incorporated with the direct review performed by professionals. Reserve the direct quarterly review format for topics that require the skilled review of a health professional.

### Quarterly record review format

When designing a format for quarterly record review, establishing an approach that mirrors the flow of an episode will increase the likelihood that reviewers will progress through the record systematically, easily recognizing the status of compliance with policies. Reviewers should understand that their role goes beyond mere data collection; it includes evaluation of direct care delivery, compliance with regulations, and utilization of services. Although each agency is responsible for establishing its own format, the Interpretive Guidelines: Home Health Agencies states that an agency's record review criteria should be “consistent with the HHA's admission policies and other HHA-specific patient care policies and procedures.”

Consider including at least the following topics in quarterly record review:

- Compliance with billing regulations, such as comparison of billing dates with order signature dates to ensure that all orders were signed prior to billing.
- Specific OASIS regulations, such as timeliness of completion and assessments conducted by appropriate disciplines.
- Appropriate utilization and effectiveness of the case management, such as referrals made to additional disciplines as needed, evidence of care coordination, and evidence of sufficient lead time for discharge planning. To determine adequate care coordination and implementation of orders, instruct reviewers to pay close attention to notes for visits made just before and after the receipt of verbal orders.
- Regulatory integrity, particularly related to homebound status. Reviewers should scan the chart for overall evidence to support homebound status, including review of OASIS functional items, missed visit documentation, and routine documentation of patient activity during visits.
- Appropriateness of admission, ensuring that Medicare beneficiaries meet all criteria for Medicare eligibility and that there is evidence of the need for skilled, reasonable, and medically necessary care.
- Compliance with physician's orders and orders obtained for all services delivered. Specific

attention should be directed toward medications and all steps in wound care.

- Appropriate supervision of home health aides, licensed practical nurses, and therapy assistants.

### Focus reviews

Agencies often establish quality indicators for such service components as specialty programs, historically problematic or high-risk areas, potentially avoidable (adverse) events, and standard processes such as infection control and risk management. When establishing such indicators, the agency also identifies a corresponding threshold level for each indicator, with expectations that agency processes will maintain a level of function that does not trigger the threshold.

For example, an agency may monitor the numbers of patients who are rehospitalized due to an agency-acquired infection, and may set the threshold at 10 percent. Data may be collected via routine monthly monitoring and quarterly record review. Once analyzed, if the data indicate that the number of infections is 12 percent, triggering the threshold for the reporting period, the agency will need to investigate further. Another example might be related to a potentially avoidable event. Further investigation might occur following each potentially avoidable event.

Further investigation proceeds via a focus record review, or audit. An agency may use standardized audit tools or create agency-specific audit tools to collect pertinent data from the record. For example, an agency may create a focus audit tool for infection control that would be used to review the record for each patient hospitalized due to an agency-acquired infection. The tool might collect data relating to vital sign patterns, appropriateness of wound care, presence of adequate assessment, and the pattern of assigned caregivers.

Focus record review is a more specific and higher level of review than can be obtained via routine continuing or quarterly reviews. Each type of review plays a unique role in the evaluation of agency function.

In the past three months, this series has focused on clinical record review. Keep in mind that conducting record reviews in any form is not an end in itself. The goal is that the data obtained will play an integral role in guiding decision-making and action for improvement. When an agency takes full advantage of the various forms of clinical record review, using the data appropriately, the agency achieves one component of competent agency management.



## How to Use OASIS-C Data to Improve Quality

### CMS published its fourth OASIS-C manual to encourage quality monitoring and improvement.

OASIS-C has been implemented for more than six months, and homecare clinicians are still adjusting to the changes and focusing on its proper completion. As clinicians continue to develop a stronger understanding of how to complete the data set, it is important for homecare agencies to educate themselves on how to use the data that OASIS-C will produce.

Quality improvement is a goal of the Centers for Medicare and Medicaid Services (CMS). CMS believes quality will improve if agencies have a better understanding of how to use the OASIS-C data that are being documented. CMS has published the *Process-Based Quality Improvement (PBQI) Manual*, which guides agencies on how to collect and use data from OASIS-C. The manual is the fourth in a series produced by CMS that focuses on OASIS-C.

