Evaluation of the Home Health Pay for Performance Demonstration

Contract # HHSM-500-2005-000221,
Task Order 0001

Analysis of Home Health Pay for Performance Demonstration Site Visit Protocols: Year 2

Deliverable Task 3b

December 2011

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1. Background

The use of home health care by Medicare and Medicaid participants has increased substantially during the past decade. The MedPAC Report, "A Data Book: Healthcare Spending and the Medicare Program, June 2009", indicated that the number of beneficiaries using home health care services increased by approximately 25% from 2002 to 2007 and the number of episodes of care delivered increased by a similar amount during the same time period. Likewise, the number of visits that are delivered by skilled staff (e.g., registered nurses and physical therapists) increased from 69% to 80%.

The quality of care received by home healthcare patients also has come under increasing scrutiny during the past several years, particularly since the 2001 implementation of a prospective payment system. MedPAC data show a consistent incremental improvement in risk-adjusted functional outcomes from 2004 – 2008, although a key utilization outcome indicator "Acute Care Hospitalization" remained unchanged during that same time period.

The impact of the prospective payment system on the overall cost of home health care has been equally dramatic. Spending on home health care nearly doubled from 2001 ($8.6B) to 2008 ($16.6B), but this is still less than what was spent in 1996 and 1997, toward the end of the cost-based era. MedPAC reported that larger and "for profit" agencies benefited from higher profit margins than smaller and "not for profit" home health agencies. Based on these findings, MedPAC recommended in their March 2009 Report to Congress that quality-of-care safeguards (e.g., avoidance of adverse events) be linked to payment for home health agencies (HHAs).

This notion of linking payments to home health care performance was the primary aim of the Home Health Pay for Performance Demonstration (Demonstration) project sponsored by the Centers for Medicare and Medicaid Services (CMS) and conducted by prime contractor Abt Associates. The evaluation of the Demonstration's effectiveness, sponsored by CMS and conducted by the University of Colorado, Anschutz Medical Campus, included both a quantitative analysis of the costs associated with improved performance and collection of qualitative data to explore what agencies did to achieve higher (or where appropriate, lower) rates on patient outcomes. That is, a core issue addressed in the evaluation was to describe the quality-related activities home health agencies engaged in to produce superior patient outcomes.

The study of HHA quality clinical interventions and organizational characteristics in home health care is relatively new and somewhat unsystematic. Some studies have focused on relating specific nursing interventions (Schneider, Barkauskas, and Keenan, 2008) and nurse training (Biala, et. al., 2004) to home health outcomes, while others have focused on organizational issues such as the use of teamwork (Gantert and McWilliam, 2004) and quality measurement systems (Berwick, James, and Coye, 2003; and Galvin and McGlynn, 2003) to evaluate home health care performance. Still other studies have focused on structural issues such as geography (Vanderboom and Madigan, 2008), nurse availability (Cushman and Ellenbecker, 2008), and health care transitions (Wolff, Meadow, Weiss, Boyd, and Leff, 2008) to evaluate the impact of these external pressures on the effectiveness of home health care.

Schneider, Barkauskas, and Keenan (2008) investigated the relationship between specific nursing interventions and patient outcomes for home health patients with cardiac related problems and found little relationship between the nursing interventions and OASIS outcomes. They did find some modest relationships with a few condition specific Nursing Outcomes Classification (NOC) values. Taking a more particularistic approach, Biala, et. al., 2004 found that a commitment to quality wound care training enhanced professional fulfillment and staff retention, improved clinical and outcome performance, and served as an effective business strategy. They outlined seven principles of training including providing sufficient time to teach and to learn the material, making use of external experts and offering training to multiple home health disciplines.

Gantert and McWilliam (2004) noted that interdisciplinary teamwork is difficult to achieve because of geographical separation and historically distinctive professional disciplines serving home health patients. They identified three ways to overcome these issues: e networking, navigating, and aligning practice patterns. Their research showed that there was a reluctance to establish team goals (alignment) over individual discipline goals among registered nurses, physical therapists, occupational therapists, etc. The perspective expressed by their research subjects was "They do their thing; we do our's (*sic*)." (Gantert and McWilliam, 2004, p11).

Additional challenges are found in efforts to measure and report patient outcomes to enhance home health care quality. Berwick, James, and Coye (2003) and Galvin and McGlynn (2003) described the importance of performance measurement health care delivery systems in general rather than home health care specifically. Berwick, James and Coye identified two pathways for improvement: selection of measures and changes in care. Regarding the latter pathway, they stated that organization leaders are responsible for ensuring that there is "(1) a reliable flow of useful information, (2) education and training in the techniques of process improvement, (3) investment in the time and change management required to alter core work processes, (4) alignment of organizational incentives with care improvement objectives, and (5) leadership to inspire and model care improvement." (p. I-35). This requires an investment in human capital—training, time, recognition—a strategic decision on the part of management. These authors concluded that quality improvement is a good business model and marketing decision. Galvin and McGlynn (2003) cited lessons from the past to show that reporting/making public performance measures stimulates attention and action by the organizations because there is both a business case (downside = risk; upside = reward) and pride factor (the more publicly reported, the higher the pride factor becomes). They believed that broader and more timely dissemination of health care quality information, especially outcome data provided at the time of consumer need, is needed to break the circle of inertia regarding quality improvement found in many health care organizations.

Beyond HHA organizational factors, there are other forces that influence the agency's ability to improve patient health outcomes. The impact of delivering home health care in a rural environment was studied by Vanderboom and Madigan (2008). They found that there were no statistically differences in improvement in ambulation, acute care hospitalization, and emergent care between rural and urban home health clients. Rurality affected number of visits and higher number of visits was associated with a higher hospitalization rate. They postulated that higher visit frequency at the start of a home

care episode are effective, but higher visit frequency later in the care episode may not be as effective, especially if the patient has de-stabilized. In a non-home health setting, Prentice and Pizer (2007) concluded that delays in health care services led to increased mortality rates for geriatric patients. Home health patients were described by Wolff, et. al. (2008) as having high levels of disability and conditions with substantial medical complexity requiring a wide range of assistance from family caregivers. Approximately 1/3 of these patients were dependent on others for help with ADLs. One critical external force that can affect home health care quality is the availability of qualified professionals to deliver services to patients. Cushman and Ellenbecker (2008), using data drawn from 909 self-selected, non-randomized HHAs reported high rates of staff turnover (72% overall and 86% in for-profit agencies), and found that rates worsened between 2001 and 2007. They concluded that a more comprehensive understanding of factors that increase nurse job satisfaction and retention is critical to overall HHA performance.

Two core conclusions can be derived from this brief review of research literature related to home health agency effectiveness.

1. A quality improvement culture in home health care must be championed by the organization leader, supported by trained agency staff, and validated by measurement of patient outcomes
2. While patient outcomes may be related to home health staff action, the specific mechanism(s) by which this occurs and the effect of other variables (e.g., environmental variables) are not clear.

The research and findings reported in the remainder of this report will address and expand on these themes.

2. Methodology

A total of 570 home health agencies from 7 different states (MA, CT, AL, GA, TN, IL, and CA) volunteered to participate in the Home Health Pay for Performance Demonstration project. These volunteer agencies were randomly assigned, based on agency characteristics such as for profit status, to either the treatment or control groups for this Demonstration by Abt Associates, Inc.

Starter questions for the two focus groups: management teams and clinical teams were developed, then reviewed/approved by the Centers for Medicare and Medicaid Services (CMS) Project Officer. A copy of these starter questions can be found in Appendix A. In general, the management questions focused on change in policies and company-wide practice strategies that were either due to participation in the Demonstration or to improve agency OBQI outcomes. The clinical team questions mirrored the management team questions except that the focus was on the level of implementation of these policies and/or practices.

Based on an analysis of Demonstration performance in Year 1, treatment agencies (eligible for an award depending upon performance) agencies who achieved success in Year 1 and treatment agencies that were not successful in winning any awards were identified. The response to the invitations for participation in the focus groups was very strong. In each of the four regions at least two agencies volunteered to participate in the focus groups. To reduce travel costs, the study team grouped the visit dates and

geographical locations for site visits whenever possible. Seven agencies, two from CA, IL, MA, and one TN were selected for the focus group activities. Additionally, the investigators contacted and conducted an hour long telephone interview with Ms. Tasha Mears, Senior VP of Clinical Operations (whose primary responsibility is the area of quality) at Amedisys Corporation, a large corporation owning 486 HHAs in 45 states across the U.S., as of December 31, 2010.

The following table provides a summary of the site visits and conference call information for the Year 2 site visits.

HHA Name	Location	Date of Visit	Winner Information
VNA Middlesex East	Wakefield, MA	06/30/2010	Yr1 (7 High Performance); Yr2 (7 High Performance)
Whittier Home Health Care Agency	Haverhill, MA	06/30/2010	Yr1 (2 High Performance; 3 Improvement); Yr2 (3 Improvement)
American Care Quest	San Francisco, CA	08/10/2010	Yr1 (4 High Performance; 1 Improvement); Yr2 (5 High Performance)
Asian Network Pacific Home Care	Oakland, CA	08/11/2010	Yr1 (7 High Performance); Yr2 (6 High Performance)
Heartland Home Nursing, Inc.	Sterling, IL	08/25/2010	Yr1 (3 High Performance: 1 Improvement); Yr2 (2 High Performance; 1 Improvement)
Delnore Community Hospital Home Health Services	St. Charles, IL	08/26/2010	Yr1 (3 High Performance; 1 Improvement); Yr2 (2 High Performance)
Amedisys Corporation	Conference call with Ms. Tasha Meyers, Senior VP of Clinical Operations (quality)	12/02/2010	Amedisys had 35 participating HHAs in the Demonstration; 16 Amedisys agencies received awards for either high performance or improvement or both in Year 1, and 15 agencies received awards in Year 2.
University of Tennessee Medical Center Home Health	Knoxville, TN	01/19/2011	Yr1 (no awards); Yr2 (no awards)

The lead author conducted the eight focus groups at the two sites in IL and the two sites in MA. The second author conducted the three focus groups in CA (note: one agency requested that a single focus group be held due to logistical issues) and the two focus groups in TN. Both authors participated in the conference call with Ms. Mears from the Amedisys Corporation. After each site visit, a set of field notes was developed and sent to the senior administrator of the focus group site. The senior administrator was asked to review the notes for accuracy and to add any other information that was presented at the focus groups that was missed in the field notes. There were very few, and all very minor, corrections or additions to the field notes made by the senior administrators. Copies of the final field notes for each site as well as for the conference call are included in Appendix B.

A total of 59 individuals contributed to the 13 focus groups, plus one corporate individual who represented 35 agencies that participated in the Demonstration. Job classifications

for these individuals who participated in the clinical focus groups included office secretaries, billing clerks, Outcome and Assessment Information Set (OASIS) coordinators, home health aides, physical therapists (PTs), occupational therapists (OTs), social workers, registered nurses (RNs), clinical supervisors, and Directors of Nursing (DON). The DON, Medical Director, Chief Financial Officers (CFO), Administrators, Chief Executive Officers (CEO), and a Senior VP of Clinical Operations participated in the management focus group. The Director of Nursing and/or the Administrator often participated in both focus groups. In all but one instance, the management focus group preceded the clinical staff focus group.

The perception of both authors was that focus group discussions were very energized and positive. Most exceeded the allotted time of 1.5 hours. The host agencies were most gracious toward both authors. Host agencies ensured that food was available (when appropriate) to create a congenial atmosphere and that the needed participants for both focus groups were notified of the meeting place and time to ensure prompt starts for the focus groups.

3. Consensus Among Highly Effective Home Health Agencies

Based on an analysis of the Year 1 site visits a set of themes and strategies were identified. These are summarized in the following figure:

Themes of Highly Effective Home Health Agencies

Leadership and Organization Themes
Theme 1—Leadership
Theme 2—Administration and Clinical Teams are a single system that focuses on patient care

Patient-oriented Themes
Theme 3.1—Use of multidisciplinary teams (continuity of care/alignment)
Theme 3.2—Communication and feedback loops (patient focus)
Theme 3.3—Adopt Technology to make work more efficient (patient focus)

Organization-oriented Themes
Theme 4.1—Data driven, Proactive Approach to Quality
Theme 4.2 (same as Theme 3.2)—Communication and feedback loops (organization perspective)
Theme 4.3 (Same as Theme 3.3)—Adopt Technology to make work more efficient (organization perspective)
Theme 4.4—Commitment to staff education / development

Organizational Culture Themes
Theme 5—Long history of strong quality culture
Theme 6—Integration into community

The intent in presenting these themes and strategies was two-fold. First, they encapsulated what was heard in response to the general question "How do highly effective / high performing home health agencies describe themselves and how they do their job?" Second, the themes provided a framework for the strategies that these highly effective agencies used and could potentially be used by other HHAs to improve performance.

