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Evaluation of the Medicare Home Health Pay-for-Performance Demonstration

CY 2009 Annual Report – Volume 2: Themes and Strategies for Highly Effective (High Performing) Home Health Agencies

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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", indicates that the number of beneficiaries using home health care services has increased by approximately 25% from 2002 to 2007 and the number of episodes of care delivered has increased by a similar amount during the same time period. Similarly, the number of visits that are delivered by skilled staff (e.g., registered nurses and physical therapists) has increased from 69% to 80%.

The quality of care received by these patients has also come under increasing scrutiny during the past several years, particularly since the advent of the prospective payment system in 2001. The MedPAC data show that there has been a consistent incremental improvement in risk adjusted functional outcomes from 2004 – 2008. However, a key utilization indicator "Acute Care Hospitalization" has 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 has nearly doubled from 2001 ($8.6B) to 2008 ($16.6B) during the prospective payment era, but this is still less than what was spent in 1996 and 1997, toward the end of the cost based era. MedPAC reports that larger and "for profit" agencies have a higher profit margin 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 as exampled by the avoidance of adverse events be linked to payment for home health agencies (HHAs).

This perspective of linking payments to home health care performance is the driving force behind the Home Health Pay for Performance Demonstration (Demonstration) project sponsored by the Centers for Medicare and Medicaid Services (CMS) and conducted by its contractor Abt Associates. The evaluation of the Demonstration's effectiveness, sponsored by CMS and conducted by the University of Colorado, Anschutz Medical Center, includes both an 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 to be addressed in the evaluation is to describe the quality-related activities home health agencies engaged in to produce superior patient outcomes.

The study of HHAs 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 enhances professional fulfillment and staff retention, improves clinical and outcome performance, and is an effective business strategy. They outline seven principles of training including providing sufficient time to teach and to learn the material, as well as making use of external experts and offering training to multiple home health disciplines. These concerns about staff retention and creating effective business practices are revisited in other research on home health care.

Gantert and McWilliam (2004) note that interdisciplinary teamwork is difficult to achieve because of geographical separation and historically distinctive professional disciplines used to help home health patients. Three ways to overcome this are 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).

Similarly, the measurement and reporting of particular patient outcomes to enhance home health care quality sounds simple but can be quite difficult. Berwick, James, and Coye (2003) and Galvin and McGlynn (2003) describe how measurement of performance is imperative for health care delivery systems in general rather than home health care specifically. The former identify two pathways for improvement: selection of measures and changes in care. Regarding the latter pathway, Berwick, James, and Coye (2003) state 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." (Berwick, James, and Coye, 2003, p. I-35). This requires an investment in human capital—training, time, recognition—a strategic decision on the part of management. These authors conclude that quality improvement is a good business model and marketing decision. Galvin and McGlynn (2003) cite 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 believe that broader and timelier dissemination of health care quality information, especially of outcomes and at the time of consumer need, will break the circle of inertia regarding quality improvement found in many health care organizations.

Beyond the individual organization there are other forces that influence a home health 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 affects number of visits and higher number of visits is associated with a higher hospitalization rate. They postulate that higher visit rates at the start of home care are effective, but higher rates later in the care episode are not as effective especially if the patient has de-stabilized. In a non-home health setting, Prentice and Pizer (2007) concluded that delaying health care services led to an increase in mortality rates for the geriatric patients in their study. Home health patients are 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 home health agencies report that home health agencies have a high rate of turnover (72% overall and 86% in for-profit agencies) and that the rate has worsened between 2001 and 2007. They conclude that a more comprehensive understanding of factors that will increase nurse job satisfaction and retention is critical to overall home health agency performance.

There are two core conclusions that can be derived from this brief review of research literature related to home health agency effectiveness.

1. While patient health outcomes may be related to home health staff action, the mechanism(s) that generate these changes are as yet unclear.
2. Quality improvement in home health care is a culture championed by the organization leader, supported by trained agency staff, and validated by measurement of patient outcomes.

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.

Using the list of treatment home health agencies provided by Abt Associates, Inc, data on how these agencies performed during calendar year 2007 on the 7 Outcome Based Quality Improvement (OBQI) measures that were identified in the demonstration were downloaded from the Quality Information Evaluation System (QIES) Workbench application. Groups of 5 - 10 agencies from each state were identified as the highest performers in their states on these measures. Invitations to participate in the focus group activity along with a general description of the two focus groups that would be conducted were sent to several agencies in seven states.

Starter questions for the two focus groups—management team and clinical team—were developed by the authors of this paper and 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.

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 preference was to group the visit dates and geographical locations for site visits. Eight agencies, two from CA, IL, CT and one each from GA and TN were selected for the focus group activity.

The two authors conducted the first four focus groups at two agencies in CA. This allowed the authors to

1. establish consistency between researchers when asking the starter questions;
2. practice recording participant responses to these and follow-up questions;
3. standardize their strategies for probing focus group member answers when following up on these answers; and
4. establish consensus on what was heard in the answers to the questions.

After each CA site visit, field notes were written separately by the two authors. Using these written documents, the authors discussed what was in common and what was different in the content of the field notes. These written documents were used as the basis for evaluating the four preceding items.

The lead author conducted the eight focus groups at the two sites in IL and the two sites in CT. The second author conducted the two focus groups in GA and the two focus groups in TN. After each site visit—including the CA site visits—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. Some field notes were returned unedited with a comment such as “we appreciated the opportunity to review your notes and have no changes”. Copies of the final field notes for each site are included in Appendix B.

A total of 92 different individuals contributed to the 16 focus groups. The job classifications for these individuals 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, Directors of Nursing (DON), Medical Director, Chief Financial Officers (CFO), Administrators, and Chief Executive Officers (CEO). 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 the focus group discussions were very energized. Most of the focus groups exceeded the allotted time of 1.5 hours. The host agencies were

most gracious toward both authors. Host agencies ensured that a parking space was available at a very crowded, urban agency, that food was available 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. One agency even requested a group picture to commemorate the occasion!

3. Themes and Strategies

After completing the first two site visits, the senior author developed an outline of common organizational themes for these two home health agencies in their attempt to achieve their high performance on OBQI measures. While there were a limited number of themes, the specific strategies used by these agencies to address an identified theme differed and were specific to each agency. The authors discussed these themes and strategies to validate and add any missing components. The initial "themes and strategies" document was shared with the CMS Project Officer in March 2009 and discussed on the monthly conference call.

These original themes were reinforced throughout the remaining site visits. The field notes for all of the visits were assembled and discussed by the two authors. These notes provided new examples of the strategies used by the other home health agencies to address original themes. The authors reached consensus on the sequencing, organization, and consolidation of the themes found in these highly effective home health agencies.

The intent in presenting these themes and strategies is two-fold. First, we would like to "describe what we saw and heard" when we conducted these focus groups. This addresses the question "How do highly effective / high performing home health agencies describe themselves and how they do their job?" Second, we would like to convey some ideas that these agencies shared—both explicitly and implicitly—on how other HHAs can become high performing agencies. All of the agencies volunteered for the Demonstration because their already were already high-performing agencies. Some participants from a few agencies were willing to share that they had not always been high performers. We will use their stories to describe a possible path from lower to higher performance in home health.

The following provides an outline of how these quality-related themes are organized in the discussion that follows.

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

While each of these themes could be identified in the site visit home health agencies, how the individual HHAs implemented (produced a strategy to address) the themes differed. In some cases the different strategies seemed to be related to geography—urban vs. rural and clinical practice differences by region—while in other cases, the differences might be attributed to the size or the financial resources available to the agency.