CMS has created the Process Quality Measure Report, a report that will help agencies understand what their process measure outcomes say about their agency. The *PBQI Manual* focuses on the Process Quality Measure Report and how agencies should use it for quality monitoring purposes.

### Process Quality Measures

Process measures are utilized to calculate the rate of homecare agencies' use of specific evidence-based processes of care. OASIS-C process measures focus on high-risk, high-volume, problem-prone areas for home health care. These processes are measured for many reasons, according to CMS. Of the many reasons for measurement, CMS includes:

1. Evaluation of elements of care under an agency's control
2. Promotion of the use of specific evidence-based care practices
3. Evaluation of the impact of use of best care practices on patient outcomes

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## How to Improve Quality

4. For use in agency-level performance improvement activities
5. For use in public reporting to assist consumers in cross-agency comparisons
6. For potential use in future quality-based purchasing systems
7. Promotion of improvements in patient care across settings

It is important to pay attention to the data that are calculated from these process measures because they reflect how an agency cares for the patient. The Process Quality Measure Report highlights these measures.

### How to use the report

CMS states that it hopes agencies will use the reports to better their agency. The manual states:

Once quality monitoring and performance improvement are successfully implemented in an agency and become “steady-state” activities, they emerge as powerful agency tools to continuously improve care for the benefit of patients. We strongly encourage all agencies to take advantage of the information presented in the reports to provide direction for their continuous quality monitoring and improvement activities.

In the manual, CMS provides a three-step process on how to use the reports. The steps include:

1. Evaluating or investigating the use of specific best care processes (such as conducting falls risk assessments or providing drug education) by reviewing the care provided to determine any needed changes in care delivery
2. Systematically documenting recommendations for change in a written plan
3. Implementing and continuously monitoring the written plan in order to effectively change care delivery

The manual gives step-by-step instructions for quality improvement. It explains how to select process quality

measures for investigation; conduct the investigation; and develop, implement, and evaluate a plan of action to improve process quality measures. This section of the manual is a valuable tool for an agency that doesn't understand the result of a particular process measure. The instructions explain exactly what an agency can do to get more information and improve that process measure. It also includes a sample plan of action.

### What the report will show

The Process Quality Measure Report will gather data on agencies' current use of process measures. The report will provide agencies with chances to use process measures for PBQI purposes.

Reports contain rates of compliance with 47 measures of best practices. These measures cover timely care, care coordination, assessment, care planning, care implementation, education, and prevention. The reports highlight the rate of adherence to the evidence-based practices measured and provide national comparisons. Once the first reporting period is completed, a comparison of the adherence rate to the prior reporting period will be made available. As time goes on, agencies will be able to request reports comparing their performance during different time intervals. Additionally, branch-specific reports will be made available for agencies with multiple branches.

The manual features a sample Process Quality Measure Report, which illustrates how the report will look and what information can be taken from it. It is based on hypothetical data. The essential elements of the report are the same as the OASIS-based outcome reports.

### Where to find the reports

Process Quality Measure Reports will be assessable using the CMS CASPER reporting system. This is where agencies currently find outcome reports for Outcome-Based Quality Improvement and Outcome-Based Quality Monitoring reports. The system allows the agency to request one or more reports from a certain time frame chosen by the user.

### Process measures are important, but not mandatory

CMS is encouraging agencies to take advantage of these reports, but it acknowledges that it is important to remember that process measures are not mandatory on the OASIS-C. No agencies are expected to get a rate of 100 percent on process measures that are not

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# Compliance Conundrum

**Coverage criteria are complex. Questions about chronic wounds seem to arise most often.**

**A clinical director writes:**

*I am a new director and have some nursing cases that I'm not sure meet the coverage criteria for skilled services.*

**Example #1**

*Several patients receive nursing for Unna boots twice per week due to chronic lower extremity edema. These patients don't have open wounds now, but did in the past. They were discharged after their wounds healed and admitted again later with new wounds. We manage the edema and any potential ulcers, but is this a skilled service?*

CMS Publication 100-2, the *Medicare Benefit Policy Manual*, Chapter 7, §40.1.1, states, "The determination of whether a patient needs skilled nursing should be based solely on the patient's unique condition and individual needs, without regard to whether the condition is acute, chronic, terminal, or expected to extend over a long period of time." Therefore, from a coverage standpoint, the status of the wounds should guide the determination of skilled need and not the length of service or the fact that these are chronic wounds.