In Year 2, a list of 23 consensus items was extracted from a review of the meeting notes from the site visits and conference call conducted during the second year of the evaluation. The information contained in these items appeared in the field notes from multiple focus groups and represented general areas of agreement among personnel from multiple agencies. These themes (see Table 1) have been grouped into four broad categories that parallel in many ways the Year 1 Themes and Strategies list. As with the Year 1 findings, there are clearly inter-related and/or dependent items on the list. Determination of causal or temporal relationships among items was not investigated as part of the site visit focus groups.

Year 2 Consensus Items

Culture of Improvement and Quality

1. Organization had strong improvement-focused culture
2. Overt recognition that quality "sells" externally with referrals from providers (hospitals) and patients (friends, relatives)
3. High performers viewed themselves as such prior to beginning participation in HH P4P Demo

Management and Staff

1. Consistent messages regarding approach to quality improvement and performance between management and clinical staff
2. On-going review of progress of patients (more than just "staffing review") rather than waiting until after discharge reviews; some HHAs or corporations hired companies that specialize in home health data analysis to provide more "real time" feedback on outcome trends and clinician performance; others had this but done by in-house person
3. Management recognized that "effects" are produced during staff-patient interactions
4. Variation among HHAs: Slight majority of management groups did not communicate P4P involvement with staff, just emphasized and supported effective clinical care practices with patients; remainder did emphasize P4P program, but downplayed monetary side and emphasized monitoring and improving patient processes and outcomes. Both approaches worked.
5. Some sharing of monetary awards at the staff level (from senior leadership down to the senior supervisor level) with general/group recognition for lower levels

6. Three clinical interventions were highlighted for their potential to prevent hospitalization: Falls prevention; PT to improve mobility/stability; medication management
7. Staff turnover typically very low; many/most staff had "double digit" years with the agency; high trust factor among staff
8. Hiring processes and decisions focused on an individual's ability to integrate into continuous improvement culture (hire part-time with transition to full-time; experienced clinicians with willingness to learn)
9. Staff education involved both global perspective on continuous improvement, life-long learning, "beyond competency," as well as targeted training activities in areas such as wound care, clinical documentation, and assessment practices (OASIS item response meaning)
10. Challenges were noted with the introduction of new technologies (computers, blackberries, etc.) to staff with minimal technology background and general negative affect toward use of technology; recommendation were to take it in small steps; make it fun

<u>Patient Focus</u>

1. Greater attention was given to documentation of services provided to enhance QI efforts
2. Recommended early identification of potential patient problems using technology (24/7 contact via cellphones, telemonitoring, medication reconciliation software) and front-end loading of visits
3. Emphasized team approach to communication about patients (integration among specialties)
4. Solicited patient feedback on services, even prior to HHCHAPS program; used information to review practices
5. Recognition of important role of family/caregiver involvement in patient success in outcomes
6. Some emphasis on communication efforts with physicians (HHA clinicians as collaborators, informed monitors of patient status, help them understand HHA's patient policy of "call us first")
7. Initial impression of P4P was "more work for me" and less time available for patient; result was more attention to patient-level clinical status and more effective time with patient due to focus on specific outcomes

<u>Demonstration Logistics and Recommendations</u>

1. Winners that received no money pay-out were not happy, but continued P4P efforts
2. HHAs requested "certificates of recognition" for superior performance to hang/display in office, share with local media, etc.

3. Noted the lack of on-going communication regarding P4P throughout the Demonstration; efforts were entirely self-sustained; HHAs would like more information on clinical, evidence-based practices

4. Discussion

Culture of Improvement and Quality

These highly effective HHAs reported a long history of having a strong quality improvement culture. The focus group participants expressed great pride in being members of their organizations. This pride was based on their ability to provide quality services to their patients that resulted in outstanding patient health outcomes when compared with their competitor agencies. Beyond their focus on internal systems, processes, and patient outcomes, highly effective HHAs saw themselves as learning communities where continuous quality improvement was the norm and the expectation throughout the organization.

Management and Staff

The emphasis on a data-driven approach to assessing and improving quality was evident across all visited HHAs. Several of the agencies made use of private vendors to provide more detailed and immediate feedback on performance than the OBQI reports available from CMS. These systems provided reports based on OASIS and other data and a frequent basis (often daily) and capabilities for the HHA to "drill-down" to more granular-level data. The use of technology such as telehealth monitoring, mobile communication devices from cell phones to Blackberries, and electronic information-sharing software further supported this data-driven approach to managing operations and evaluating clinical progress.

In many ways, the effective use of multidisciplinary clinical teams is an extension of the establishment of a patient-improvement, learning community focus. This approach is used not just for the delivery of services to the patient but also for enhancing the skills and knowledge of the professional staff of these HHAs. Training on the use of technology (e.g., computers used to collect OASIS data on patients during assessments), to enhance the inter-rater reliability on OASIS items by registered nurses and physical therapists who assess patients, and the meaning of patient outcomes results are presented using a team (i.e., multi-disciplinary) approach. This enhances the opportunity for professionals to learn from their colleagues by hearing how patient functional and physiological status is viewed from different disciplinary perspectives. This approach also magnifies the message that the patient's success is dependent on effective team coordination.

There were two distinct approaches used by HHAs to informing their staff about the P4P Demonstration and keeping the goals of the Demonstration in front of these individuals. One group of home health agencies had management teams that were very directive in presenting information about the Demonstration to their staff. Reports on progress on Demonstration metrics was presented regularly at staff meetings and displayed in the HHA office for staff viewing. Status updates on individual patient progress or failure were readily apparent to all members of the agency where this model was used. Conversely, another group of management teams consciously chose to not inform their

staff about the particulars of the P4P Demonstration project. While some members of this group stated that they wanted to downplay the potential monetary awards associated with high performance lest the agency fail to achieve these goals, others indicated that there was no need to clutter or distract their clinical staff from their agency's goal of high quality home health care for their patients. Regardless of the rationale for not informing their staff, the messages of quality documentation, monitoring patient progress, attainment of desired patient outcomes, team approaches to problem solving, and continual improvement of the care provided were conveyed to staff members. There was remarkable consistency with which focus group participants described "how things are done at our agency," regardless of the degree to which their P4P Demonstration participation was reinforced. While the DON often attended the clinical staff focus group, neither of the authors sensed that the DON's presence prevented the clinicians from offering their perspectives on how the home health agency operated.

All agencies reported that retention rates among the professional clinical staff were very high, with many of their staff having 10 or more years of experience with the agency. In large part this was due to the perception, supported by the actual experiences, of the staff that the organization valued them, treated them as professionals, and took steps to enhance their effectiveness with patients. Their effectiveness was improved through training, by providing them with the technological tools such as cell phones and high quality wound care products, managerial support, and by providing regular constructive feedback on their performance based on patient outcomes. Each of these efforts is easily viewed as flowing from the general description of these organizations as learning communities. Similarly, the hiring practices for these agencies emphasized the requirements of multiple years of professional experience, a willingness to learn and adapt to new methods and procedures, and a commitment to a team approach to delivering health care.

Patient Focus

Caregiver involvement/training and patient education were hallmarks of the strategies used by each agency that was visited. Caregivers and the patients themselves are seen as part of the care team that is working together to create positive health care outcomes. While challenges were identified in education of caregivers and patients, and in supporting staff providing that education, most clinicians seemed to view the frustrations as simply part of the price paid to achieve the desired outcomes. That is, the clinicians recognized that ultimately the patient and his/her caregiver actions in implementing and sustaining the strategies put in place by the professional staff were necessary for successful outcomes to occur for these patients.

Agencies clearly supported early and intense intervention with patients utilizing both therapists and nursing staff. These interventions were seen as a key strategy in reducing the hospitalization rates for their patients. Clinical focus group members frequently highlighted the importance of careful sequencing of visits among therapists to ensure that each clinical professional could help the patient achieve what was intended based on the home health plan of care.

Two other consensus items related to patient focus require some explanation. First, several focus groups described the need to educate physicians on the value of home

health care services in support of the physician's efforts with the patient. Similarly, these focus groups identified the need to train their patients to "call the home health agency first" if the patient noticed a change in health status. Agencies reported that too often if the patient called the physician first, the direction would be to "go to the emergency room" for further assessment. This resulted in an increase in the HHA's rates of emergency department use and acute care hospitalization, as the physician's direction to the patient prevented the clinicians the opportunity to respond to the patient's needs without the use of an in-patient facility's services. This was one area of physician education targeted by several of the home health agencies.

Second, some clinicians whose management team informed them about the HH P4P Demonstration viewed the Demonstration as "one more thing to do" that would prevent them from working with their patients. However, these clinicians relatively quickly recognized the added value to the care of their patients of enhanced knowledge about rating the patient health status using OASIS item options, monitoring of current status of patient outcomes, and the use of technology. The result was more efficient and effective care practices, with the obvious improvements in health care outcomes as an artifact of these practices.

Demonstration Logistics and Recommendations

In Year 1 of the Demonstration, agencies in Illinois with high performance levels or showed substantial improvement did not receive a monetary reward for their performance because there was no cost savings in the region as computed by Abt Associates. Both of the agencies in Illinois that were visited stated that they were very disappointed that they did not receive the expected monetary reward based on their effort. The researchers were contacted by an Illinois agency that was visited in Year 1 of the Demonstration when they learned that they "won" but would not receive any monetary award. Similarly, management representatives from virtually every agency visited of these focus groups requested that they receive some sort of certificate or formal letter of recognition of their high performance. The stated possible uses for these documents of recognition were for display at the home health agency and sharing with discharge planners, other health care providers, and community news agencies.

In addition to the request for recognition, virtually all focus groups (especially the clinical care focus groups) requested a wider and on-going dissemination of specific strategies or approaches to patient care that were shown empirically to improve patient outcomes. There were a wide range of methods that were suggested for the dissemination including having the implementation contractor for the Demonstration provide a regular newsletter highlighting these strategies or approaches and including this work as part of the QIO activities for their state/region. The request seemed to stem from the heightened commitment to continuous improvement of care processes evidenced by these home health agencies.

While the study findings may not be generalizable due the small number of home health agencies visited (although this is not unusual for qualitative studies), it should be noted that there was remarkable consistency across the 13 focus groups and the one large health care corporation representative regarding what highly effective home health agencies do

to produce outstanding patient outcomes. Additionally, there are strong similarities between the Year 1 and Year 2 findings from these focus groups.

5. Conclusion

The overarching characteristic of high-performing HHAs is a palpable culture of commitment to the quality of patient care and continuous self-review and improvement. This is overtly communicated by management to staff in a manner that supports and enhances the professional stature of the staff. Services provided by the agency are viewed as team efforts that include individuals at all levels of the agency, include administrative and clinical personnel (both full-time and contract) and focus on working in partnerships with patients and informal caregivers. This integrated approach to home health care appears to produce demonstrable results as evidenced by outstanding performance on multiple P4P Demonstration metrics across both years of the study.

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Appendix A: Management Focus Group Starter Questions: Year 2

Logistics: Time: 60 – 75 minutes;
# of participants: 4 – 6 (not more than 8);
Preferred participants: Executive Director; DON; Quality Mgr; Senior Clinical Staff, including RN, PT, OT
Location: Meeting room at HHA

List of Actual Attendees:

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Part 1: In Year 1, you won recognition for your high performance in: A, B, C; and for high improvement in: D and E. Congratulations! (example list)

Imp HOSPDC
Imp ER
Imp BATH
Hi AMB
Hi ORMED

1. Did you know before you won recognition that you had done well in these outcomes during CY2008? If so, how did you know?
2. [For HHAs with high improvement] What did you do in CY2008 (Year 1) to improve your performance in "D and E"? Prompts: Improve technology? Improve timing of service? Improve monitoring?
3. [For HHAs with both high performance and high improvement] What did you do differently (if anything) to win recognition for high performance vs. high improvement?

Part 2: There was a significant time lag between the end of Year 1 (CY2008) and the recognition of your CY2008 performance near the end of Year 2 (late Fall 2009).

1. How did you sustain your HHAs efforts during these intervening months prior to the award?
2. What specifically (outcomes, processes, practices, policies) did you work on in CY2009 that you did not work on in CY2008?
3. What did you learn as an organization from your experiences in HH P4P that will allow you to sustain your efforts in CY2010 and beyond?
4. What could you have done better (e.g., organizational strategies, policies, clinical practices, use of technology) in either CY2008 or CY2009 to improve your performance on these outcomes or other outcomes? Please be specific.
5. Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.

6. What could CMS, the QIOs, or national organization (e.g., NAHC) do to support your HHA's in these efforts to improve patient outcomes?
7. What has changed (how are things different) in your organization (or in your community) that has influenced how you deliver your health care services to your patients?