These themes represent a core set of common characteristics and processes found within each of the eight agencies visited. The apparent success of these agencies was based on the HHAs addressing all the themes in a way that was unique to the specific agency. The themes are clearly inter-related and dependent on each other for support and sustainability.

Leadership and Organization Themes

Theme 1: Leadership
While sometimes seen as a cliché in the business environment, in these health care agencies every leader was committed and willing to do "whatever it takes" to help patients get better. Every senior administrator who participated in the focus groups—and virtually all participated in both the management and clinical team focus groups at each site—stated that placing an emphasis on excellence in care delivery was "a good business model". Nearly every agency reported that they have recently changed to using more expensive, but more effective, wound care products. While there is an added expense for materials, there is an overall reduction of cost because fewer nurse visits are needed to change dressings. As one Chief Financial Officer stated, "the Director of Nursing (DON) has the final say" regarding care products and services provided.

Strong leadership was the clear starting point in developing the organization systems needed to achieve a consistent high level of performance. The personal styles of the leaders of these eight agencies were diverse. However, the leaders in these agencies could articulate what needed to be done by the organization and emphasized a patient-

centric approach to care delivery led by nurses and supported by the clinical specialists and administrative staff. As described in the previous paragraph, these leaders were very supportive and proactive in providing clinical and administrative staff the resources and tools they needed to do their job effective, efficiently, and professionally. Perhaps even more important than being supportive of staff efforts was their ability to articulate that helping patients get better was the goal and primary concern of the entire home health staff—both clinical and administrative. This is the second theme.

Theme 2: Administration and Clinical Teams are a single system that focuses on patient care

During each of the two focus groups for each site, home health agencies (HHAs) expressed the common theme that administration and clinical staff viewed themselves as a single, integrated system that was focused on helping patients get better. Administrative systems seemed to be consciously designed to support clinical staff. Clinical staff repeated cited administrative staff as "being there to support us". More than one administrator clearly articulated this "single system" approach to patient care.

Each agency emphasized cross-training administrative staff. The emphasis on cross-training had both practical and organizational implications. Most organizations were relatively small and had few full-time administrative staff. Cross-training allowed for business operations to continue smoothly during the normal events of staff being out sick or on leave or otherwise unavailable to work. Administrative staff welcomed the opportunity to learn other individuals' jobs. The organizational benefit when the agency was fully staffed was that each member of the administrative team understood how his/her job affected, or was affected by, the other administrative positions. This resulted in enhanced communications (Theme 4.2) across the organization. Effective communication is likely to be related to the low staff turnover (high retention) and high levels of job satisfaction reported during the focus groups.

More than one agency leader took over an organization that was previously not functioning at an optimum level. In each case, the administrator articulated how she fixed the administrative systems first with an eye on the flow of information from the field. Once the administrative systems were stabilized, the administrator turned her attention to the clinical side—both systems and personnel. The result, as expressed by both administrative staff and clinical staff, was a single, integrated system of care where clinical staff felt supported by administration and understood the administrative requirements for accurate and quality data on the patients.

Interestingly, this "single system" approach is mirrored in these agencies' perspective about treating patients. The oft-repeated phrase was that their agency deals with the "whole" patient. Some agencies described this as treating the patient "holistically" while other described paying close attention to both the emotional and physical needs of their patients (and caregivers). One group of clinicians provided the assessment that "happy patients get better quicker."

Patient-oriented Themes

This section of the report focuses on several themes that are related to patient care. The clinical staffs at each agency emphasized how quality care would not be possible without the support of these systems and approaches. Senior management emphasized that these approaches were not by happenstance. Rather, they resulted from a conscious effort to establish the agency-wide use of excellent patient care practices.

Theme 3.1—Use of multidisciplinary teams (continuity of care)

Agencies used multidisciplinary teams to provide more continuity of contact with patients. They recognized that some "poor" results were an artifact of miscommunication among HHA staff members who saw the patient at different times or were from different disciplines. This led to coding discrepancies at different time points for the assessment (clinical staff to administrative staff communication) or in the patient notes (clinical staff to clinical staff patient care issue). There was an attitude of "how can we fix this problem" among both administrative staff and clinical staff. The answer across these agencies was to form multidisciplinary teams.

Virtually all of the multidisciplinary teams were in the clinical area. The clinicians viewed the collegial effort of registered nurses (RNs), physical therapists (PTs), occupational therapists (OTs), Social Workers, and home health aides toward patient care to result in many benefits. First, they believed that the multidisciplinary team approach was more responsive to both the patient and the patient's caregiver's needs. Second, the multidisciplinary approach led to easier and more efficient sequencing of care for patient. The clinical focus groups emphasized that no single discipline could meet the needs of the patient—even when the patient was receiving "PT only" care. The multidisciplinary approach sensitized the clinicians from each discipline of the value of the other disciplines. Third, the multidisciplinary team approach emphasized the patient-centric focus of home health care. The two comments heard in many focus groups were that there were no "silos" and "we no longer speak about 'my' patient, but 'our' patient". These comments demonstrated that multidisciplinary teams represented the core clinical approach for each of the agencies.

Each agency provided examples of how short-term, highly focused, multi-disciplinary teams were used to maximize information flow throughout the organizations. Membership included agency personnel from the administrative and clinical work groups. These multi-disciplinary teams address topics such as why there are high rates for hospitalization, why there are coding inconsistencies, and the value (both from a patient care and a return on investment perspective) of front-loading and sequencing PT and OT visits. The multidisciplinary teams supported a goal-directed approach to both meeting the patient care plan objectives and reinforcing the "single system" approach to patient care.

Theme 3.2—Communication and feedback loops (patient focus)

The "single system" approach provided the opportunity for very open, on-going communication among staff members. Examples of both formal (team meetings about patient care plans and staff meetings), as well as informal contacts both at the main office and via email and cell phone were provided in great numbers by each of the focus groups. The agency personnel recognized the importance of, and the continued attention needed

for, effective communications among all levels of staff. They emphasized the value of and the importance of communication among all areas of HHA and in all directions (top down, bottom up, horizontally) across the organization.

Each HHA provided numerous examples of how effective communication flow prevented problems from developing or escalating, thereby reducing the number of chronic and/or severe problems. Monitoring patient vital signs and communicating changes to senior clinical staff and to the primary care physicians was seen as critical to minimizing hospitalization of the patients. Providing high quality empirical data on patient status using technology created a high level of trust by physicians in the professional competence of the HHA staff. Cross-training of staff, especially on the administrative side and creating multidisciplinary teams on the clinical side, puts a structure in place that enhances communications. The communication flow extends beyond the agency. Several agencies report formal sharing of patient health status information with the patient's primary physician using either high tech, e.g., telehealth monitoring data, or low tech methods, e.g., patient's "in-home" treatment documentation folder carried to the clinic or doctor's visit.

One interesting and contradictory finding from the open communication systems reported seemed to be that in a few agencies, clinical staff members were essentially unaware that their agency was part of the Demonstration project. In these instances, this was the result of a conscious decision on the part of the administrator. As one administrator said, she wanted to "insure incorporation of improvements in delivery of care as part of the on-going agency culture, not just for the time of project."