However, there is also a need to consider whether the care requires the skills of the nurse. In the case of an Unna boot and

ongoing circulatory issues, a patient might be considered "unstable" in that there is an established pattern of deterioration, even though the skin is clear. The Unna boot may be the primary method of controlling the edema, and there is a need for skilled nursing assessment and wrapping of the boot.

The case described potentially meets the criteria. However, if questions remain, this director could choose to implement the HHABN process, explaining to the patient that there's a possibility of noncoverage, but also the option of requesting a demand bill to obtain a specific coverage determination.

**Example #2**

*Another patient has a non-healing sacral wound and receives wound care three times per week. The physician has changed orders every other month. The wound appears to be stalled and/or non-healing, and the physician isn't responsive to the nurse's communication. The patient is homebound and has no able and willing caregiver to do the dressing change. If we discharge her due to non-healing, the wound certainly would deteriorate and risk her overall health status.*

As long as this is skilled wound care, there is no coverage requirement that the wound must heal. In other words, chronic wounds are eligible for coverage if they require skilled care, without regard to

length of service unless there is an indefinite need for daily skilled care.

This case would be appropriate for assessment by a wound care specialist. In addition, the director should be certain that clinicians have considered other factors contributing to the situation, such

as patient/family compliance with positioning, the type of bed surface, and nutritional status.

The question doesn't indicate

the specific types of communication with the physician that have already occurred. After ensuring that all other assessments have been completed, there may be a need to make a written recommendation and to meet directly with the physician. If the agency has a medical director, the clinical director should also discuss the case with them.

If lacking resolution via the methods suggested, the agency may have to resort to considering discharge and assisting the patient with a referral to another agency. Discharge in this case would be due to agency-related reasons (inability to collaborate with the physician), rather than due to the non-healing wound status. The appropriate HHABN process should be used.

**Lessons learned:** Chronicity is not equated with noncoverage. Individual and unique patient needs should be the basis for coverage determinations. Always consider the HHABN process when complex coverage questions arise.

**Chronic Problems?**



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## How to Improve Quality

relevant to their populations. That being said, many of these process measures will be reported publicly with Home Health Compare (HHC), so investing time and energy into improving outcomes will be reflected publicly.

It is important for agencies to understand how to use these reports, even if the agency plans on studying certain measures. Agencies have worked hard to educate themselves on the information that gets put into the OASIS. Now it's time to focus on the information that comes out.

To obtain more information about the Process Quality Measure Report, please visit [www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOASIS-PBQI.pdf](http://www.cms.gov/HomeHealthQualityInits/Downloads/HHQIOASIS-PBQI.pdf).



### Four OASIS-C Quality Manuals

The *Process-Based Quality Improvement (PBQI) Manual* is the fourth in a series produced by the Centers for Medicare and Medicaid Services that focuses on OASIS-C.

The other manuals that CMS has published so far include:

- The *Outcome and Assessment Information Set (OASIS-C) Guidance Manual*, which is intended to introduce agencies to OASIS and the collection of uniform health status data on patients receiving home health care.  
– [www.cms.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp)
- The *Outcome-Based Quality Improvement (OBQI) Manual*, which focuses on the OBQI Outcome Report.  
– [www.cms.gov/HomeHealthQualityInits/16\\_HHQIOASISOBQI.asp](http://www.cms.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp)
- The *Outcome-Based Quality Improvement Monitoring (OBQM) Manual*, which focuses on quality monitoring using Agency Patient-Related Characteristics (case mix) and Potentially Avoidable Event (adverse event outcome) Reports  
– [www.cms.gov/HomeHealthQualityInits/18\\_HHQIOASISOBQM.asp](http://www.cms.gov/HomeHealthQualityInits/18_HHQIOASISOBQM.asp)

## Measuring Patient Satisfaction

### The HHCAHPS survey measures perceived quality of care.

One way to measure whether your agency is providing quality care is to review how patients perceive the care they are receiving. The standardized survey measuring patient satisfaction, (HHCAHPS), will collect the data. To receive high scores, note the language used in the survey. The survey captures whether patients perceive they are being treated “as gently as possible,” with “courtesy and respect,” and whether the caregiver is providing comfort and listening carefully to the patients.