Part 3: Winning recognition in so many areas in CY2008 certainly must have made you feel proud of what your organization did to demonstrate how well you care for your patients.

1. How did you share this information with your staff and the community in general?
2. [Omit for Illinois] While the monetary awards associated with the recognition came with "no strings attached," can you share how you used (or plan to use) your winnings?
3. [For Illinois] The HH P4P demonstration is funded using an "award based on savings" model, and your region showed no overall cost savings. This resulted in no monetary award to provide special recognition for your excellent performance.
    a. How was this communicated to your staff?
    b. How did this affect your performance in CY2009 or after you were notified that you had "won," but there was no associated monetary award?

Part 4: The national data presented on Home Health Compare show that HHAs have reported substantial gains in the improvement rates for many functional outcomes. However, these increases in success on functional outcomes have not translated into decreased rates of hospitalization or emergency room usage. Your HHA seems to have generated both improvement in functional outcomes and utilization rates.

1. How do you explain your HHAs ability to influence both functional outcomes (bathing, management of oral meds, transferring, etc.) and a reduction in utilization outcomes (hospitalization, emergency room usage)?
2. From your perspective, what is (are) the key(s) to creating a linkage between these two types of outcomes?

Part 5: Given that three of the four regions involved in the HH P4P showed a net savings in hospitalization costs, CMS obviously is interested in (although no decision has been made) implementing the HH P4P program nationally.

1. If the HH P4P program is implemented nationally, what recommendations do you have for:
    a. Other HHAs (similar to yours; different from yours)?
    b. CMS, QIOs, and national organization (e.g., NAHC)?
    c. Your own organization?

2. What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

Appendix A: Clinical Focus Group Starter Questions: Year 2

Logistics: Time: 60 – 75 minutes;
# of participants: 4 – 6 (not more than 8);
Preferred participants: DON, Clinical Staff including RN, PT, OT, Social Worker
Location: Meeting room at HHA

List of Actual Attendees:

-
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Part 1: Base on your HHA's performance during Year 1 of the Home Heath Pay for Performance Demonstration project (CY2008), your HHA won recognition for your high performance in: A, B, C; and for high improvement in: D and E. This means that your HHA out-performed most (if not all) of the HHAs that volunteered to participate in the P4P Demonstration in your Region. Congratulations! (example list)

Imp HOSPDC
Imp ER
Imp BATH
Hi AMB
Hi ORMED

1. Did you know that your HHA was participating in the HH P4P Demonstration during CY2008 and CY2009?
2. Did knowing or not knowing that your HHA was participating in the two-year Demonstration project matter to you in your daily work with patients? Why or why not?
3. How does your HHA make use of its outcome report information?
   a. Are these results reviewed/presented regularly to staff?
   b. Do you/your team review on a regular basis how individual patients did on their outcomes to see how you could be more effective with your care/intervention activities—either individually or as a group? Any examples?
4. Did you know that your HHA was recognized for it outstanding performance during CY2008? If yes, how was this communicated to you?

Part 2: As I mentioned previously, your HHA was recognized for high performance in several patient outcomes, including A, B, and C. I would like you to tell me about why you think you had high performance in "X" functional outcome.

1. Can you tell me about how you care for (what you do) patients to get such a high performance score in "X" functional outcome? For example,

a. Do you start your intervention with this outcome before other outcomes that need to be improved for the patient?

b. Do you use any special techniques or intervention strategies with this functional outcome that you think really make a difference in helping the patient to improve?

2. Choose another "X" functional outcome that you received recognition for high performance. Tell me about how you care for (what you do) patients to get such a high performance score in this area? For example,

   a. Do you start your intervention with this outcome before other outcomes that need to be improved for the patient?

3. Do you use any special techniques or intervention strategies with this functional outcome that you think really make a difference in helping the patient to improve?

4. You also did very well in Acute Care Hospitalization (and Any Emergent Care).

   a. Why do you think that you did so well on these outcomes?

   b. Is (Are) there any specific techniques, strategies, or clinical practices that you can point to that really seemed to make a difference in this (these) outcomes?

[For HHAs with high improvement] Your HHA received special recognition for high improvement in "X" functional outcome.

1. What did you do in CY2008 (Year 1) to improve your performance in this outcome compared with what you did previously to help these patients improve? Prompts: Improve technology? Improve timing of service? Improve monitoring?

2. Were there any outcomes that your HHA specifically targeted for "improvement" during CY2009 (or CY2010)?

   a. What were these?

   b. What strategies, techniques, practices, etc. are you implementing now that you did not use in the past?

   c. Do you think that these are working? Why or why not?

Part 3: Thank you for your sharing of information. I would like to conclude with three more general questions about the P4P Demonstration.

1. Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.

2. If the HH P4P program is implemented nationally, what recommendations would you have for clinicians in other HHAs who would be experiencing the program for the first time?

3. What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

Appendix B: Field Note Summaries for Focus Groups

VNA Middlesex East: Management (MA) 06/30/10

Attendees:
MerryBeth Rucker, Director
Karen Apahigian, COO/DON
Jackie Hall, Liason
Larry Lespra, CFO

1. Did you know?
We (the management team) suspected that they might be winners. There was no information from Abt regarding progress. Nothing was communicated to the staff. They knew we were part of program, but we didn't burden them with the information. Our approach was to given them (staff) the tools and let the management team monitor progress.

2. Strategies?
We share information with the staff; support staff development by specialty area (RN, PT). Specific strategies include

- a shift to concurrent review of patient progress (rather than waiting until patient is discharged and look at outcomes achieved)
- front-end loading of visits
- emphasis on telehealth monitoring
- needs assessment (?)
- target high risk patients using a screening tool that includes >5 meds, recent hospitalization, COPD, falls, etc. Any 2 of these gets patient on the "high risk list."

3. How have you evolved?
HHA has been working at this since first HHC report in 2003. We were embarrassed by the low scores. Specific actions included:

- Developed a large number of staff teaching tools to use with patients
- Card "cheat sheets" for helping staff work with patients.
- Case conference every two weeks, with the whole team who has worked with patient
- Focus on patient goals and progress
- Have a tech install telehealth equipment; RN can teach patient how to use
- Use multiple disciplines (beyond RN) to help patient get better
- Paradigm shift for RN (from "caring" to "helping get better")
- Needed to micromanage some older nurses

Part 2
1. How sustain?
We look at processes and see what results they are getting. You need to focus on results. If the processes are working, change them to get the results you want. There is a strong

belief that processes create functional changes that in turn create utilization rate changes. They make use of many assessment scales with the patients.

2. Data driven

VNA Middlesex East regularly reviews their CASPER reports. They are unhappy that CMS has a blackout period and have hired OCS to do interim outcome reports so that they can continue to monitor their outcomes and progress. They monitor internally the number of patient visits and whether outcomes are being achieved. The team stressed that concurrent review of progress—not retro (after the fact review)—is very important. They try to use multiple sources of data when evaluating progress. One strategy is to ensure that the person who "opened" the episode of care is the same person who "closes" the episode of care.

3. Impact of winning

HHA was very surprised by the size of the check for their high performance ($160K). They are focusing on medication management now. They expect to "win" in Year 2.

4. How have things changed?

There is an emphasis on front-end loading, particularly with "at risk" patients. They have a telehealth nurse with a tech who does the installations of equipment. They work closely with Lahey Hospital (Clinic) on transitional care team issues. HHA is goal-oriented, more efficient in what they do, more productive, and profitable. Staff meetings are more successful with everyone focused on patient progress. The bonus was seen as a big positive. HHA emphasizes a "code as you are supposed to code" approach, not code for payment. They emphasize documentation, documentation, documentation. HHA does follow-up calls after discharge to check patient's status.

5. Other

HHA is paperless, to the point that the system was down the day of my visit, so everyone was happy to talk to me so that they could "do something." HHA is very supportive of telehealth systems, including keeping monitoring systems beyond end of care if patient can do private pay.

Appendix B: VNA Middlesex East: Clinical Team (MA) 06/30/10

Attendees:
Chris Judge, Telehealth
Sandra Crowley, RN, PI
Donna Silva, OT, Clinical Mgr
Gary Woodworth, RN, OASIS / Staff Ed
Kathy Hayes, RN, PI, Staff Development

Did you know?
Oh yes, MerryBeth was "all about this." We thought winning was a "possibility." Being recognized as one of the high performing groups is nice for our community. We have always been on a P4P system—just high performing.

How do you make use of outcome reports?
This has changed the standards for everything. We document our activities the same day as they are delivered. We needed to change, and we did. We regularly hear about CASPER Report results and HHC results.

Strategies with patients?
We use the same clinical team members with a patient. We like it because we can share information easily. Patients like it because they develop a sense of trust in the team members (consistency). We do a lot of listening to the patient and a lot of teaching. The materials developed by VNA Middlesex East are really very helpful. This makes teaching much easier. Materials include visuals, patient teaching tools, lots of stuff—maybe overwhelming to the patient. The team is responsible for helping the patient achieve a positive outcome.

Patient review process?
We do regular chart audits with case manager and during case conference. We are a single unit (no branches) so this makes communication easier. Processes are always changing if we are not getting results. There are protocols, but we need to be willing to change approaches and try new ones. There is an emphasis on monitoring and quickly changing strategies if there is not progress. No one messes with the patient's records—document.

More strategies
We triage patients and everything starts with admissions. We can do this and monitor over the phone or in person. We look for signs that a patient might be at risk of re-hospitalization. The team will look at hospital notes when they are available. Good rapport with discharging hospital (Lahey).

Next big push?
There is a big emphasis on using the screening protocol (paper and pencil instrument), especially if this is an ROC patient. ROC patients are very challenging all around. We try to keep them out of the hospital for the first few days especially. Look at the whole

patient. Is the patient "not feeling well"—we will send in the case manager, not just any nurse. Is patient "feeling fatigued"—this is a leading symptom of some other problem. Concurrent audit of patient progress approach helps—results count. We do telehealth from day one with a tech doing the install. Emphasis on care transitions for patients—record and information sharing is important.

What can you tell others?
They will need to make changes in communication, policies, and practices—team approach. Quality will not happen over night. Constantly monitoring everything about the patient is important. Use of teams and learning to work within a team structure is critical to success. Case conferencing (concurrent) is valuable in working things out for the patient. Use of personal technology—cell phones—very helpful. Be proactive in your approach.

Do patients' notice a difference in what you do?
Yes, especially patients who were with a different HHA. Yes, hospitals know who will do a good job when they discharge patients to home care—and they prefer us. We recently have expanded the communities we serve, and part of this is because we make a difference with the patients.

Other?
What about your colleagues? Either they buy-in to the way we do health care (proactive, positive, treat the whole patient, etc.) or they leave. We feel valued as employees. VNA Middlesex East has high standards and high expectations in its employees.

Appendix B: Whittier HHC Agency: Management (MA) 06/30/10

Attendees:
Marty Hood, Clinical Director
Helen Deline, CEO
Mindy Mangual, PI

Note: Marty has been with agency for several years. Helen was brought in about four or five years ago as the "last straw" attempt by the hospital board to make home health work. Mindy was their first administrative hire and charged with keeping track of the OASIS data and performance.

Did you know that you were making a difference?
We found the P4P experience interesting. We do our own surveys to get follow-up information on how we did with patients. We shared our experiences and reviewed the follow-ups. We used to meet infrequently about patients. Now everyone meets and shares information about the patient, especially at key points like admission and discharge. We focus on providing better care to the patient.

Specific strategies for improving performance

- PI does a 100% check on all SOC/ROC and TRNF/DC assessments for completeness; strong effort to have same person open and close episode of care;
- Commitment to case conferences for every new patient, all recerts, and the data provided by DON;
- Team approach with patients;
- CEO focuses on insurance perspective, but keeps this separate from patient care needs;
- Peer review of documentation;
- DON orients staff (new and continuing) on policies, how we expect things to function, role performance, and even does "OASIS item of the Month", uses skits for training
- Organization commitment to staff competence, data, and team approach; commitment by owners/leader (CEO) to quality of care; no pressure to decrease care from a financial perspective [The finances of the organization are good.]
- Computerized data collection using "Care-any-ware" software (reasonably user friendly); commitment to this from top-down; provides an opportunity of time information sharing.
- QIO efforts (6th and 7th Scope of Work) were very helpful; we made big progress with their general and 1-on-1 help

Did the staff know how you were doing?
We provided lots of encouragement to the staff based on the data we were seeing on outcomes. We think they knew we were doing well. We shared results (and did the encouragement) using "subversive training" like in skits, monthly and bi-weekly meetings. We used Ishakawa techniques to prioritize focus. We tried to get staff to think about ways to reduce re-hospitalization.

Strategies to reduce hospitalization
We want our patients to call us. If they call their doctor, the doctor says, "Go to the ER." We are especially concerned about patients with a history of falls. Strategy is to get a plan to reduce and to monitor.