Theme 3.3—Adopt Technology to make work more efficient (patient focus)
The agencies differed widely in their use and integration of technology into patient care. A few agencies use telehealth monitoring equipment to provide a continuous flow of data about patient status for both internal monitoring and transmittal to primary care physicians. These agencies were very committed to the use of this technology and saw its use as a way to differentiate their agency from other HHAs in the area. Several other agencies reported trying to use telehealth monitoring equipment with their patients but deemed the effort "more trouble than it was worth." Our focus group sample was too small to reach a conclusion about why some agencies found the technology very useful and others did not.

All of the focus group agencies moved their staff into the "cell phone and email" world of communications. The evaluation of using these technologies to support patient care was uniformly positive. Clinical staff at all of the agencies provided numerous stories of how they were able to contact senior clinicians or clinical specialists (e.g., wound care) while they were at the patient's residence using one of these technologies. The immediate sharing of patient information and the opportunity to receive expert guidance "real time" was seen as very beneficial to improving patient outcomes.

While telehealth monitoring equipment was not widespread, the use of other clinical technologies such as pulse oximeter clips and Prothrombin Time and International

Normalized Ratio (PT/INR) analyzers were universal among these agencies. More than one agency reported that their clinicians used electronic data collection devices and electronic health records to reduce the paperwork associated with completing the OASIS assessment and other clinical documentation. Agencies also reported investing heavily in staff training on these care-related tools—a point that will be emphasize in Theme 4.4. While the use of high quality wound dressings was mentioned previously, the clinicians were very clear that they valued the opportunity to use high quality tools to care for patients. The availability of these tools was seen by the clinicians that the agency management valued them as professionals. Staff morale conveyed at each of the focus groups was quite high. Many of the participants had been part of the organization for many years. The agencies reported very low turnover among their staff and indicated that they had many professionals seeking to join their staff "because they had heard good things" about the organization. As one of the clinicians stated, "Give us the tools and we are happy campers."

Each of the agencies reported using both high tech and low tech approaches to helping patients get better. Some of the less well funded agencies tended to emphasize the low tech approaches over the high tech ones due to financial considerations. Low tech approaches included using larger fonts for HHA contact numbers on the patient's information packet and helping the patient or caregiver to read and understand the ingredients on food packaging. The common component to the use of technology—either high tech or low tech—was the focus on enhancing patient self care/self monitoring. Several agencies made use of local Quality Improvement Organization (QIO) suggested strategies. One popular strategy for helping patients' self-monitor their health status is to use a "green light, yellow light, and red light" approach. Patients are given specific health parameters for each color of light. If their health parameter value (e.g., weight) is in the "green light" area, then no contact with the HHA or doctor is needed. If the patient's health parameter value is in the "yellow light" area, then they need to monitor their condition more closely and perhaps contact their HHA nurse. If the health parameter value rises to a value in the "red light" area, then the patient should immediately contact the HHA or doctor as indicated on their plan of care. This strategy is emblematic of the "help patients get better" approach to patient care for these agencies. Patients using telehealth monitoring had to be carefully transitioned off of the monitoring devices to lower tech self-monitoring systems because they had learned the value of self-monitoring their vital signs.

Organization-oriented Themes

Each participant agency was extremely sensitive to the unique health care needs of its clientele and the care practice patterns found in its geographic location. However, the agencies shared many similar organizational themes as described in the following section. Organization themes in aggregate are characteristics of these agencies' corporate cultures. While there were some differences in how the agencies created their corporate cultures, there is little doubt that each agency visited would find the other agencies quite familiar in terms of corporate culture.

Theme 4.1—Data driven, Proactive Approach to Quality
In every focus group at every site, participants described a data driven approach to monitoring quality. While all agencies made use of the CMS provided reports in the Certification and Survey Provider Enhanced Reports (CASPER) system, several agencies found these reports provided either insufficiently detailed information about their outcomes or information that was too out-of-date to allow a proactive approach to quality improvement. Outside vendors such as Outcome Concept Systems, Inc (OSC) and Strategic Healthcare Programs, LLC (SHP) were used to augment—and to a large degree, replace—the CMS CASPER reports.

Participant agencies appeared to be nearly obsessive in their desire to measure their effectiveness based on patient outcome results, to compare their current performance with their prior performance or their competitors, and to address potential problems immediately as they were identified. All of the agencies shared these reports with both administrative and clinical staff at formal review meetings and/or informally by posting results in an easily seen location, e.g., bulletin boards, break rooms, lavatories, etc. Agency staff reported that they were fully aware that quality, as measured by patient outcomes, is important to the agency.

The agencies were very open to making changes in care practices that were suggested by clinician groups, QIOs, or discovered at conferences. However, these changes were monitored, not just implemented, to see if they made a difference in patient outcomes. At smaller agencies the senior administrator, who also was usually the DON, played the role of director of quality improvement. Larger HHAs had full or part-time staff with committed time for quality/performance monitoring and improvement activities. The interesting commonality was that quality was not seen as "something else" that the staff does. Rather, quality was simply the way things were done and was fully embedded with the HHA culture. Quality was evaluated based on whether care practices led to improved patient outcomes. Quality was simply the use of best administrative or clinical practices and seen as a separate entity.

The management staff at each organization emphasized the need to be "ahead of the curve" by discovering issues that might escalate into problems. Perhaps as an artifact of the "single system" approach or due to the effective and redundant communication systems, less than optimal performance in a particular area was identified quickly. Once the problematic area was identified, management coordinated the effort to bring together all the resources needed to address the problem proactively. One common problematic area of need was wound care. Several agencies reported that they brought in multiple wound care material vendors to both train their clinical staff and provide detailed cost/benefit comparisons for their financial staff. These agencies took the approach of "let the vendors compete for our business." Similarly, many of the HHAs reported making efforts to reach out to the health care community—both hospitals and individual physicians—to share what they learned and "market" their success. This is part of Theme 6 (Integration into community). These agencies were always looking for the next issue to attack based on quantitative, quality data.

Theme 4.2 (same as Theme 3.2)—Communication and feedback loops (organization perspective)

As stated previously, the "single system" approach facilitated open, on-going communication among all members of the staff within the agencies that were visited. While none of these agencies could be described as "very large", some management focus groups included nearly a dozen individuals all representing a variety of clinical and administrative functions. These individuals provided numerous examples of effective "open-door" communication regardless of position in the organization. Disagreements and concerns appeared to be handled in respectful ways. The emphasis in the communications was on identifying and fixing the problem, not identifying the "problem maker".

Clinical focus groups often shared that "they understood" what the needs of the administrative staff were with regard to data collection and reporting. Similarly, clinical staff stated that the administrative staff and management understood and addressed their needs to provide patient care that resulted in the patient getting better. The establishment of the systems to make this happen was clearly a goal of the senior administrator. Once the systems were in place, in many ways the communication among agency staff created the synergistic energy to keep the communication going. The authors sensed that the leader monitored these cross-organization communications in an informal, yet serious, level to ensure that the focus was on the problem, not the individuals involved.

Theme 4.3 (Same as Theme 3.3)—Adopt Technology to make work more efficient (organization perspective)

Technology was used to simplify, streamline, and reduce the burden of data collection and transmission. The previous section (Theme 3.3) presented examples of how technology is used directly with patient care. The commitment to the acquisition and use of technology to monitor and care for patients as well as to support the business component of health care was evident. Each agency to the extent financially supportable had invested in software systems that allowed a free flow of clinical health record information—field notes, OASIS assessment, patient monitoring data, etc.—into business information systems—CMS data transition and financial reporting. This was another example of the "single system" approach to home health care delivery.