Several questions state:

- “In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?”
- “In the last 2 months of care, how often did home health providers from this agency listen carefully to you?”
- “In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?”

If your patients perceive that they are receiving high-quality care from the agency’s staff—including aides, nurses, and therapists—that perception will be reported in the survey.

#### Timeline

Many agencies have been participating in the HHCAHPS survey for months on a voluntary basis, and some agencies are waiting for the dates to be mandatory. That time is fast approaching. The voluntary time period is almost over. All Medicare-certified agencies that want to receive their full annual market basket increase must participate.

#### Mandatory data collection:

- Quarter 3, 2010 (July, August, September)—agencies must conduct at least one month of a practice or dry run (won’t be publicly reported)
- October 2010—National implementation; data must be collected every month. Vendors will collect the survey data and submit it to the Centers for Medicare and Medicaid Services (CMS) on a

quarterly basis. After the first 12 months of submitting data, CMS will publicly report the data on a quarterly basis. The first public report will be available in spring 2011.

The goal of the survey is to ensure high-quality patient care by having agencies demonstrate accountability. The intent of having data publicly reported on the Home Health Compare website is to prompt agencies to provide patient-centered care and enable consumers to make informed decisions when choosing an agency. Agencies must work with an approved survey vendor. The goal is to obtain 300 completed surveys over a 12-month period. The guidelines of the *Home Health Care CAHPS Survey Protocols and Guidelines Manual, Version 2.0*, indicate that survey vendors and agencies determine how many patients they will survey in a 12-month period and then evenly distribute the number of patients to survey each month. The number of patients sampled each month should be relatively constant within any given quarter.

#### Access to training

For more information about the survey, visit [www.homehealthcahps.org](http://www.homehealthcahps.org). The next training webinar "Introduction to the Home Health Care CAHPS Survey Webinar" will be presented on Monday, November 8, and

Tuesday, November 9. The training will consist of two four-hour sessions. Attendees should register online on September 20.

If agencies were interested in seeking an exemption from participating in the survey for the 2012 annual payment update, they needed to be either newly Medicare-certified agencies or agencies with less than 60 eligible patients, and they needed to make their request by June 16.



## New Audio Series

The four-part fall 2010 audio conference series called "Reducing Rehospitalizations in Homecare" includes:

- "Patient Coaching": September 16
- "Transitions and Communication": October 21
- "Disease Management": November 18
- "Medication Reconciliation": December 16

For more information, please visit [www.beaconhealth.org/audio\\_conferences.php](http://www.beaconhealth.org/audio_conferences.php).

## FAQ

### What are the RAC record review limits for home health and hospice?

Although the Recovery Audit Contractor (RAC) program has, to date, largely focused on inpatient, outpatient, and durable medical equipment providers, a review of homecare and hospice organizations could occur at any time. As part of the education supporting rollout of the RAC program, the Centers for Medicare and Medicaid Services (CMS) established and communicated limits as to the number of records that could be reviewed every 45 days by a RAC. For fiscal year (FY) 2009, these limits were 1 percent of average monthly claims every 45 days with a 200-record limit for home health, and 10 percent of average monthly claims every 45 days with a 200-record limit for hospice.

Earlier this year, CMS published an update specifying FY 2010 RAC additional development request (ADR) record limits for institutional providers. These limits were set at 1 percent of all claims submitted for the previous calendar year, divided into eight 45-day periods, with a 200-record limit. Beginning in April, providers who billed in excess of 100,000 claims the previous year had the limit increased to 300 records every 45 days. In addition, in FY 2010, CMS will allow the RACs to request permission to exceed the cap following approval by CMS on a case-by-case basis.

Record limits for noninstitutional providers, such as home health and hospice organizations, have not yet been set for FY 2010.

The CMS institutional provider ADR limit update can be viewed at [www.cms.gov/RAC/Downloads/DRGvalidationADRLimitforFY2010.pdf](http://www.cms.gov/RAC/Downloads/DRGvalidationADRLimitforFY2010.pdf).