Plan for the future?
This is a long-term commitment. We are not doing anything different now. We just keep going and working on good patient outcomes.

Why has P4P worked for you?
The QIO involvement early on was really big. It gave us a push in the right direction. Hiring Mindy (PI) was a big help because someone could always be looking at the data. We had some billing issues a few years ago, but these problems have been resolved. Being part of a hospital has helped with resource sharing (minimal added cost).

Organization issues
We are expanding; opened a branch (drop off) in NH to serve clients there (about 20 miles away?). Whittier Hospital supplies about 50% of our patients, and we are trying to expand the percentage of other patients.

How did you share the results of your win?
We made the announcement at our staff meeting, and we shared the results with the Board of Directors. We did not make any announcement to the community. Our staff was very proud, and the Board was very pleased.

Teaming and staffing
The therapy staff is very committed [I noted that all of the clinical people I met were either PTs or OTs.] compared with RN staff. They have very few LPNs now. The staff has used a decision tree process to look at bathing, and this made a big difference. We like to have the same person open and close the case; keep the same person doing the evaluation of the patient creates more consistent assessments. We need to retrain staff who come from other HHAs because they usually have lots of bad habits, even though they may have the clinical skills. Some of the skills that are needed for our HHA are being confident in the community (with patients) and with the MDs. MDs want to hear a plan of action from the RN or PT, not just that their patient has a problem. Staff needs to have customer relations skills, be attentive to documentation, and meet the work expectations of our HHA. New staff either "buy-in" or they leave. Some new hires could "talk-the-talk" but could not "walk-the-walk" and both they and we discovered that you need to do the latter to be part of our staff.

Organization decisions
We believe that a big reason for ER use is that the MD orders it (patient did not "call us first"). We focus on the patient, not the financials. We do what we can do and don't worry about everything else. We share performance stats with staff, but not financials.

We look at the bottom line, but don't use this to guide patient care. We front load visits. We look to wean patients from our help, and work to keep patient in home.

Challenges?
We have some challenging staff issues, especially finding enough PTs (they have many options). Bring back the QIO support (MassPro was terrific) to help HHAs. Trade associations in MA are a big help and need to do more with in-service training. We really don't like the "blackout" period because we are not getting feedback on how we are doing.

Advice to others?
Use teams and team approach.

Appendix B: Whittier HHC Agency: Clinical Team (MA) 06/30/10

Attendees:
Amy Lyons, PT
Deborah Schmidtt, PT
Kelley Porazinski, OT

How do you do your work?
We form groups/teams. We stress best practices and a multi-disciplinary approach, even with ADL outcomes. Our staff meetings present reports and updates on how we are doing. We have new tablets for data collect which are easy, efficient, and complete. The software is good, but could be more user-friendly. This is a software issue, not an OASIS instrument issue.

How do you use outcome reports?
We get printouts of the reports from Mindy (PI) monthly. These are easy to read and include HHC information. We do case conferences within two weeks of SOC. Everyone on the team is there. We focus on goals, if recerts are needed, if more disciplines are needed (e.g., social worker, nutritionist. Because we share the same building with a rehab hospital, we have resources (people, equipment) available to us. Marty (DON) provides cumulative chart of progress. We are a small HHA and this helps communications. Other techniques that we use are telehealth, front loading visits, and on call patient check-ups.

Next big push?
We are working on oral meds—everyone is part of this effort. As PTs and OTs we have input regarding the choice of pill bottles or daily dispensers—easy of reading information, bigger ones for opening, storing in easy to reach location, etc. We have the patients prove (demonstrate) that they can do things, not just take their word for it. We open cases and always check medicines—get right on top of this issue.

General strategies
Scoring of OASIS items are different for PTs/OTs than for RNs, especially on the ambulation item (use of assistive devices). We (PTs/OTs) needed to train the RNs how to assess item. We take a very holistic approach to working with our patients; we treat the whole patient. [There is a sensitivity by the staff to all the messages being sent by the patient during a visit.] We can and do access other resources when needed. There is an effort to keep in contact with our patients—cellphones, rehab line, nursing line, and regular (admin) line.

How did you lower your hospitalization rates?
We use a "call us first" approach—and really emphasize this with our patients. If something serious happens, go to the ER. However, if you are not feeling well, call us first—not the PCP. We have a person available (on call) 24/7 so patients always get a live person. We begin emphasizing this approach during the admissions process and repeat and remind patients on every visit. We tell them to call us if there is any change in

how they are feeling. Our goal is to keep the patient in the home—and that is the patient's goal also. We make the connection between this goal and them calling us. Another important piece is telemonitoring—can't fake the data. Front-end loading visits especially in the first week are a big help in reducing re-hospitalizations. If we can keep them from returning to hospital in the first week, we are golden. We do follow-up calls on how the patient is doing after our visit—within 24 hours.

Do patients see a difference in your care?
We have strong patient satisfaction scores. When we are in the home, we point out the progress a patient is making by asking the patient to remember what they could (or could not do) when our visits began. This helps them see the progress they are making. The patients don't really care about P4P or even HHC. The caregiver might look at HHC. Their choice of HHA is based on location, availability of staff to visit, availability of their social network, and the desire to not be alone. [Emphasis on staying in home vs. institution.]

Who does well working here?
If you are not into teams, you are "cooked." We are always looking to attract the "right" people to our HHA. You can't think in silos; and definitely no newbies—no matter how smart they are. Our practices and procedures produce outcomes in our patients, and this is our validation that we are doing things right.

What are the secrets to your success?
We are small, so we can provide continuity of care. The patient knows who is coming. The number of visits with a patient is not driven by administrative decisions but by what the patient needs.

Appendix B: American Care Quest: Management (CA) 08/10/10

Masha Rudokov, Director of Operations
Erik Levsky, Director of Nursing
Margarita Riskin, Administrator
Natalie Budyanova, Clinical Manager
Marina Gocha, QI/OBQI

The agency received P4P incentives for high performance on: Improvement in Management of Oral Meds (highest score in state), Acute Care Hospitalization, Improvement in Transfer, Improvement in Ambulation; and an incentive for improvement for Improvement in Bathing (showed most improvement for ANY agency in CA from 2007 to2008)

Service Area: SF Bay area toward San Jose

Background: The agency has experienced rapid growth since it started in 2002; they became licensed in 2004; obtained JCAHO accreditation in 2005 (most recent survey was 2008). In 2009, there were approximately 430 unduplicated admissions. Because of a large Kaiser contract, they continue to see rapid growth and expect a higher admission count for 2010.

The P4P incentive payments were a surprise. We have been working on medication issues; our efforts are aligned with the JCAHO focus on med issues. During JCAHO survey, the surveyors are checking every patient. We have found that when they monitor medications on every visit, we see better scores for ambulation outcomes. We begin by doing medication reconciliation and a med profile on admission; they give the list to the patient to take to MD appointments. The MD is called right away if there are any problems.

We hired a QI person in 2008 to check OASIS and charts and feel this has a major impact on outcomes. The position was created because of agency growth and success and efforts to market to the Medical Association and others in the community. We realized it was important to provide better documentation and to ensure the accuracy of OASIS.

Clinical processes related to the excellent hospitalization outcome: clinical managers are available by phone 24/7. The clinician sees the patient as soon as possible (24 hours) after hospital discharge; focus on meds and obtaining a thorough history/physical; visits are frontloaded for all patients and rehab is initiated as quickly as possible (much less than 5 days if possible) to implement falls risk program. The therapists tailor the care plan

Clinicians are using EHRs and this promotes better communications between clinicians. Case conferences are held weekly and are reported to the clinical supervisor.

Regarding the excellent outcome in bathing, a lot of patients become eligible for in home support services. We are able to get those services in the home and then we are able to teach home care givers to do the bathing; and they in turn were able to help the patients to become more able to bathe.

Other reasons for excellent outcomes overall:

- See quality outcomes as a way to get more business (quality as part of the business model)
- Careful monitoring of each patient
- Look at every survey as a way to learn areas to improve: Kaiser, JCAHO. High Kaiser standards have been very helpful
- Very open to identifying ways to improve continuously

CMS reports are printed quarterly. For adverse events, each chart is reviewed. For the outcome report, if see something getting a little worse, then we jump on it to improve—set a goal and evaluate again. Find these reports very useful to improve services. Staff members are involved in providing initial information around the outcomes, then the management team coordinates what can be done and that info goes back to clinicians. Sometimes we involve 1-2 clinicians in brainstorming improvement efforts. Management is open to any suggestions that people may have. We have a weekly staff meeting, always checking in to see if they have problems or suggestions.

In 2008, we began sending satisfaction letters to patients; but due to a low response, began calling the patients. Now we use Pinnacle for patient satisfaction data, but agency staff also call patients and check on them to see if they like the services (this is done during the episode so that problems can be addressed).

There is a new project starting in September to increase the educational sessions available for field staff. Educational sessions for CE will be available once/month (used to be quarterly).

Lumetra (the CA QIO) provided some recommendations for outcomes.

It would be hard to say if patients would say that care has improved as a result of P4P, but they do have good satisfaction with the quality of care.

The Kaiser contract and growth have been main impetus for changes. Focus on quality is central. Over the past two years, we have evaluated staff carefully and identified those who were not responsive to educational efforts and let them go. New staff are hired on a per-visit basis for the first 3 months, then get promoted to fulltime. Focus on trying to move people to full time when possible. Full-time staff are dedicated and we have a little more control.

Signed up for HHP4P and forgot about it because lack of communication. Just kept doing what we were doing. The changes we made were not because of P4P demonstration participation.

We are now working on implementing a telemonitoring program. Patients are getting d/c from the hospital before they are ready to be independent, so we hope that telemonitoring can help to prevent hospitalization.

We are now opening DME, hospice, CNA school. We have a personal care agency, and can get a caregiver in the home right away. We are a one-stop shopping company and this allows us to get resources to patients more quickly, as well as allowing our clinical staff the ability to closely coordinate with caregivers. This also promotes continuity for patients.

In terms of market/environmental factors: there is a lot of competition. We work with the MDs and keep our word (regarding the high quality of care promised). We want to make MDs feel proud (to be associated with us). SF very environmentally focused, trying to go green. Want to do more holistic things but not clear on what is covered by CMS. Kaiser is taking the initiative on this as well.

When we received the money, we didn't learn what outcomes we were rewarded for until we received a letter a month later. We informed staff during an end of the year party; administrator stood up and went over all the outcomes. After that, we gave FT clinicians bonuses.

We have an employee of the month program, giving incentives for good performance including good care, timeliness of paperwork, etc. The gifts are personalized to the individual receiving them. We explain to our staff that we want patients to be treated like a family member so they can be comfortable sharing any issues or problems they are experiencing with us. We establish close relationships with patients. We have a group of clinical staff nurses who are very committed to patient care.

Recommendations for other agencies wanting to achieve good outcomes:

Close monitoring of each patient: communications with patients, case conferences, etc. From the financial point of view, that is expensive, but you have to be willing to sacrifice a little of the bottom line. So many patients can slip between the cracks and we don't want that to happen. We closely monitor each and every patient. As we expand, it will be a challenge but need to maintain adequate QI staff to review every patient.

We got lost in translation for the HHP4P demonstration, but it was good to get the awards. This is a big marketing tool, allowing us to say we are in a good position on outcomes. We share the information with every pt. we open. We do feel like we earned it because of all of the changes we implemented to improve patient care.

*Suggestion for Abt to send out some sort of award certificate to show recognition for the outcomes.

Appendix B: American Care Quest: Clinical Team (CA) 08/10/10

(Focus group was combined with management focus group per American Care Quest management request on the day of the visit)

Appendix B: Asian Network Pacific Home Care: Management (CA) 08/11/10

Asian Network Pacific Home Care
Management Team Interview
Ivy Kwong, Director of Rehabilitation Services
Nancy Chang, Administrator
Theresa Moguel, QI Coordinator

Outcomes: The agency is one of three in the demonstration project receiving incentives for high performance in measured outcomes: Hospitalization, Emergent Care, Improvement in Ambulation, Improvement in Bathing, Improvement in Oral Meds, Improvement in Surgical Wounds, and Improvement in Transferring

ANPHC has been in existence for 20 years in Oakland, CA

Regarding participation in the HHP4P demonstration and the award for high performance: We knew that we had signed up to participate, but never got any communication, so just went on with our business. We got a call asking where the money could be wired. We called and found out that it was for the demonstration, but didn't know exactly what outcomes we were getting the money for. Your communication asking us to host a site visit was when we realized that this was a big deal and how well we did on our outcomes.