These HHAs were very cost aware, especially with regard to wound care supplies. While each agency indicated that it either formally or informally did a return on investment (ROI) analysis or the like for wound supplies, their individual conclusions differed. Some agencies' analyses showed that the more expensive supplies led to an overall decrease in costs because of the reduction in the number of RN visits. In other agencies, the use of generic (but still effective) wound care materials rather than the more expensive materials initially prescribed by the doctor generated the best ROI.

The acquisition and use of electronic technology varied widely among the agencies. Some agencies had very sophisticated systems including the use of Blackberries by senior supervisory clinicians for daily patient data updates. Other agencies made use of global

positioning system (GPS) technology to help clinicians locate their patients' homes in rural areas. These systems had the added benefit of creating documentation about when (date and time) that a visit took place. Agencies recounted stories of family members or clients calling to complain that no one from the agency had shown up to care for the client or was extremely late and how the GPS data were shared to eliminate the individual's concern. Lower tech versions of this approach involved writing a brief field note in the patient's own home health care folder and having the patient sign, date, and time the visit for verification that the visit did occur. One organization used the GPS data to record clinicians' mileage and eliminated that data collection task from the clinician's list of things-to-do.

Theme 4.4—Commitment to staff education / development
These agencies demonstrated a commitment to staff training and development by engaging with supply vendors to provide in-house training for clinicians, as well as encouraging and supporting the pursuit of additional clinical certifications in specialty areas such as wound care. There was some, and in one case quite extensive, in-house training from staff member to staff member, except for the cross-training activities. Some agencies engaged clinical specialists from local hospitals to improve the competency level of their clinicians.

This commitment to staff training and development had benefits beyond individual skill levels. As mentioned previously, there was very little staff turnover in the agencies that were visited. The staff turnover that was identified typically occurred after intensive management effort to improve the skill and attitudinal levels of individual staff members who were ultimately judged to not be able to meet the expectations of the agency. Additionally, during introductions at both the management and clinical focus groups there were multiple individuals who had 10 or more years of experience with the agency. When asked why they have remained with the agency, they made statements like "we are the best; why should I leave?" and "they (management) let us do our job." and "management treats us as professionals."

Organizational Culture Themes

Each of the agencies conveyed an interest in home health care beyond their own agency. We have labeled these "Organizational Culture Themes". These themes represent how the agencies view themselves relative to other home health agencies as well as their chosen role in their community.

Theme 5—Long history of strong quality culture
Each of the agencies reported that they made no significant changes to policies and practices because of the Pay for Performance Demonstration. Perhaps this is an artifact of selecting these agencies from among the "best of the best" in their respective states. These agencies were already high-performing agencies as demonstrated by their OBQI scores. One might reasonably expect them to continue with what they were doing.

Several of the agency administrators during the selection process stated that they had purposely not told their staff that they were participating in the demonstration. This was confirmed during the clinical focus groups when they were asked when participating staff learned that they were part of the Demonstration. In some cases their answer was "when we were invited to come to the focus group."

The agencies viewed the Demonstration as an opportunity to help sustain the quality effort/culture that they had already put in place for their HHAs. There was a pride in the quality of service that these agencies provided to their clients that they wanted to share by competing with other home health agencies as part of the Demonstration. The Home Health Pay for Performance Demonstration was seen as an opportunity to challenge themselves to see how they measured up against other excellent HHAs. All of the HHAs had vibrant cultures of quality prior to their volunteering for the Demonstration, with "buy-in" from all levels of the organization.

Theme 6—Integration into community

The agencies were passionate about their mission of serving their clients. They viewed their clients as the individual receiving the services, the caregivers who assist in the healing process, and the broader community that they served. Both management and staff described a broader vision of their purpose than just "making money". Several agencies reported how economically depressed the communities they served were relative to other nearby areas. All agencies spoke about out-reach activities with their staff volunteering for community service work like health fairs and immunization efforts. Several of the agency directors served on hospital review boards and had leadership roles in these community-oriented organizations. One agency has a foundation whose efforts include giving scholarship for local students preparing for health-related careers.

The participant HHAs were sensitive about other HHAs that were perceived to have the wrong vision about home health care. There were questions posed to the investigators about what we could tell them about how their competitors were doing relative to the focus group agencies. Some agencies shared concerns that other agencies were manipulating how the OASIS was completed vs. the actual delivery of quality home health care resulting in inaccurate outcome rates. Nonetheless, these agencies had a clear vision of how the services they provided to their clients improved the overall quality of life in their community. Finally, these HHAs viewed the delivery of quality health care as the best advertising possible and absolutely critical to their financial bottom line.

4. Discussion

As Berwick, James, and Coye (2003) noted, leadership is critical to focusing the efforts of everyone within the HHA. Each of the agency Administrators could articulate clearly her vision and implementation strategy for her agency. In every case this vision was to establish information and clinical care systems that had a single, unified, and consistent focus on helping the home health agency's clients get better. These administrators—and their business manager / CFO staff—agreed with the previous authors, Berwick, James, and Coye (2003), and MedPAC (2009) that high quality performance is an excellent business model for their agency. However, each Administrator and all of their staff who

commented on the topic were very clear that excellent business results were a secondary effect to the primary reason to pursue high quality performance—the well-being of their patients.

Highly effective home health agencies put the vision and systems into action with specific strategies to help their clients get better. From the clinical perspective, they corroborate the MedPAC (2009) findings that patient functional outcomes can be improved dramatically and are working diligently to reduce hospitalization and emergent care rates for their patients. These agencies have solved the "silo problem" noted by Gantert and McWilliam (2004) in the extensive use of teamwork to address patient needs. In many ways the effective use of multidisciplinary clinical teams is an extension of the establishment of single, unified systems focused on patient improvement. Clinicians from multiple sites who had worked in other HHAs reported the vast difference in the effectiveness of multidisciplinary teams in their current agency versus their previous agencies where the "silo" approach was more typical. Early and intense intervention with patients utilizing both therapists and nursing staff was seen as a key strategy in reducing the hospitalization rates for their patients. The 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 was also important. For example, some agencies sequence physical therapist visits before occupational therapist visits to ensure that patients have the range of motion necessary to participate in the tasks presented by the occupational therapist.

A related clinical theme is the emphasis on communication among staff members, both back office and clinical staff. Each agency emphasized how information about patients gathered using formal tools such as the OASIS and informal tools such as patient visits by home health aides is shared systematically at regular meetings about patient progress and informally (and often more immediately) with phone conversations, email messages, and impromptu meetings in the office. There is a conscious effort to ensure that these communications do not add to the paperwork burden of clinicians. The clinicians are very supportive of the need to document their clinical assessments and interventions accurately, because that information is used by other care team members.

This data driven approach to quality and quality improvement, supported in the research findings of MedPAC (2009), Galvin and McGlynn (2003), and Wolff, et. al. (2008), is seen in the organizational themes exhibited by these highly effective home health agencies. Several of the agencies make use of private vendors to provide more detailed and more immediate feedback on performance, both at the agency level and at the individual (clinician) level. The use of technology such as telehealth monitoring, mobile communication devices from cell phones to Blackberries, and electronic information sharing software further support this data driven approach to ensuring patients' needs are being met and clinical progress is being made.

Contrary to the findings of Cushman and Ellenbecker (2008), there were no problems with either the retention or recruitment of registered nurses (RNs) in these agencies. The agencies were almost exclusively staffed with RNs rather than LPNs and only agencies in the Northeast reported challenges in hiring RNs. All agencies reported that retention rates among both professional clinical and back office 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.