## What's Happening...

➔ The Centers for Medicare and Medicaid Services has updated Chapter 3 of CMS Publication 100-16, *Medicare Managed Care*. The most significant changes occur in Section 50, Marketing Material Types and Applicable Disclaimers. The 12 new pages address television and radio ads, marketing material, and disclaimers. New language has been added to sections on educational and marketing and sales events, for example. Visit [www.cms.gov/transmittals/downloads/R93MCM.pdf](http://www.cms.gov/transmittals/downloads/R93MCM.pdf).

➔ Agency patients will soon receive a letter about the impact of the Affordable Care Act on Medicare beneficiaries. The letter will discuss provisions affecting the prescription drug benefit. Several million Medicare beneficiaries who entered the Part D donut hole and are not eligible for Medicare Extra Help will receive a one-time check for \$250. See the June 4 item at [www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp).

➔ CMS requested renewal of the approval for the Home Health Agency Cost Report. Freestanding agencies in the Medicare program complete these forms annually. See <http://edocket.access.gpo.gov/2010/pdf/2010-12624.pdf>.

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## HEMOCARE IN A DIFFERENT LIGHT



I recently had a chance to see homecare from a new angle when a relative received services. An experience at discharge gave me some insight, so I thought I'd share it with you.

My brother, who is quite a few years older than me, was receiving intravenous antibiotics. He's a very active senior citizen who still works full time, so he administered the drug himself and continued to go to work every day (being a workaholic seems to run in the family). Although his health is very good, he always seems to run into problems whenever he has any "minor" healthcare issues, and this time was no exception. We've decided he should never have elective *anything* again!

His homecare routine went well. I knew that he was receiving services, but I live several states away and there was no reason to be involved. My niece, also a nurse, was minimally involved because my brother is so independent. However, on the day of discharge, a problem kept my niece, a couple of homecare experts, and me on the phone throughout the day.

It's not necessary to describe the problem here; it's enough to say that, although there's no specific blame, risk did exist. I just have to say that the experience reminded me of the complexities of homecare; the need for explicit communication and coordination, both internally and externally; and the importance of clinical procedures and the risk management process. It also reminded me that, no matter their age or level of independence, patients often don't know how to advocate for themselves, and what's more, they don't recognize the need to do so.

My takeaway message is that risk management has to be a primary concern. When the unusual happens, be sure your staff is prepared to set routine aside and focus on the event *until there's resolution*. In my brother's case, while we tried very hard not to be "meddling" family members, my niece and I felt the need to determine the standard of care and to advocate to be sure that it would be carried out. Had we not done so, I believe my brother would not have received the follow-up that he eventually received. He's fine, but the level of risk mandated a greater sense of urgency and increased attention to detail. This would be true for any patient, not just because this one happened to be my family member.

*Jane Miles*



**TOPIC: QUALITY IMPROVEMENT**

## Strategy for Chronic Care Management Reduces Hospital Readmissions

One solution required a paradigm shift that reaped positive rewards.

**A**s the number of people living with chronic diseases increases in the United States and the cost of healthcare continues to rise, innovative leaders and organizations seek solutions to address these problems.

Partners Home Care in Waltham, Massachusetts, is one of those innovative companies addressing chronic care management. The agency adopted a program that aims to reduce costs by driving down hospital readmissions while delivering quality care.

“We’re focused on moving from disease-specific programs to chronic disease management and care coordination because people don’t have chronic diseases in isolation,” says Susan Beausoliel, RN, MS, vice president of home care services. “We have to change from our current, directed acute episodic focus to a more guided healthcare approach that emphasizes self-management and is best practice-driven.”

The agency, which employs about 800 healthcare professionals and serves about 3,000 patients a day in homecare in eastern Massachusetts, adopted the Home Based Chronic Care Management program developed by Baptist Health Home Health Network in Little Rock, Arkansas. The program is based on a patientcentric model and incorporates evidence-based practices. The first teams began using the program in February, and the goal is to have the organization trained by the end of the year.

“Our goal is to be the highest-quality organization that we can be,” says Beausoliel. “Quality and utilization of best practice is what’s going to resonate everywhere and drive financials in CMS’ value-based purchasing initiative.”