Hospitalization outcome: At the time the project started, we were beginning to get concerned about our hospitalization rates. We wanted to be proactive and started a hospitalization reduction project about the same time that we signed up for the project, but it really had nothing to do with signing up for project. For the hospitalization reduction project, we followed recommendations. We started telephone monitoring for patients with CHF, DM, COPD, and Cancer. We hired a medical assistant who called patients (after they were opened) on non-visit days and went through a series of questions with patients that were specific for the diagnosis (e.g., did you weigh yourself today, etc.). If she had any concerns, she requested an RN visit win 24 hours. We also started frontloading visits for first **two w**eeks because of published evidence (that it reduces hospitalizations). This was hard to implement at first with our staff because they didn't understand why, but now it is a part of how the clinical team opens the case and sets up the care plan. After around 6 months or so of implementing the hospitalization reduction program, we saw our hospitalization rates drop. We monitor this rate using HH Compare and OBQI reports. We no longer have the medical assistance to the calls, because the frontloading visits seems to be working.

In our office, patient hospitalizations have a negative association. The incidences of hospitalization are posted for the whole team to see, and no one wants to be pointed out for their patients being hospitalized. Nancy audits records for all hospitalizations; look for patterns with clinicians and counsel clinicians if the hospitalization was preventable. We are small; staff are more like a family and they know we only mean well. Therapists know if patient starts to look unstable and call the RN right away. We worked with staff on how to deal with situations such as a physician who does not call back (did role plays with staff on what to do if MD not available, etc.), and how to be assertive about getting the patient's needs addressed and how to overcome barriers. We do not accept excuses.

Everyone is aware the hospitalization admission is no good, so that is in the front of our minds. We identify frequent flyers and address how to avoid rehospitalizations directly.

We provide therapy directly and normally do a lot of fall prevention. Therapists were educated on how to do a comprehensive falls risk assessment and how to do caregiver training. If there is no caregiver, we get community resources and other family involved. If the patient is PT only, the therapist was to evaluate whether a nurse was needed for medication management. The therapy staff is very focused on getting patients up and moving, and on medication management. They do a comprehensive drug review that includes whether the patient can actually get to their medications.

Medication is a big issue in preventing hospitalization. We really focus on that—tell staff to have the patient get all meds out (ask 3 times if they have any more medications); and have patient identify each medication and how many times/day they take it. We do a complete medication reconciliation, as there can be a lot of confusion with the hospital d/c meds when they are different than what the patient used to take. Also, we make sure patients follow up with the MD in 7-10 days, despite what's on the referral form.

Currently, our QI focus now is on fall prevention. We have seen that some of our OBQM adverse events are falls-related, so we are looking at the falls by clinician (to see if any need counseling). For the OBQM reports, we investigate every outcome. The OBQI reports are run every quarter. Any outcomes that are worse than prior year or lower than the national average are examined. We know that for the last two years, our outcomes have been very favorable. The OBQI reports are very helpful, particularly the comparisons. There is a long time lag between the data being collected and the reports being available. We were getting hospitalization reports from the state, but then they stopped coming.

We review all records and are able to identify patients who were hospitalized or visited the ER on regular reviews. Nancy reviews all the OASIS assessments, and all the Plans of Care are reviewed by the clinical director.

We did share our success in this P4P Demonstration with staff, but they weren't really excited; they just ask, "Why aren't we getting more referrals?" The big agencies have a lot of money and do a lot of marketing, but their quality isn't necessarily all that good and being recognized for high performance and high improvement has not be as helpful as we hoped. We hired a Clinical Nurse Specialist with the money. We are starting a "Beyond Competency" project and the CNS will be able to provide a lot of additional staff education.

Each staff has to review article and report prior to staff meeting; have to present it to the rest of the staff meeting.

We have high standards for staff, and our staff members have their hearts in their jobs. All staff members are bilingual. They go through a clinical assessment at application time before being considered an employee. We have nursing staff, it can be little tough to find therapy staff. We hire high achievers-- best qualified people who are committed to excellent. Our people bring in a strong skill set for each discipline; adhere to mission of providing the best services even if we aren't always recognized for it. We emphasize safety and quality of care.

Recommendations to agencies: Clearly communication to staff what goal is; share big picture. Make sure that staff understands what our responsibilities are as an agency in caring for patients. Getting staff to buy in is important for the agency, their own profession, and society as a whole. Get staff excited to work together. Each discipline needs to understand what their role and what other disciplines can contribute. If you see a problem, you need to address it right away and see the patients right away (even if it means not getting paid. We have a 24 hour admit policy. Staff members are very comfortable talking to supervisors—keeping open communications is critical. It is important to train staff adequately; once they are competent they can make good decisions. Make sure staff are competent (critical thinking and problem –solving skills) at hire, then offer ongoing training.

Most of the agency managers have been here since beginning the agency 20 years ago; many staff here for a long time as well. Our staff members are very committed and have a passion for helping community.

Recommendations to CMS: It would be helpful to have continual information on clinical evidence-based practices; need clear guidelines for that sort of QI projects. If P4P is implemented nationally, should provide recognition for high performers and results shared publicly. Need to do more education to public for how to find quality services. Many people do not know about HH Compare and the tendency or trend is often to give referrals to agencies based on convenience instead of quality. Agencies with a lot of financial resources hire marketing people who are there in the hospital all day long to perform the work of referring patients for the discharge planners. Gatekeepers don't know the value of using high performing agencies would save money. There should be more oversight on huge chain agencies that get all these referrals and aren't necessarily high quality agencies because the survival of smaller community based agency is already being threaten and their marketing techniques.

Appendix B: Asian Network Pacific Home Care: Clinical Team (CA) 08/11/10

Clinical Team Interview
Tracy Wei, DON
Keith Wong, PT
Franklin Leung, MSW

We didn't really know that we were participating (in the HHP4P Demonstration). We were informed after you asked us to host the site visit.

The demonstration hasn't had an impact on patient care; we always give out the best care anyway from the get- go.

We get a printout of OASIS reports; it points out areas for improvement during conference meetings. We also post these on our website. Keith checks the comparisons to other agencies on HH Compare.

We have had two special agency quality improvement projects. Once we worked on improving our feeding outcome. At the opening, clinician would do analysis of why the patients needed help with feeding and address those things. Falls prevention was a special project. We had a fall prevention checklist and clinicians would check things off (risk assessment checklist). Now this is more second nature. We had an in-service; one therapist did a lit review and pulled that together. QI identified high risk falls group (based on diagnosis); request PT consult for those patients. RNs and therapists are prompt in alerting SW for safety issues. MSW goes in and addresses the safety issues/needs with the patients and make sure patients and families are aware that they need to have more supervision and an increased awareness of safety, as well as providing counseling re: independence; and mobilize resources.

Improvement in Oral Meds: We had a pretty intense medication therapy in-service for nursing and therapy. We make sure we start with meds at the first visit (high risk). We follow-up with MD on same day or next day. Med boxes are available for all patients. If they need a timer device (med dispenser), we try to help them get funds for purchasing (involving MSW). Also, we involve the family; some patients wait until too late. PT coordinates closely with getting RN in. For us, we may have added challenge of language (barriers). Nursing really works on overcoming knowledge deficit due to language problems (e.g., pharmacy instructions). A lot of our patients are immigrants; not so into prevention/health promotion. They may not want to discuss because taboo. Have to educate family education and promote prevention. From cultural perspective, very much have to focus on entire family—in Asian community family makes decisions.

For the hospitalization outcome: Everyone knows that hospitalization is not good. The hospitalizations are posted for everyone to see. We had a medical assistant who called patients and made sure a nurse went out of there were any deviations from what they were supposed to be doing. We frontload visits for the first three weeks. We no longer have the medical assistance to the calls, because the frontloading visits seems to be working.

Improvement in bathing: This starts with getting right equipment. For the first visit; we identify any needed equipment and get it to them as soon as possible. We do a lot of education on transfer, safety. When nursing does admission, they always check the bathroom. If the patient can't purchase equip, we have a fund and donate DME to them.

Team communication is daily or more frequently. We make sure to indicate if a message needs to be addressed right away. We have a strong team approach. Jump on things; don't just let things go. Keep in mind that the purpose of our services is to prevent hospitalization and address this together—and with the patient and family.

QI efforts: Beyond competency, lifelong learning mentality. We are looking at an EHR project. We don't really target specific outcomes, look across the board. All the outcomes are interdependent.

Recommendations for other agencies: a) involving the families very important—works for us (may be difficult for other cultures); b) communication with other staff important—i.e., if implementing a falls prevention program how does it work cross disciplines , and prompt communication; c) work collaboratively and with family. We really have a lot of trust among team members and we are honestly there to help family get better. It's never money first; it's about what to do to get the patient better. Our primary focus is on helping patients, not just money. We all work together; nobody ever says it's not my responsibility.

Appendix B: Heartland Home Nursing, Inc.: Management (IL) 08/25/10

Actual Attendees:

- Kim Gaffey, CEO
- Dan Gaffey, CFO (co-owners)
- Carol Kelemen (data entry, coder, quality checker
- Vanessa Fiorini

Part of original demonstration of OASIS—went to training in San Diego

In Year 1, you won recognition for your high performance in: A, B, C; and for high improvement in: D and E. Congratulations!

Imp AMB	4	147503 Heartland Home Nursing Inc. Sterling IL 2 1
Hi SWOUN	4	147503 Heartland Home Nursing Inc. Sterling IL 2 5
Hi ORMED	4	147503 Heartland Home Nursing Inc. Sterling IL 2 5
Hi BATH	4	147503 Heartland Home Nursing Inc. Sterling IL 2 7

1. Did you know before you won recognition that you had done well in these outcomes during CY2008? If so, how did you know?
    a. Only CEO and CFO knew about P4P Demo. They did not expect to do this well—but were hopeful. Nurses have difficult time making time to complete data. They found that nurses did not do assessments well. This required some training, especially with the transition to computers. Older nurses had problems. CEO developed (and used) a pinball program game application to breakdown the anxiety/apprehension about using computers. Now, nurses "don't leave home without it." They would be upset if we took them away.
2. [For HHAs with high improvement] What did you do in CY2008 (Year 1) to improve your performance in "D and E"? Prompts: Improve technology? Improve timing of service? Improve monitoring?
    a. We do lots of cross checking; we do a 100% review of OASIS items. We focus on coding, care plan, and doctors' orders. If these don't match, the package goes back to clinical team for resolution. This does cause strife every once in a while; but they work it out. HHA is a very flat organization. We can make decisions quickly and change quickly. We use technology to get clinical support faster (phones, care kit, top of the line). Clinical team gets what they need to do their job.
3. [For HHAs with both high performance and high improvement] What did you do differently (if anything) to win recognition for high performance vs. high improvement?
    a. We have lots of training and support materials that were, in many cases, developed by CEO (PhD almost). We obtained training and materials from Medtronics (e.g., IV pumps). We do in-services with both staff and docs regarding products.

There was a significant time lag between the end of Year 1 (CY2008) and the recognition of your CY2008 performance near the end of Year 2 (late Fall 2009).

1. How did you sustain your HHAs efforts during these intervening months prior to the award?
    a. We never told them (our choice). We really didn't need to say anything. We saw this as an opportunity to educate because P4P is coming.
2. What specifically (outcomes, processes, practices, policies) did you work on in CY2009 that you did not work on in CY2008?
    a. We noticed that our LOS is shorter. Patient care decisions drive the business, all of the business. Financials decisions don't drive clinical business. The shift from FFS to PPS was a challenge. Administration emphasis was a shift back to clinical; we did not wait. HHA still runs lean; and we are making a profit and still take charity cases. Doing it right is good for business. We had OIG visit and they found no problems.
3. What did you learn as an organization from your experiences in HH P4P that will allow you to sustain your efforts in CY2010 and beyond?
    a. We are a good agency. We knew the staff mindset. We use a team approach throughout the organization. Sometimes it is challenging, but we know what to monitor to tell how things are going.
4. What could you have done better (e.g., organizational strategies, policies, clinical practices, use of technology) in either CY2008 or CY2009 to improve your performance on these outcomes or other outcomes? Please be specific.
    a. We want to use outcome data to improve outcomes. One focus was getting bathing outcome improved. This may have been caused by one nurse—and may have caused problems in several areas, but nothing systemic. If the problem is one person, you can make a change. For our size agency, cross training is critical. It is difficult when people leave for personal/medical reasons to need to keep on moving forward because no effective back-up. We use care kits that are standardized; organization of materials especially for infection control. The new OASIS—falls risk assessment, risk for re-hospitalization, opened up lots of eyes among RNs. We like that some assessments are embedded—all helpful, may have been overlooked in the past. We use the SW more and integrate this person into team. This is making a big difference.
5. Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.
    a. Yes—patients notice. They are not bashful about who they want HHAs services from (sometimes they say, "Oh no, not them again.")
6. What could CMS, the QIOs, or national organization (e.g., NAHC) do to support your HHA's in these efforts to improve patient outcomes?
    a. A big issue is standard information systems, reports, and making standard resources available. QIOs focus is always changing, so there is no

implementation of their ideas. Things get tracked, but then get dropped in many cases.