Beyond their focus on internal systems, processes, and patient outcomes, highly effective HHAs look outside their agency at local and national trends. Additionally, each of the agencies demonstrated a presence in their local communities by providing health care services such as supporting community immunization efforts and participating on boards of local hospitals. Finally, these highly effective HHAs report a long history of having a strong quality improvement culture. There was a notable lack of "new" agency initiatives that were implemented by these agencies specifically in response to the Home Health Pay for Performance Demonstration. 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.

The study is limited due to the number of home health agencies visited, but is not unusual for a qualitative study. Further, given the consistency of "story being told" by the 16 focus groups from 8 agencies across 5 different states regarding what highly effective home health agencies do to produce outstanding patient outcomes, the sample size seems to be less of a problem than it would if the target population was more diverse. The analysis was intended to accentuate the commonalities among these agencies. There were differences among the agencies in the number of clients served, the urban or rural setting where the services were provided, the use of technology such as telehealth monitoring, and specific care practices by hospitals and doctors. Despite these differences, the six major themes and related subthemes identified were easily identifiable across all of the HHAs that participated in the focus groups.

5. Conclusion

The characteristics of high-performing HHAs mirror the characteristics of high-performing organizations in all industries: strong leadership, open communications, and a clear focus on delivering a high-quality product. All employees are highly valued for their role in achieving organizational goals, and managers provide them with the training, tools, and support necessary to allow them to perform their work at optimal levels. Quality home health care organizations require strong, effective, and purposeful leadership as the starting point for creating a high-performing home health care organization. The integrated, single-system approach that these leaders created in their organizations created the fertile ground that grew the strong quality culture and multi-disciplinary teams that put patient care first. The participant HHAs reported that this environment was both fiscally profitable and created very positive morale (and high levels of retention) among its employees.

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Appendix A: Starter Questions

Management Focus Group Starter Questions

Home Health Pay for Performance (HHP4P) Demonstration Evaluation

Semi-structured Interview

Administrator/Director of Nursing/Management Team

1. Since you began the participating in the P4P program, what changes in policy or practice have you made?

2. Did participation in the demonstration improve quality of care overall or for specific services or types of patients?

Probe on responses from survey:

a. Did you measure changes in the quality of care? If so, how?

3. Would you say that participation in the demonstration resulted in a) no changes in the way you provide care; b) a few changes in the way you provide care; c) many changes in the way you provide care or d) dramatic and widespread changes in the way you provide care?

Probe on responses from survey:

a. Describe the changes:

b. Did you change care-related policies (e.g., front-loading visits, evidence based practice (EBP) guidelines, etc.)?

c. Did you invest in new technologies to improve care?

d. Did you add positions or full time equivalent (FTE) %?

e. How did you inform staff/train on changes in practices?

f. Were these changes made specifically to improve your chances of receiving a HHP4P incentive payment or were there other factors that influenced your decision to make changes (please describe)?

4. Were there changes in any of the following areas made as a result of participation in the demonstration?

a. Agency management practices (e.g., hiring, supervision, staffing, etc.)

b. Patient admissions procedures

c. Data systems

d. Marketing

e. Other (describe)?

4. Are there contextual or organizational culture factors, e.g., new (competing) HHAs, new emphasis on home health usage by hospitals/ nursing homes (NHs) that affected quality of care and/or success of the demonstration?

Probe on responses from survey:

a. If yes, please describe the factors.

b. Elaborate on how you believe these factors affected quality of care.

c. Elaborate on how you believe these factors affected your agency's success in the demonstration.

5. Do you have other comments or suggestions on the P4P program?

a. Which aspects of the program work well?

b. Are there aspects of the program that could be improved?

Clinical Focus Group Starter Questions

Home Health Pay for Performance (HHP4P) Demonstration Evaluation

Semi-structured Interview

Clinical Team Focus Group

1. What were your initial thoughts when you learned that you would be participating in the P4P demonstration?

2. How did you think that it would affect your work?

3. Would you describe how your agency's participation has affected the way you provide care?

4. In what ways has your agency's participation affected the way that you do your paperwork, if at all?

5. How has your agency's participation changed any aspects of your work flow (probe—changes in communication patterns among care providers, coordination, etc.)?

6. How has your agency's participation changed (if at all) your other obligations to the agency (probe—emphasis on participation in QI studies, more meetings, etc.)?

7. Can you identify any other agency changes that were made as a result of participation in the project?

8. Do you think that the quality of care for patients has changed a) for the better; b) for the worse; or c) not at all as a result of participation in the demonstration?

9. How is the quality of care measured in your agency?

10. Do you have any comments about the P4P demonstration in general?

Probe: What has worked well? What could be improved?

Appendix B: Field Note Summaries for Focus Groups

1. Adventist Home Health Services (CA)

Adventist Home Health Services
February 17, 2009 (Angela and Gene)

Management Team Meeting:
Susan Myers (RN, Administrator)
Grace Canovas (RN, Quality Improvement (QI) Coordinator)
Melody Stopher (RN, Clinical manager)

1. Experience with P4P: We don't really do anything differently. We look at The Joint Commission's performance measurement system (ORYX) data, OCS data, and bring this information out at staff meetings. We address problems areas head on. What we do daily didn't change. We always evaluate ourselves. When dyspnea was a problem, we did in-service training. We had OTs talk about energy conservation and had an equipment company representative come in to do some education. This helped us standardize respiratory assessments within and across disciplines—make sure everyone interpreting assessment the same way. We increased OT visits to teach energy conservation. We realized that we had OT in too early when the patient was still recovering and decided to change the timing of OT visits. Better to get PTs in early; then, get OTs in later once the patient is feeling better.

2. The Carescribe program is homegrown to Adventist. Used to collect OASIS via SmartPhone. This has really cut out manpower hours to compare data and to do data entry. By having the information aggregated in one area—we can look at how OASIS is collected differently by nursing vs. therapy.

3. We now don't discharge patient until the end of certification period (60 days). After the specific care needs for the patient end, we place the patient "on hold" until day 50-55; then, we do one last visit for the discharge. This helps us show better outcomes. Also, we tell the patient that we want to do a discharge visit. If patient no longer homebound, then we do a non-billable visit.

4. Only way that P4P has affected processes is that it has helped identify other areas to focus on for improvement. For example, we wondered why we had low rates of Discharged to Community. Often doctors discharge the patient and don't tell us. Then, our patients "on hold" awaiting a discharge visit were on record for hospitalization. We changed our processes to identify discharge status based on last home care visit.

5. We do better than other agencies on 10 out of the 12 of the P4P indicators. We decided to look at the Improvement in Urinary Incontinence outcome. Before, we didn't think that we could really improve incontinence, but we are now looking at continence restoration and timed voiding. We had an expert urinary and gynecological problems come in and give an in-service.

6. We tried telehealth units but did not find that they decreased hospitalization. We had a problem with doctors not wanting to intervene but used the printouts as justification to admit the pt to acute care. (Note: doctors (MDs) get better reimbursement for acute care services.) There were other issues with the patients using the units (e.g., hand-eye coordination, privacy issues, etc.)

7. We have added staff member with a Masters in Social Work to increase patient/family support. This has decreased hospitalization. We get the social workers (SW) in before issues get out of hand. Every clinical visitor has to voicemail their assessment to entire care team and manager within 24 hours of the visit. This helps identify problems early so we can get SW out earlier. This was not done in response to P4P participation, but generally to improve care. We identified it because of Clinical Manager (Melody) listening to reports and identifying continuous ways to improve care.