The solution is based on Dr. Ed Wagner’s Chronic Care Model, which provides strategies to manage

chronic illnesses. One focus is prompting patients to take a more active role in their care. “We’re finding that it’s a change in practice and a change in thought process for the nurses,” says Judy Flynn, vice president of patient care quality. “You’re not going out and dealing with the tasks, but really engaging the patient in understanding what their goals are and then basing their care on these goals. We are so acute care-focused at times that we base it on, ‘You have this disease, this is what you need to do, this is what the literature dictates.’ ”

“What we really don’t understand is why the patients don’t do what’s recommended. Oftentimes

**P**artners learns leading strategies by taking part in many quality initiatives, such as:

- The Continuity Assessment Record and Evaluation (CARE) tool demonstration project with the Centers for Medicare and Medicaid Services and RTI International, which aims to improve the quality of care for Medicare patients who transition among care settings and to reduce hospital readmissions
- Two HHCAHPS survey demonstrations, which measure patients’ experience with an agency
- Medicare’s Home Health Pay-for-Performance (HHP4P) demonstration, which intends to improve the quality and efficiency of care (<http://www.hhp4p.info/>)
- The State Action on Avoidable Rehospitalizations initiative, led by the Institute of Health Improvement, which aims to reduce rehospitalizations by improving the coordination of care

it's because people have to change, and people are often ambivalent about making a change," says Flynn. "This is really about the nurse engaging patients in a conversation to understand why they have resistance, and then working through that so that you come around to an understanding. The patient comes up with their own goals of what they want to do. They become engaged in that care."

"Now the clinician might say, 'You've been a diabetic for five years. I see your blood sugar is a little low. Can you tell me what you want to do with this?'" says Beausoliel. "After they communicate their goals, the next question might be, 'And how confident are you that you can make that happen, and what steps can I take to help you achieve that?' It's a paradigm shift."

To begin implementation, clinicians received 12 hours of training and a competency test. Role modeling was important.

## Improving Ambulation Outcomes

Partners Home Care ensures that it provides top care to patients by closely monitoring its quality outcomes. For years, it has looked at which teams had good outcomes, recognized those team members, learned what practices the team followed, and implemented the best practices companywide.

To improve outcomes for ambulation, for example, the agency established a goal of being in the top 20th percentile nationally in that outcome. In 2008, the agency started to discover which clinicians had the best outcomes and what processes they used that led to their success. First, Partners looked at its data analysis and reporting software to access its OASIS data. The leadership team reviewed outcomes to understand which clinicians and therapists had the best results.

They realized that the nurses with the highest outcomes were assessing their patients using a standardized screen, the Timed Up and Go. Management decided to incorporate the tool into its processes. "Now every admission and recert includes a Timed Up and Go," says Susan Beausoliel, RN, MS, vice president of home care services. "It's built into our process because it's very measurable and very objective."

Patient falls per 1,000 patient days decreased 42 percent from 0.52 in the first quarter of 2009 to 0.30 in the second quarter, then decreased another 17 percent to 0.21 in the third quarter. This lower rate has been maintained over subsequent quarters into 2010.

"It's a different way to talk with a patient," says Flynn. "There's a lot of practice and getting used to it. Before the training they thought they did this already. After the training they realized they didn't do this. They're really excited about it." The program has allowed for a meaningful dialogue with patients about their goals, fears, and ambivalence to care.

Training involves teaching clinicians:

- How to assess health literacy
- The importance of doing a depression screening for every patient
- Motivational interviewing
- Coaching techniques to be sure clinicians know how to engage the patient

Clinicians receive a toolkit that includes:

- Evidence-based practices to teach clinicians the most advanced and supportable practice guidelines. For diabetic patients, for example, nurses would receive standards set by the American Diabetes Association for their own knowledge and to share with patients.
- A teaching tool that instructs patients on what to do for specific symptoms.
- A tool to assess the importance of a change and how confident the patient is that he or she can make this change, which helps with discussions.

"We found that the clinicians love it," says Beausoliel. "They say this is care like it should be. The patients have been very satisfied.

"Our vision is to create a partnership," she concludes, "that assists the physician and the patient to achieve the goals for successful management of their disease."

*Note:* For more information about the program developed by Baptist Health Home Health Network, visit [www.bhhhn.com](http://www.bhhhn.com), where you can access two white papers.



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