7. What has changed (how are things different) in your organization (or in your community) that has influenced how you deliver your health care services to your patients?
    a. P4P strongly encouraged us to use a team effort. We are a cohesive organization, quality of organization. We are probably spending a little more—on therapy costs in particular. We now have a Masters prepared Quality RN and our outcomes have improved commensurate.

Winning recognition in so many areas in CY2008 certainly must have made you feel proud of what your organization did to demonstrate how well you care for your patients.

1. How did you share this information with your staff and the community in general?
    a. Staff meeting.
2. [For Illinois] The HH P4P demonstration is funded using an "award based on savings" model, and your region showed no overall cost savings. This resulted in no monetary award to provide special recognition for your excellent performance.
    a. How was this communicated to your staff?
        i. No mention of this.
    b. How did this affect your performance in CY2009 or after you were notified that you had "won," but there was no associated monetary award?
        i. No reaction. We were disappointed with no money (co-owners). We are trying to off-set costs as reimbursements decrease.

The national data presented on Home Health Compare show that HHAs have reported substantial gains in the improvement rates for many functional outcomes. However, these increases in success on functional -outcomes have not translated into decreased rates of hospitalization or emergency room usage. Your HHA seems to have generated both improvement in functional outcomes and utilization rates.

1. How do you explain your HHAs ability to influence both functional outcomes (bathing, management of oral meds, transferring, etc.) and a reduction in utilization outcomes (hospitalization, emergency room usage)?
    a. Acuity of patients (severity of initial status) has increased (e.g., coronary care patients stay 3 days vs. 10 days in a hospital; hip/knee replacement now come home the same day as surgery). These patients are less able initially, so there is now more room for improvement. Our goal is to not return patient to hospital; this will lead to less hospital-based infections. There is also an older clientele balancing gains made at other end. Our fastest growing segment is = >85 and hospice rural rates.

Given that three of the four regions involved in the HH P4P showed a net savings in hospitalization costs, CMS obviously is interested in (although no decision has been made) implementing the HH P4P program nationally.

1. If the HH P4P program is implemented nationally, what recommendations do you have for:

   Other HHAs (similar to yours; different from yours)?

   a. Focus on building a team-approach to patient care. There needs to be a willingness to go beyond (e.g., give out phone numbers, fax info to lawyers; sat with caregiver at funeral). You need to do the right things for patient. Coverage (geographic) can be a problem in rural HHAs. Understand the family perspective and involvement in the delivery of care. Our mission = competent effective efficient health care. We keep costs under control, but care comes first.

   CMS, QIOs, and national organization (e.g., NAHC)?

   a. Management looks at HHC results regularly. Without knowing where you are at, you don't know what to fix. We need (would like) to know sooner not later.

2. What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

   a. The Nurse/CEO is over-seer of the operations and decisions, but only steps in extreme cases. Our health agency is the HHA of choice for Iowa VA (because we are so close to the IA border). We emphasize the use of computer technology (e.g., 485) to reduced duplication and reduce the amount of time consume to do comparison checks. We monitoring things closely and pay attention to the little stuff. Our staff picks up on this and this allows our nurses to do what they do best.

Appendix B: Heartland Home Nursing, Inc: Clinical Team (IL) 08/25/10

Actual Attendees:

- Kim Gaffey, CEO
- Vanessa Fiorini, DON
- Lynette McFadden, RN
- Cindy Hoyle, LPN
- Nikki Burkett, RN

Based on your HHA's performance during Year 1 of the Home Heath Pay for Performance Demonstration project (CY2008), your HHA won recognition for your high performance in: A, B, C; and for high improvement in: D and E. This means that your HHA out-performed most (if not all) of the HHAs that volunteered to participate in the P4P Demonstration in your Region. Congratulations!

Imp AMB	4	147503 Heartland Home Nursing Inc. Sterling IL 2 1
Hi SWOUN	4	147503 Heartland Home Nursing Inc. Sterling IL 2 5
Hi ORMED	4	147503 Heartland Home Nursing Inc. Sterling IL 2 5
Hi BATH	4	147503 Heartland Home Nursing Inc. Sterling IL 2 7

1) Did you know that your HHA was participating in the HH P4P Demonstration during CY2008 and CY2009?
   a) We didn't know; the agency got its letter for CY2008 and then we were informed. The staff was not informed about the demonstration ever. This was by choice of administration.
2) Did knowing or not knowing that your HHA was participating in the two-year Demonstration project matter to you in your daily work with patients? Why or why not?
   a) It didn't matter. Would it have? No. We would do the same work with our patients regardless.
3) How does your HHA make use of its outcome report information?
   a) The CEO gathers the information and shares it with the staff. We focus on patient outcomes that are poorer. We (CEO) picked a goal—wound care in 2008. We held in-services on charting, photos, assessment, staging, etc.
   b) Stress incontinence is a problem; this never seems to improve.
   c) There are quarterly outcome reports to clinical staff; we meet weekly on clinical matters. The CEO works with DON and QA nurse (started in 2008) to do chart review and OASIS reviews.
4) Are these results reviewed/presented regularly to staff?
5) Do you/your team review on a regular basis how individual patients did on their outcomes to see how you could be more effective with your care/intervention activities—either individually or as a group? Any examples?

a) Yes—that is what the weekly staff meeting is all about. We brainstorm and talk almost daily. HHA uses a team approach including PTs, OTs, aides, RNs, SW, etc. We use both a prospective and retrospective approach to problems (or potential problems). We work hard at not sending to patient to ER; and especially on admissions on weekend.

b) HHA is For Profit and private. We compete with hospital-based group. Our approach is to call the MD to see if we can do something different so patient doesn't need to go to ER. There is a tendency for others to use their (Heartland's) services. Our attitude is "show us train wreck and we will help." HHA stresses education with patient and spend time needed to teach. We use telehealth especially with VA and "Carelink/Lifeline".

6) Did you know that your HHA was recognized for it outstanding performance during CY2008? If yes, how was this communicated to you?

a) This was presented at a Staff meeting.

As I mentioned previously, your HHA was recognized for high performance in several patient outcomes, including A, B, and C. I would like you to tell me about why you think you had high performance in "Status of Wounds" functional outcome.

1) Can you tell me about how you care for (what you do) patients to get such a high performance score in "X" functional outcome? For example,

a) Do you start your intervention with this outcome before other outcomes that need to be improved for the patient?

(a) Our use of PTs, OTs, aides as a team is really a strength. We ask what they think about the patient's status. We focus on medications and wounds and team approach works really well with RNs. The OTs focus on helping the patient to become independent. Our bath aides liked to keep their patient. We needed to restructure how aides understand their role and this was a big challenge two years ago. Our OT really helped to train the aides; our OT is "big" on the use of technology.

b) Do you use any special techniques or intervention strategies with this functional outcome that you think really make a difference in helping the patient to improve?

(a) Aides like to have patients dependent on them; our goal was to help patients become independent. We changed the wound technology. We introduced the use of laptops. We changed how we document wound care and built this into care plan. This improved our scheduling and measurement because it standardized the process and by happenstance/experience our wound expert is an LPN.

[For HHAs with high improvement] Your HHA received special recognition for substantial improvement in "Ambulation" functional outcome.

1) What did you do in CY2008 (Year 1) to improve your performance in this outcome compared with what you did previously to help these patients improve? Prompts: Improve technology? Improve timing of service? Improve monitoring?

a) We did this by tying together PT & OT w/ nursing. Our OT has gone to OASIS training. We have more communication; OT did not attend patient review prior to 2008 and now demanded to be there. We look at patient though both (RN & OT) sets of eyes and review reports on patients. Our RNs always open a case, usually because there are medical things to do at SOC. PTs will discharge, especially if they are the main discipline interacting with the patient.

2) Were there any outcomes that your HHA specifically targeted for "improvement" during CY2009 (or CY2010)?

   a) What were these?

      i) We have been worked on hospice care, but this has been a struggle. We are working on patient LOS because we don't want patients to be dependent long-term. Our goal is that patients are being kept on "as reasonable/necessary." This has gotten better.

   b) What strategies, techniques, practices, etc. are you implementing now that you did not use in the past?

      i) We emphasize education at the beginning of the care episode. We emphasize to the patient that the HHA's goal is to help them be independent. There is some problem with care-giver support not available and providing necessary services. The HHA is in a rural area with no public transportation, few "meals on wheels," challenges for doctor visits, and only one pharmacy that will deliver medications.

   c) Do you think that these are working? Why or why not?

      i) Yes! Getting patients who are willing to do their part helps them achieve the outcome. If the patient needs help later, the patient comes back to us. Our level of care is well known, especially by the VA in the area.

Thank you for your sharing of information. I would like to conclude with three more general questions about the P4P Demonstration.

1) Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.

   a) Our patients choose to come back to us; we have repeat customers. This is true across the board for things like knee replacement. The quality of our work is spread by word-of-mouth, friends of former patients, etc. We will choose our CAHPS vendor in 4th quarter—but we know what our results will look like. A good example of our quality is when local MDs have (their own) heart attacks, they ask for us.

2) If the HH P4P program is implemented nationally, what recommendations would you have for clinicians in other HHAs who would be experiencing the program for the first time?

   a) You need to develop a mindset of a team approach to home care. Commit to an "our patient" approach or the HHA will not survive. HHAs need to change from FFS (how many visits and get paid) to PPS (how can we get patient better in

fewer visits). We pay our staff by visit not by hour. This gives staff the perspective that they need to focus on helping rather than staying for hours with the patient. This facilitates both patient and staff independence. Staff is more aware of their time and others time.

3) What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

   a) We covered everything. Our OT & PT are contract (by their choice) and PTA is employee. Our RNs do reconciling of medications. HHA does front load visits depending on condition, e.g., stroke patient. They regularly do 3-4 visits to get the patient over hump (care transition) especially with coronary by-pass.

Appendix B: Delnore Home Health Services: Management (IL) 08/26/10

Actual Attendees:

- Reidun Juszczak, Mgr Home Care
- Michele Batterson, Patient Case Coordinator
- Debbie Costello, QI / Education Specialist
- Dolores Mayo, Documentation Specialist

In Year 1, you won recognition for your high performance in: A, B, C; and for high improvement in: D and E. Congratulations!

Hi BATH	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 10
Hi AMB	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 13
Imp TRNFR	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 4
Hi ORMED	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 7

1) Did you know before you won recognition that you had done well in these outcomes during CY2008? If so, how did you know?
   a) We were notified but had forgotten. We expected more feedback but got none from month-to-month or quarter-to-quarter. We joined because wanted to learn about P4P and use this as a preparation for national implementation.
2) [For HHAs with high improvement] What did you do in CY2008 (Year 1) to improve your performance in "D and E"? Prompts: Improve technology? Improve timing of service? Improve monitoring?
   a) How we used the P4P demonstration? We made it part of our goal for annual raises. We emphasized staff education, especially uniform (consistent) assessments standards. We asked everyone to use the same methods for assessments. We taught staff to understand what the response (OASIS item option) meant. We began with audit/analysis of trend at both the individual OASIS item and outcome levels. We recognized that we not where we want to be. We asked ourselves, "how can we improve?" We did inter-relater reliability activities in home, used patient scenarios, and quizzes (both individual and as a group). We used information packets for the individual items based on Ch 8 info.
3) [For HHAs with both high performance and high improvement] What did you do differently (if anything) to win recognition for high performance vs. high improvement?
   a) We use an electronic OASIS assessment system that only allows one assessment (can't look back at SOC/ROC). Our systems are wireless, and staff can VPN, so data are updated in a timely manner. We can consult across disciplines. We have a safety focus across disciplines. Our technology allows us to screen print SOC and transmit to PT/OT so they can go in and verify. This is an integrated system so we can match to payroll info with download. The system has increased accuracy of OASIS data and POC documents.

b) HHA has held training sessions on oral meds, cognitive function, caregiver education using an integrated approach. For bathing outcome we coordinate with OT and aide. From our perspective, almost all improvement starts with improvement in ambulation/transferring.

There was a significant time lag between the end of Year 1 (CY2008) and the recognition of your CY2008 performance near the end of Year 2 (late Fall 2009).