8. We have case conferences that focus on "what's challenging about this case" and "let's get on the same page" and have a team goal. Case conference format: first discuss patients needing to be recertified; second, multidisciplinary cases, then we cover any other case, tweak care plans (e.g., shouldn't go in the a.m., etc.). We do conferences every other week.

9. We call report to hospital discharge planners to give them the social/clinical heads up; let them know if this is an open antiphospholipid antibody syndrome (APS) case. This helps with transitions.

10. We recently did in-services on appropriate actions for particular type of pain. Longer-acting vs. shorter-acting drugs, e.g., opiates vs. steroids vs. NSAIDS. Describe detailed pain (pounding, tingling, etc.).

11. We do a lot of wound visits and weren't seeing great outcomes. We called the wound care product vendors and they came in and gave in-services and let us try out the products. Some of our MDs also came in to see the products. We now use the more high-end products but have seen a big difference in wound healing. We were able to "heal" four Stage 4 pressure ulcers in a bedbound patient with incontinence. We also now are able to identify the best products for different types of wounds (e.g., pressure ulcers, venous stasis ulcers) and have done MD

education. Because the products are so much better, we don't have to do daily visits—average # visits for wound patients is 16 vs. 22 like it was.

12. We don't wait to make changes. When we identify a problem, we get on it right away.

13. We also have staff look at their own records during clinical record review. They are more critical of themselves.

14. The Administrator (Susan) has to report to the hospital quality council. We report on why we are not seeing improvement across measures. Sometimes this is challenging because of there is a baseline that cannot change (e.g., we will never prevent all hospitalizations).

15. P4P hasn't changed what we have done, but gives us additional motivation to sustain what it is we do already. If we continue to focus on improvement processes, it will pay off under P4P.

16. We have seen decreases in hospitalization rates and improvements in other outcomes.

17. Our case mix average is 1.36, aging population (mean of 75-78). Have a lot of respiratory diagnosis, lots of pulmonologists in this area. We see a lot of patients with Parkinson's, some with Multiple Sclerosis (MS), Alzheimer's. These co-morbidities make improvement very difficult.

18. If we get the incentive payment, we will celebrate successes with staff. This is part of the feedback loop.

19. If we were making recommendations to others, we would tell them: involve clinical staff, maintain open communication. Share financials, share successes. Solicit staff feedback, get buy-in; it inspires a sense of ownership and pride. The Administrator (Susan) noted that it's about processes and feedback. Prioritize processes that needs to be improved, then that builds on other processes needing improvement. Ongoing feedback to staff: employee compliment program, feedback from pt satisfaction survey, MD satisfaction survey. Everyone shares in the compliments and feedback. There are no secrets. Everyone knows, gets feedback, and is expected to give feedback. Provides checks and balances, administration and clinical, higher administrators and clerical staff. Everyone is on the same team; we don't have a clinical/administration divide.

20. It gets down to consistency in the message. Expectations don't change. Hold people accountable to expectations. We have a high caliber of people and a commitment to quality. Orientation process has to be very good. Extended

orientation, even for people with previous home care experience. Staff is cross-trained to cover for each other. Administrator who sets the stage for a commitment to quality.

Clinical Team Meeting:
Sue Martinez (Aide)
Maureen Payne (MSW)
Debbie Britton (Department secretary)
Laurie Shahrokhfar (Biller for Medicare)
Jill Miller (Secretary, POC orders, medical orders, etc.)
John Noonan (PT)
Meg Jenks (OT)
Gracie _____ (RN and now QI coordinator)
Chris Robinson (PT)
Eileen Tondreau (RN)
Maria Barsuglia (MSW)
Patty Tenney (RN)
Renee Kieselbach (OT)

1. We use voicemail a lot. Whoever sees the patient first leaves a report. Call for SW, OT, PT, etc. referral.
2. We have case conferences every two weeks. All disciplines that works with patients are here. This helps with coordination of care, troubleshooting, identification of needs/referrals.
3. The opening care provider leaves a blank calendar in the patient's home—we try to schedule visits so don't bombard pt too much on same day, patients can write in MD appointments.
4. We reconcile the medication list against MD orders at Start of Care. If question, call the MD right away if questions/concerns. We leave med sheet in the home so others can see. Give report on special meds. If the patient goes to hospital, we fax current medication list to pharmacy at whatever hospital.
5. The experience level of our staff is very high. Everyone here is doing an outstanding job. No slackers on the team, brings us all up to that level. We have high standards. There is no "my patient"; it is "our patient". We back each other up. There is excellent communication and everyone helps out. We are all cross-trained in the office for coverage in the event of absences.
6. We have a great management team. They are smart and understand the business very well and listen to questions. Expectations are high here, too.
7. Interdependency. We give information to help others do their job better. Home care is not a solo sport. There is overlap, a team approach. This enables us all see the big picture.

8. We are resilient to unexpected changes—sick leaves, difficult patient situations, etc.
9. The hospital Chief Nursing Officer (CNO) very supportive for home care, gives the Administrator (Susan) freedom to do her job.
10. 90% of time the RN opens the case. At the hospital we have home care coordinator (liaison) who helps smooth the transition. She orders equipment, etc. based on hospital team evaluation.
11. Disciplines are assigned based on patient needs. We try to get out as soon as possible after get the referral. Have to schedule visits based on patient needs and priorities.
12. The whole idea is to make patient as self-reliant as possible, whole team goal. We can't treat all the social/emotional needs during the home care episode. We really let family know that we are just passing through—get SW in to get the appropriate referrals made. We try to identify need for ongoing custodial services as early as possible, make those phone calls.
13. Quality improvement is a standing item in staff meetings. When we do clinical record review, we review our own records. We do a lot of problem solving at team meetings. OCS/ORYX quality and satisfaction data are reviewed during meetings. There are a lot of in-services and they tend to be mandatory.
14. The patient satisfaction survey was developed by corporate and benchmarked within system. Moving to a Press-Ganey survey this year, corporate-wide implementation.
15. We started looking at a trend of inappropriate discharge to home from the transitional care unit. Initiated a transitional care center (TCC) to discharge performance team. The team met every other week with the TCC team and looked at d/c process start to end. They initiated standards for discharge planning TCC to home. Now we work very closely with the TCC discharge planner to ensure that the appropriate level of care for discharge is adequately assessed.
16. What would you recommend to others? Team approach. Communication, communication, communication. Quality philosophy from top down. Ongoing staff education, keeping up with current trends. MD education (e.g., wound care). Reinforcement of best practices. Focusing on practices that work for that patient and documenting your impact.

2. Interlink Health Care, Inc. (CA)

Interlink Health Care, Inc.
February 18, 2009
Angela and Gene, Site Visitors

Management Team Meeting:
Mary Jean Guanzon (RN, Administrator)
Cristina San Nicolas (Director of Business Development)
Mary Ann Pantangco (Operations Manager)
Theresa De La Torre (Community Liaison)
Chris San Nicolas (IT Manager)
Loida Ilio (RN, Clinical Supervisor)
Glenora Mitchell (RN, Team Manager)
Dr. Rhona Kamoku (MD, Quality/Medical Director)

1. No information from Abt—no updates. The website needs to be updated. This is the second year, you can't tell what's going on, who else is participating, is there anything else I should know. The same information has been up since a year ago.
2. They use SHP for additional, more detailed analyses of performance, including benchmarking and real time data sweeping. OBQI reports are OK, but data are delayed and there are no common reasons for hospitalization. Used OCS beginning in 1999, but switched to SHP in 2006 because we knew that so many changes were coming our way (e.g., value-based purchasing) and for overall agency improvement. OCS was not sweeping data for us on home health resource grouper (HHRG) case mix points. SHP provides additional benchmarks for us. The data that SHP provides is very intuitive and can be used in the daily work we do with clients.
3. SHP allows agency to work with real time data for quality improvement. The information technology (IT) group is developing a system to track different trends with data. All staff carry Blackberries. Email is used for report and other information sharing which has been very beneficial.
4. They are developing their own electronic health records; reviewed several vendor products, but none had all they wanted.
5. All field staff use Field Force Manager software on smart phone; tracks mileage; tracks how much time with patient; includes a GPS to help locate patient homes; can communicate through it; has email capabilities. This is part of a corporate compliance program. Interlink uses the data to make sure there is sufficient time is with patient; clocks in/out. They have used this to validate (or invalidate) information/statements by patient or caretakers (e.g., didn't spend any time, wasn't there, etc.).

Administrator (Mary Jean) correction 3/6/09: The software used is Field Force Manager (FFM) application using a Blackberry phone, which creates the job assignment as approved by the Clinical Supervisor, records mileage and monitors real time arrival and departure of staff from the patient locations, as well as, use for GPS

device. The FFM provides the office mileage and real time spent with patient. This also validates confirmation of visit performed to ensure compliance with the approved frequency of visits. The FFM reduces the back office work in calculating mileage and they discontinued use of Activity Route Sheet.

6. Another electronic system, Santrack, is a telephony system used by contract personnel and aides instead of Field Force. It is used for clock-in/clock out. The contract staff calls in from the patient's land line and connects to an Interlink database.

Administrator (Mary Jean) correction 3/6/09: Santrax Data System is telephony device use for contracted and per diem staff. This allows for the agency to monitor the in/out into visit using only the patient's landline that is connected to the agency's database. Daily the Santrax is validated against the approved schedule to ensure compliance to plan of care.

7. We see patients with a variety of diagnoses, including diabetes; chronic heart failure (CHF); respiratory; post surgical (total hips), gait dysfunction. There are a lot of wound patients: infected wounds; surgical wounds, venous stasis. Patients are sicker than ever and sometimes are prematurely discharged from the hospital.
8. They are developing algorithms and clinical pathways for diabetes and CHF.
9. We really emphasize wound care. Have had numerous in-service trainings. Goal for this year is to have all RNs (and some licensed practical nurses (LPNs)) wound care certified. Tested lots of wound care products and interact with doctors re: choice and innovative use of products. Interlink HHA is known by local doctors to do well with wounds. Rapid response to wounds helps (with outcomes). We are doing fewer daily visits with innovative use of wound care products. We take pictures before and after.
10. We have seen improvement in outcomes. We plan to investigate patients visiting the ER due to wound infections. This can be complicated by docs who can be nonresponsive to suggestions about changing the approach to treatment and will wait for wound to deteriorate and then tell patient to go to emergency room (ER) or the MD's favorite wound clinic. (MDs can benefit financially from acute care reimbursement).
11. We have just made a major structural change in care delivery processes. We have created four interdisciplinary teams (RN, licensed visiting nurse (LVN), aide, PT, OT, MSW) led by RN under the overall supervision of a clinical supervisor (worked was the point of contact for all patients before). Each team manages about 60 patients. The opening RN will make recommendations for staffing, oversee the care plan and coordinate with the MD. RN will do the complex visits, intravenous-related (IV) visits, etc. The reason for the change is increasing complexity of patients and increased patient load. We had to change our business model. SHP data showed increased hospitalization and ER use and we thought we may be prematurely discharging patients. The team approach increases accountability for all professionals on team; there is much sharing of ideas from staff level. The idea for this team approach came from staff brainstorming.

12. We focus on effectiveness of interventions. We have had some concerns about pre-mature discharge for rehab patients especially—sometimes the patient went in for a MD visit after a week or so and was then referred to outpatient rehab (and were discharged from to home care), so our outcomes for rehab patients didn't look as good. This led to us to decide to frontload interventions especially PT in the first two weeks, and maybe back off some of the others license practical nurse (LPNs), OTs, etc. so patient is not overwhelmed. PT often does daily visits so that we can maximize the potential for good outcomes, especially if the doc likes to send patients to outpatient rehab too soon. (Note: this trend is interesting because the MD may have ownership in the outpatient clinic). We have to be careful that we don't overwhelm patient.
13. We have recently put a CHF program together to decrease hospitalization. It is based on nurses accurately assessing symptoms, and trying to keep the patients out of the ER. The protocol was developed with medical director input, and has assessment and visit notes designed to cue nurses to pay attention to symptoms, then a cue sheet for calling the MD. Often can give intravenous (IV) Lasix in the home instead of sending patient to ER. Hope to see a 5% reduction in hospitalization for CHF patients. We are getting as well known for CHF program as wound efforts. Interoffice communication facilitates these interventions.

Administrator (Mary Jean) correction 3/6/09: We just launch the CHF program in February and making the medical community informed of this newest program. The protocol is developed with the input of several community physicians, as well as, the medical director and quality management (QM) Director

14. Another change is rehabilitation documentation. Before, we couldn't really track improvement when reviewing clinical record. The new therapy tool helps us to quantify changes across the episode and helps us determine if we are maximizing use of therapy.
15. We have invested in Prothrombin Time and International Normalized Ratio (PT/INR) machine for use by Interlink personal; physicians like it—can get quick accurate results without hospitalization; quick intervention. We also have ordered "lab in a box"; previously had to drop off at hospital and could take 30-45 minutes per sample; now everything is in box—drop off at Fed Ex, they send it to a lab in AZ; and we get results by 11 AM next day.
16. We recognize that this is a very competitive market; declining reimbursement. We simply have to do better to be one of the HHAs that remains in business.
17. There is a cost for creating quality; the PT/INR strip is $4, but the results validate what we are doing. Quality changes are made to improve the agency and be the one that stands out in the competitive environment. P4P outcomes validate that we are moving in the right direction. We highlight our participation in marketing materials.

Administrator (Mary Jean) correction 3/6/09: Item#17: Cost of PT/INR strip is $7.00

18. Our general approach is to emphasize quality in hiring staff; greater responsibility for RNs doing their jobs. We provide extensive staff training and continuous MD

education on what quality in HH care is. Patients tell us that we are the best one because of the knowledge of the nurses and commitment to quality.

19. There is a strong management commitment from management to quality improvement. This commitment to quality is how we are positioning ourselves for the future.
20. Fall prevention next emphasis; start with formal falls risk tool;
21. GENERAL ADVICE TO OTHER HHAS: Don't only talk it (quality), walk it and measure it; pay attention to your data;
22. This approach makes a difference in the morale of the people in the practice; "I did good for the patient"; they want to be a role model agency; this approach (when you do things right) helps retain employees.