1) How did you sustain your HHAs efforts during these intervening months prior to the award?
   a) We are very used to watching outcome scores. We bring to these meetings and figure out how to do something about those numbers. We focus on HHC results. We are stilling working on the information internally even during the blackout period.
2) What specifically (outcomes, processes, practices, policies) did you work on in CY2009 that you did not work on in CY2008?
   a) We are working on re-hospitalization and CHF. We have focused on telehealth and standardizing pathways, and are trying to compare telehealth vs. no telehealth. We used QIO materials. We have looked at visit frequency, patient buy-in, and physician buy-in. We try to get standing order for CHF to add diuretics. Some PCPs are reluctant; cardiologists were reluctant at first, but we are making progress, especially with one MD at that clinic. As a result, hospitalization rates have improved.
3) What did you learn as an organization from your experiences in HH P4P that will allow you to sustain your efforts in CY2010 and beyond?
   a) You need real-time data to be effective. There are resources that are needed and our current system is lagging in these right now. We are looking at a new system. Our current system can look back, but we would rather look forward. We analyze data and question. We use comparisons across charts and raise issue to clinicians who review and decide what is likely happening.
4) What could you have done better (e.g., organizational strategies, policies, clinical practices, use of technology) in either CY2008 or CY2009 to improve your performance on these outcomes or other outcomes? Please be specific.
   a) We prioritized our outcomes by looking at state and national comparison. We had some deficits and identified where we could make a difference. We chose transferring. We needed to do more real-time audit.
5) Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.
   a) We did really well on our first HCAHPs results. We personalized the instrument by adding a special section from Press Ganey. We received back 37 patient reports, which is very high percentage because small agency. We survey active patients as well as patients who are discharged. Patient see (and report) the high quality of care Delnore gives. This is also document in "Daughter" reports and other anecdotal reports.

6) What could CMS, the QIOs, or national organization (e.g., NAHC) do to support your HHA's in these efforts to improve patient outcomes?

    a) We monitored how the process was going while it was going on. We want to see how we are doing. We look at HHC data.

Winning recognition in so many areas in CY2008 certainly must have made you feel proud of what your organization did to demonstrate how well you care for your patients.

1) How did you share this information with your staff and the community in general?

    a) We shared OCS scores (not part of system) with community, but not our scores.

2) [For Illinois] The HH P4P demonstration is funded using an "award based on savings" model, and your region showed no overall cost savings. This resulted in no monetary award to provide special recognition for your excellent performance.

    a) How was this communicated to your staff?

        i) This was rather at downer. We communicated the result to staff and it was a downer to them also.

    b) How did this affect your performance in CY2009 or after you were notified that you had "won," but there was no associated monetary award?

        i) There has been no decrease in staff or management motivation. It did not affect pay. We have not been able to improve computer systems and staff education (certs and recerts) as much as we would have with the money.

The national data presented on Home Health Compare show that HHAs have reported substantial gains in the improvement rates for many functional outcomes. However, these increases in success on functional outcomes have not translated into decreased rates of hospitalization or emergency room usage. Your HHA seems to have generated both improvement in functional outcomes and utilization rates.

1) How do you explain your HHAs ability to influence both functional outcomes (bathing, management of oral meds, transferring, etc.) and a reduction in utilization outcomes (hospitalization, emergency room usage)?

    a) We have created a rather lengthy report if a patient has gone back to the hospital within 30 days of SOC/ROC that tries to document why patient went back. We ask, "what could we have done different; was this a missed opportunity?" Some of the things that we are seeing involve patient compliance with POC/therapies, if the patient called us vs. if the patient calls the PCP, or if the patient goes to the ER on his/her own (e.g., for UTIs). We see patient confusion about protocols more than everything else. We only see a small percentage return to hospital within a week.

Given that three of the four regions involved in the HH P4P showed a net savings in hospitalization costs, CMS obviously is interested in (although no decision has been made) implementing the HH P4P program nationally.

1) If the HH P4P program is implemented nationally, what recommendations do you have for:

a) Other HHAs (similar to yours; different from yours)?

   i) Staff education is key activity. Communication within organization is important. They should monitor their data and respond to what you are seeing. Point of Care documentation has been a big help. The use of integrated computer systems allows for real time interventions. We have no contract staff. We don't have some nurses who only "open" a case; everyone knows about OASIS. We share information on patient outcomes.

b) CMS, QIOs, and national organization (e.g., NAHC)?

   i) We would suggest that CMS unbundle supplies for ostomies and for other conditions (like hip/knee replacement, foli patients for monthly supplies). We need to do more to help patient as a community service. We found that the QIO materials had some good materials and allowed us to increase staff consistency in reporting.

2) What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

   a) The wound section is confusing at ROC and discharge. We have to look back to see if the wound was present (function of their electronic system). Sometimes this takes lots of chart digging.

Appendix B: Delnore Home Health Services: Clinical Team (IL) 08/26/10

Actual Attendees:

- Lynn Vitali, RN
- Renee Zange, RN
- Julie Winkelmann, OT
- Meghan Burton, PT

Base on your HHA's performance during Year 1 of the Home Heath Pay for Performance Demonstration project (CY2008), your HHA won recognition for your high performance in: A, B, C; and for high improvement in: D and E. This means that your HHA out-performed most (if not all) of the HHAs that volunteered to participate in the P4P Demonstration in your Region. Congratulations!

Hi BATH	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 10
Hi AMB	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 13
Imp TRNFR	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 4
Hi ORMED	147093 Delnor Community Hospital Home Health Services Saint Charles IL 2 7

1) Did you know that your HHA was participating in the HH P4P Demonstration during CY2008 and CY2009?
   a) We were told before it started. We were given target outcomes, especially Improvement in Transferring. We focused on patient outcomes.
2) Did knowing or not knowing that your HHA was participating in the two-year Demonstration project matter to you in your daily work with patients? Why or why not?
   a) There was training on OASIS item scoring on-going monthly basis, especially the transfer item. It was very clearly a goal. Some of the variation was due to the scoring on the item. Some of the variation was due to how we worked with the patient on that function. We focused on treatment strategies = large skills first, then fine skills. We found that by having the RNs and PTs discuss the OASIS item scores (what each value means) that this was very helpful in both directions.
3) How does your HHA make use of its outcome report information?
   a) Are these results reviewed/presented regularly to staff?
      i) We heard about the reports on a monthly basis--very outcome-oriented meeting topics. We have regular monthly OBQI meetings as well as staff meetings. We focus on how are we are working on things; these are not case meetings but general strategies.
   b) Do you/your team review on a regular basis how individual patients did on their outcomes to see how you could be more effective with your care/intervention activities—either individually or as a group? Any examples?

i) We have case conferences at least monthly with Michelle whether the therapies involved or not involved in the case. If there is a problem, we can communicate either face-to-face or by Outlook (a big help!) or both. Our agency is very computer driven. We can look up notes, labs, x-ray; charts exported by midnight of patient visit. We can call Jenn regarding wound care and have a camera available to transmit pictures from the home.

4) Did you know that your HHA was recognized for it outstanding performance during CY2008? If yes, how was this communicated to you?

   a) We do a lot by looking the trend lines for the different outcomes. We have our list of HHC to focus on. The OBQI meeting is used to discuss progress in-between these presentations. This allows us to come up with ideas and be more proactive about potential problems. There is lots of input during the month from both individuals and small groups. One specific example would be the resources we have on how to assess balance. We can bring both experience and different disciplines to bear on an issue. We try to do same measurement (give the same score on the OASIS item). Our HHA has a clinic available for wounds—beyond their internal specialist.

As I mentioned previously, your HHA was recognized for high performance in several patient outcomes. I would like you to tell me about why you think you had high performance in Improvement in Oral Meds functional outcome?

1) Can you tell me about how you care for (what you do) patients to get such a high performance score in "X" functional outcome? For example,

   a) Do you start your intervention with this outcome before other outcomes that need to be improved for the patient?

      i) Both RNs and PTs open cases. We try to be very patient specific and goal oriented from the start. Med issues are started (focused on) very early—because possible complications. Some patients have 20+ meds—and we can do drug review right in home. HHA tries to coordinate (ensure consistency) with both (RNs & PTs) groups

   b) Do you use any special techniques or intervention strategies with this functional outcome that you think really make a difference in helping the patient to improve?

      i) Early intervention makes a big difference, especially with CHF patients—3 out of 39 go back quickly. We use a "well at home" system/approach with patients. We try to teach patients about signs and symptoms (e.g., swelling). We emphasize a "Call me first" approach—but some patients don't. We find out after the fact that the patient has gone to the hospital or ER. One cardiac care group is gaining confidence in HHA staff skills in this area, but PCPs will often send patient to ER.

2) You also did very well in Acute Care Hospitalization (and Any Emergent Care).

   a) Why do you think that you did so well on these outcomes?

      i) Part of the issue is that patients are coming home sicker. Patients don't have just one symptom. They come home sick (not able to function independently)

and family members can't deal with these challenges. There are increased fall risks or CHF for these patients. Patients fall getting to bathroom. Patients can be overwhelmed by first HHA visit and sometimes things happen between first and second visit. The PCP general strategy is to send patient to ER. We look at trends (not orthopedic cases), but patients with multiple symptoms. We use a "Why did they go to the ER?" analysis sheet. So far, we have very scattered results and we have tracked this for about a year.

b) Is (Are) there any specific techniques, strategies, or clinical practices that you can point to that really seemed to make a difference in this (these) outcomes?

   i) Remove throw rugs (patients can be resistant); emphasize patient training; but there is non-compliance by the patient.

[For HHAs with high improvement] Your HHA received special recognition for high Improvement in Transferring functional outcome.

1) What did you do in CY2008 (Year 1) to improve your performance in this outcome compared with what you did previously to help these patients improve? Prompts: Improve technology? Improve timing of service? Improve monitoring?

   a) Much of our success is because of our staff. We hire someone who is flexible (willing to try different things). We have (and hire) very experienced people--no newbies (inexperienced) hired. Some HHAs hire over the phone. Our staff needs to be able to work autonomously but we use peer interviews to see if the new person will be a good fit. We have very low turnover, e.g., there has been no change in RNs for 8 years. The same is true for our home health aides who are assigned to home care only.

   b) The HHA has upgraded both technology and individual skills on computers including going wireless. We still use paper (resource) kits that include many helpful worksheets including fall prevention sheets as appropriate. These are prepared for us in office. So we have lots of teaching information to make available to patient.

Thank you for your sharing of information. I would like to conclude with three more general questions about the P4P Demonstration.

1) Do you think that your HHA's patients have noticed a difference in the quality of care that they receive as a result of the HH P4P? If so, describe.

   a) Patients tell discharge planners "I want Delnor." We have many "repeat offenders" who will ask for certain staff people by name. We help patients to work toward their goals. They are generally motivated to get better. Our message is that we help you to keep yourself safe at home so you can stay at home. If a patient says "I am not going to NH." We say, "OK, you need to allow PT in and do what s/he asks you to do." We work with families or if no one is available, we try to contact multiple other sources. HHAs need to do more teaching with family members, assisted living aides, etc. There are some additional cognitive issues with about 20-30% of patients in assisted living situations. HHA needs to be seen as a resource to assisted living situations.

2) If the HH P4P program is implemented nationally, what recommendations would you have for clinicians in other HHAs who would be experiencing the program for the first time?

   a) Agency put patient functioning at the forefront of our work. That is, staff doesn't just act, but they act to help the patient improve his/her functioning. Action <> improve function; HHA staff must be aware of outcomes. There is an on-going focus on where we are vs. where we need to be. Focus attention of staff by breaking complex task up into smaller chunks. Enhance communication within the group; information flow across disciplines and those who touch patient is critical to success. Our supervisors challenge us, "Why are you in there? Are you really making change?"

3) What else should we (as evaluators of the HH P4P Demonstration) know that you have not yet shared with us?

   a) We do most of our charting while we are in the patient's home (point of care documentation). Office/Supervisory staff can review these immediately. This increases our accuracy and consistency in coding. We received some new training on wounds.

Appendix B: Conference Call with Amedisys Corporation, Ms. Tasha Mears, Senior VP of Clinical Operations, 08/26/10

Attendees: Eugene J. Nuccio, Angela A. Richard, Tasha Mears

1) From the corporate perspective, how well did the Home Health P4P Demonstration work for you? (Improved practices/services; administratively; financially)

Ans: Did some in-services about the project; focused more on education for agencies in the treatment group.; partnered w/ OCS; looked at risk for hospitalization (NOTE: later comment indicated that Amedisys has worked with OCS for about 10 years and expanded its involvement in response to the P4P activities); worked with the QIOs under the 8th SOW; flagged virtually everyone—moved to a 5-level model; got feedback on a week; corporate roll-out get 25% buy-in; manage by exception; provided financial incentives to agency management team—director, clinical managers (down to this level))—occasionally to clinician level.

2) Your agencies were in both groups (Treatment & Control)—and some of the Treatment HHAs did extremely well, while others did not do so well. What made the difference between your "winning" vs. your "non-winning" HHAs from among the Treatment HHAs?

Ans: Held focus groups of high performance; no real demographic (size, etc.) differences; leadership, staff turnover, physician relationship, telephone contact between visit; closer relationships w/patients; centralized approach worked better; strong education and documentation; strong rehabilitation program. Relationship w/ physician—how to communicate (actionable information, let leadership know if clinician needs help with physician communication) is really key. Breakdown silos with physician.

3) What, if any, differences did you observe between your Treatment vs. your Control HHAs during the two years of the demonstration? (Turnover rate? Staff motivation/performance levels? Patient outcome performance?)

Ans: Many of the same patterns with both the Treatment and Control HHAs in Amedisys; Company has global initiatives that apply to both control and treatment groups; the early adopters = Treatment winners (and Controls who would be winners)

4) What P4P-specific support efforts did Amedisys make to either or both the Treatment and Control HHAs? (Training? Technology support? Care practices? Care management policies?)

Ans: Disease management program; point of care devices; contain best practice algorithms; finished roll-out in 2007; 13K clinician on laptops; 5-level= daily feed to OCS partner for 10 years; robust upgraded version in 2008 (smart link portal) reports are pushed right to supervisors and patient view stratified levels (5 levels). The report details why they (the patients) are at risk—as well as level of risk. These results point the

clinician in direction to intervene. If the patient is scored as high or very high risk, Amedisys instituted a Friday call list to check on these patients.

5) How did Amedisys disseminate the news about the successes that their HHAs had during Year 1? How did Amedisys use the monetary awards?

Ans: At the HHQI kickoff, reduce hospitalization; model campaign; met Mr. Cohen heard results their; conference call with winners; press release to shareholders; leadership meeting in March—lunch seminar recognized directors who won; directors got to do show and tell on what they did; invested money in training materials; EBSCO database w/ patient materials & staff education; palliative care

6) From a corporate perspective, how has the performance of your HHAs changed (if any) between Year 1 (CY2008) and Year 2 (CY2009) of the Demonstration? Do you think you will be more or less successful than in Year 1?

Ans: Although no cost savings—by the time you get your results we were long past that activity; still didn't know really if it making a difference; gave incentives; purchased TLC—high grow w/ new HHAs; weekly care coordination conferences; multi-disciplinary in person all patients; embedding the reports into this team review; lots of eyes on these data; consistent, receptive to changes.

7) From a corporate perspective, how has participation in the HH P4P Demonstration influenced (changed?) the cost of delivering care to patients?

Ans: (Silence—TM did not respond for a few moments) Amedisys invested more in technology; this is hard to quantify; better integration of systems than competitors; try to provide a higher quality of care. OCS costs increased; some increase in training costs.

8) What recommendations would you make to CMS regarding a national implementation of the HH P4P initiative?

Ans: 1) Real time data and feedback on data; transparency. 2) If HHA is a poor performer—you really need real time, transparent data. 3) Include process measures based on OASIS-C. 4) hospitalization calculation—proportional to length of stay; 5) measure us on 30-day readmit rate total number of readmit; 6) align them with hospitals; patient going in once a month vs. w/ home care reduce to once every six months. 7) work with QIOs—although these QIOs are very uneven in recommendations regarding care practices.

9) What recommendations would you make to other corporations as the support the national implementation of the HH P4P initiative?

Ans: 1) greater consistency in terms of care delivery—telehealth, tele-monitoring; consistency. 2) more open in sharing of information regarding best practices.

Appendix B: University of Tennessee Medical Center Home Health: Management (TN) 01/19/11

Kathy Smith, Office Manager
Lois Dave, Team Leader RN
Geri Rainey, Team Leader RN
Susan Sylvester
Keith Slater, Administrator
Sarah, DON

The agency has several branches and covers 16 counties. Within the past xxx years, the agency was acquired by LHC in a joint venture agreement with the University of Tennessee Medical Center.

Learning about P4P Demonstration Participation

Heard about it in a staff meeting; not really brought up on a regular basis. We are always focused on outcomes, so didn't associate [related efforts] with a project. LHC focuses on the patient; we want to be the best in terms of providing care.

QI/PI

We have OCS to look at outcomes. The LHC Performance Improvement Coordinator is very involved and has an ongoing quality control study. LHC has a corporate outcome support team that helps educate staff on OASIS assessment/documentation consistency. We monitor and audit charts for regulatory issues. We do HHCAHPs assessments for satisfaction. We are JCAHO accredited and look at those indicators.

Effect of participation in P4P Demonstration

There have been changes, but can't attribute necessarily to the demonstration

Care-related policies and processes

We do a hospital risk assessment on admission. We front load visits. We do phone calls [between regular visits] as part of the plan of care. The frequency is based on patient-specific needs and preferences.

We provide incentives for patients to "call us first" and have the clinical team emphasize that to the patients.

3 months ago we implemented clinical pathways for DM, HTN, COPD, CHF, and CVA.

We use the Krames patient education modules and Mosby Steps. We focus on falls education

We are about to invest in Homecare Homebase EHR system. This may provide us with some dashboard QI/PI reports.

We have five teams, each with a team leader, assistant team leader, clerical support and clinical staff. With the LHC joint venture, we had to adjust our staffing model. This involved directly hiring therapists vs. relying on contract therapists and changing the way we looked at territories—now geographically based, opened branch offices.

We now have a part-time OT and have them working more closely with the aides. We are working with therapy and nursing to coordinate goals and processes of care for patients.

We added on position—the rehab coordinator (LPN). This is not the LHC model, but Sara convinced us that it was needed.

LHC offers centralized coding.

We did do some telehealth under a rural health grant and did see some decrease in hospitalization. But without the grant, we couldn't continue [that program].

Every visit, the care provider assesses for new/changed medications. They educate on the meds and teach patients how to evaluate when something isn't right and the medications need to be reviewed [by the HHA and/or MD?]. We use the Allscripts printouts that show side effects, interactions, etc.—leave a copy in the field folder and another with the patient. We had one patient whose daughter found a medication problem by reviewing the printout.

Staff education

We worked with the clinical staff so that when they contact the physicians, they offer suggestions on treatments that can prevent hospitalizations

Staff do monthly in-services using LHC connect. In-services are related to OASIS, disease processes, safety, etc.

The LHC outcome support team works with staff on patient assessment consistency. They [audit charts?] to look for discrepancies between OASIS documentation and other documentation. The goal is to be able to show patient improvement.

Regional MD practice patterns/culture

Physicians tend to recommend that patients visit the ER, and both ER and hospitalization rates are high. This may be due to a) risk aversion/liability; b) heavy workload; and/or c) reluctance to deal with after-hours calls. Need to continue physician education [on ways that home care can help avoid rehospitalizations]. The hospitalist model also may encourage increased hospitalization (AAR note: PCPs not responsible for care when under the care of the hospitalists). Dialysis patients are almost always admitted instead of trying to handle care at home and we have a fair number of those patients.

Patients tend to go to the ER/hospitalization; often because the MD has told them to go to the ER for problems. Also, they may be isolated (rural and/or mountain cultures) and select to go the ER rather than trying to handle it at home. Very high use of prescription medications in this region compared to the rest of the country. Some patients do not have phones or have limited cell phone "minutes" and may not want to use them to handle health-related questions or problems.

Admission Patterns

We haven't changed the type of patients that we take. We get most, but not all, of the UT Medical Center referrals, including those for whom other providers can't do the care. Because of the University of Tennessee Medical Center referrals, we seem to get the sickest patients. UTMC is a teaching hospital and a Level 3 trauma center.

There were some changes with the LHC joint venture in terms of insurance contracts. We have grown, primarily because of opening up the branch offices which allowed us to expand our service area. We don't focus on any particular group of patients.

Very competitive environment with multiple competing agencies, hospital based and otherwise.

Recommendations for P4P program

Would like to see increased communication/feedback. Would be great to see the outcomes take culture (as discussed above—physician culture, patient culture, etc.) into account. Regionally-based comparisons?

Appendix B: University of Tennessee Medical Center Home Health: Clinical Team (TN) 01/19/11

Susan Sylvester, Division VP of Home Care Operations
Sarah, Director of Nursing
Shane McMahan, PTA
Marylou Agdaca, PT
Sally Dawson, PT
Keith Slater, Administrator—3 days on the job
Barbara Hahn, LPN
Ralph Woods, RN
Janet Kerr, RN
Beverly Bryan, PTA

Thoughts about learning you were participating in the demonstration.

Learned about it in a staff meeting. Thought "oh no," more work for me. Thought it would make me have to slow down and think about what you are doing, retrain myself to be more efficient, had a fear of not being able to spend time [with the patient].

How has participation in the demonstration affected the way you work?

Made us more aware of the outcomes.

New forms: these make us better able to document and show that the patients improve. The forms help to emphasize goals. Not using EHRs at this point; we were but with the LHC joint venture, we went back to paper. Plan to implement Homecare Homebase in 2011.

With the LHC joint venture: we are not relying on contract therapists but have our own rehab staff. We have seen improved outcomes.

We now have Krames educational materials. It gives us teaching plans and written materials to leave with the patients.

Clinical staff in-services are online.

Coordination: We are working (therapists and nurses) to look at situations in the same way [to increase consistency in assessment and documentation]. We have meshed together, and now have a more holistic approach with better communication/coordination. We do case conferences and direct communication. Agency reimburses cellphone charges. We have interoffice communication forms that are copied and provided to the clinical team and MDs.

New position: Sara brought in an LPN as a rehab coordinator between therapists and nurses; she takes calls from patients/families; takes verbal orders from MDs; checks schedules against Plans of Care to make sure visits are not missed and/or rescheduled and that the supervisory visits are made. She acts like a team leader. That position is not in the LHC staffing model, but staff members are very pleased and feel like they can respond better and faster to patients; and that patients feel that they are getting a more personal approach.

Approaches to improving Outcomes:

The increased coordination between nursing and therapy, new rehab coordinator position addressed these. Having our own rehab team vs. contract therapists addresses these outcomes, and increased therapist/therapy aide; therapist/nurse; and CNA communications have improved. We think we will continue to see a decrease in hospitalization.

We have a fall policy and a prevention program. If the patient falls, a nurse or therapist goes out on the next day. Therapists are making extra efforts to get equipment and services to the patient right away.

"Call us first": we tell the patient on admission and at visits that we are available 24/7, and that they should not wait to call us for any problems or questions. We have always had the call staff, but we emphasize it more for patients. We have a 3-tiered call system: an RN, an LPN, and an administrator are all available and this helps if someone gets backed up or is seeing a patient and needs some help.

An RN does an evaluation for each patient, even those with therapy only orders. A risk assessment is performed at start of care for all patients. This is on a separate page from the OASIS assessment. It is updated at recertification.

We offer a Lifeline to each patient at start of care, and they can get it at any point during the [care episode] if they don't get it on admission. The patient keeps it until we discharge them, and they can elect to purchase the services after we discharge.

We use an SBAR format for physician communications and make recommendations for what we think would help the patient.

At each visit, the nurse or therapists asks if the patient has had any changes in medication orders. If so, a change in medication form is completed and goes to a team leader who lets the rest of the team know. There is also a medication sheet to keep track of those.

For pain, LHC used more modalities for pain treatment, including ultrasound units and Anodyne units (infrared therapy to treat conditions such as increasing circulation for DM neuropathy). We are using those.

For patients with low vision, an OT goes out and evaluates and obtains adaptive equipment/teaches compensatory techniques. This can help with decreasing falls risk and helps them to read the medication bottles, etc. The OT also provides education on low vision. This was initiated with the LHC joint venture.

We also use the LHC model of educating other providers on pelvic floor dysfunction.

We have noticed an increase in reliance on community services: sheriff visits, churches, diabetic association, MOW, buddy system, etc. We give the patients a list of community services.

We have started using clinical pathways—that's something that LHC didn't have before.

Quality Improvement/Performance Improvement

Our goal is to be the best provider in town. LHC did bring in a new Performance Improvement (PI) coordinator, Sherree. She was needed because of LHC's structure and

the need for more PI resources. She has focused on the P4P demonstration outcomes and she is very straightforward [when we need to make changes]. But we want outcomes to improve regardless of financial reimbursement.

Staff participate in QI projects. We have in-services on OASIS documentation to get everyone on the same page/increase consistency in documentation and to make sure that what we are doing is evidenced in the documentation.

Team leaders audit a sample of records, and focus on OASIS documentation, particularly as it relates to other documentation.

General

We do the care as we always have. Any changes in outcomes may be a result of ongoing efforts to improve care instead of [being driven by] the P4P demonstration. The demonstration may have provided more awareness. When you look at what you are actually doing, it gives you an opportunity for change.

We work in teams—while anyone should be able to look at the previous chart entry and tell what to do, working with teams is helpful [for care coordination] because you know your team. It's better to have 30 pairs of eyes than one pair of eyes. We are hiring people who want to provide the best care for everyone.

We got very little information about P4P demonstration participation. It would be helpful to get more feedback and to learn what best practices the other agencies are using that impact the outcomes. Would recommend that sharing to occur even after the project is over.