Clinical Team Meeting:
Martha Eras (RN, Team Manager)
Rick de la Torre (LVN)
William Arnold III (LVN)
Hendrick Ganding (PT)
Daranee Kosel (RN)

Clinical managers, Administrator, and Medical Director stayed for this portion as well

1. New decentralized clinical care management system (small teams led by RN case manager) should be good. A RN Team Manager (Martha) noted that she would have more control, and this is important because she knows the patients and can follow up more closely, including making visits with other team members when this is called for. She thinks it will improve patient care, and that the continuity the new system will provide will allow her to see improvements over time. Focus of this approach is patient/family teaching and this new system will allow everyone to be on the same page. LVNs think the system will be helpful in giving them a point person who knows the patients (instead of office managers). This should improve communication.
2. Examples of communication--talk with the other case managers at regular review of patient progress (staffing) and anytime it is needed; continuity of care (team approach) with patients will be a positive;
3. Response to P4P: there maybe more work, but we will get credit/recognition for doing what we have been doing.
4. We emphasize communication—consistent response from all members of the team to the patient's needs; less missing/unknown information; information abut patient is more likely to be accurate. Technology's role in ensuring continuity care approach is important. The new team system also should help improve communication.
5. Technology eases burdens. Field Force means less paper work (time sheets, mileage, etc.) and allows us to get emails/information about patient; provides immediate contact if need assistance. Then, we still have access to email info

later for review/documentation. Everyone has a pulse oximeter. Agency provides lots of support, IT support available during the workday. There's still room for improvement—we can't wait to get our electronic medical record. RNs are providing input into electronic medical records (EMR) development.

6. Biggest challenge in P4P (and care delivery in general)? Getting families to participate, monitoring patient. Very diverse population, culture has a very important role in CA; language. Cultural sensitivity is very necessary.
7. What are expectations at staff care level? Agency supportive in staff education. Clinical team sees the support for certification in wound care in a very positive light—they really want this information and skill set. Would like to see more educational materials, e.g., education on medication lists; ability to print out meds, schedule, and "why taking" in Spanish.
8. How do you get pulled into QI activities? Staffing of patients, develop plan for them; this is a regular activity—not seen as an add-on, just the way we do things here.
9. How do processes get changed? Input from staff; management team meetings; departmental managers meet with the Administrator (Mary Jean) weekly; issues can percolate up, then brainstorm with larger staff. Management is very receptive to new ideas from everyone.
10. Perceptions about organization: always done well with wound improvement. This agency is willing to pay the price for better products; we continue to see more patients coming in with wounds.
11. State challenges will affect our agency—funding cutbacks in other support areas will increase demands on us—this is going to become big;
12. PT is done primarily by contractors (mostly from one contractor company) but contract staff are very involved. We developed a new assessment (patient progress tracking) form for PTs; this works well for them because it tracks patient progress well; try to be objective as possible. Contract staff is optimistic that the new clinical team approach will result in better communication and patient care.
13. Dr. Kamoku emphasized that the leadership (Mary Jean) is continually interested in quality; re-inventing herself; keeps everyone informed; helps other doctors better understand proper use of home health

3. Excellent Home Health Care (IL)

Excellent Home Health Care
02/25/09

Management Team Meeting:
Tessie Lising (RN, Administrator/ Director of Nursing)
Benjamin Lising (President/CFO)
Candice Calso (RN, Education/Telehealth Coordinator)
Ressie Krabacher (RPT)
Roberta Calso (Controller)
Dennis Clemente (OASIS Coordinator)
Carmelo (Milo) Ortega (Billing Consultant)

Note: Certificates of high performance displayed; have a "helping hands" logo; .

1. P4P initiatives: Three part strategic plan focusing on marketing, staffing, and health care delivery
    a. Staffing--nonclinical (admin staff; company drivers = when patient needs to be seen right away can shuttle clinical staff to them; they are regular employees. This creates multiple benefits for the clinical staff=parking, safety, location, timeliness of service.
    b. Staffing--clinical (DON, supervisors, charge nurse; primary nurses, and quality assurance (QA); all RN (no LPNs), PT, OT, Speech (both contract and fulltime); social worker; certified nursing assistant.
    c. Heath care delivery—Emphasize the use of teaching tool for both staff and patient; on-call 5:30PM-9AM RN; Technology—made large investment in telehealth; big expenditure, staffing—coordinator/monitor and staff training; focused on specific disease management (CHF, chronic obstructed pulmonary disease (COPD), and hypertension); chose Honeywell systems for measuring and monitoring vitals; visual and voice reminders/directions for patients; Screen patients for use of telehealth equip (will this work for them?); targeted the "frequent flyer" hospital people; use of telehealth monitoring can assist with patient safety (story about patient whose vitals did not arrive as expected; patient had fallen, medical personnel (called by HHA) found patient on floor).
2. What quality data sources are HHA using? Use HHC and OBQI/OBQM reports regularly; look at outcomes by patient condition groups; participated in a 2006 HHQI effort.
3. Clients—wide variety of patient diagnoses: arthritis, fractures, CHF, hypertension, bone/hip problems, post operative/surgical, cerebrovascular accident (CVA), ulcers =pressure, stasis, post-ops wounds, traumas; "We can handle anything."

4. HHA is new; only six years old. DON (administrator) is highly experienced staff nurse/lead at large hospital with a variety of units, including medical/surgical and stroke unit
5. Began by hiring the right people from the beginning; emphasized creative ideas, seminars, and education staff
6. Strategic plan: strategic marketing; DON and QA make appointments with physicians and/or discharge planners at the many hospitals in the six counties they serve. They provide information materials include brochures, Home Health Compare (HHC) results, copies of "Excellence" awards from OCS, telehealth materials and examples of patient usage.
7. Doctor involvement with telehealth: They began with doctors with whom HHA had developed a rapport. First, negotiated frequency and content of report to individual doctors—their choice/customized. Most doctors seem to choose "change in status" reporting; telehealth coordinator/QA person does weekly trending of telehealth data by patient. QA person also does follow-up phone calls to remind patients who are missing data. The data are sent by phone line to server at HHA. Since start of use (late 2006) only one doctor has discontinued use and for just one patient. They have very good success with other patients with new physicians.
8. Telehealth results: Agency staff has looked at first year results. They seem to be reducing hospitalization rate, and definitely are reducing nursing visits. Telehealth improves teaching compliance (with taking medications) with patients, especially CHF compliance issue. Patients don't like the machine to go; they like it because gives them an independence. Agency staff looks at patient vitals trends weekly. This is important and doctors report feedback as helpful also.
9. Telehealth costs: Using telehealth monitors reduces nursing visits. We balance cost of instruments vs. RN visits in first two weeks vs. 3-4 for a month with daily monitoring of vitals. Telehealth is large part of marketing. HHA recognizes that quality is an investment; there are savings and it grows/expands the business.
10. Business systems: There is an internal review system for billing issues, i.e., monitoring of billing. Supplies can be an issue, but care needs of patient come first. If there is a request for more expensive patient supply, accounting and DON discuss—DON has final say.
11. Wounds supplies: Some very expensive materials are ordered by doctors. We work with doctors to use generic medications instead of expensive ones and working vendors for other discounts.
12. Coordination of care: Scheduling visits with patient is a coordinated effort led by the primary nurse. The primary nurse is responsible to assess the energy level and physician visits of the patient for scheduling RN, PT, and other services with the patient. Primary nurse sets frequency of treatments and visit. The primary nurse can call on the charge nurse (a supervisor-level nurse). Charge nurses rotate weekly. Primary nurse can contact charge nurse by cell phone for immediate questions during patient visits. Full time primary nurses have between 15-20

patients, while part-time primary nurses have 8-10 patients assigned. Communication is described as "daily", with report at end of day with DON

13. Durable medical equipment (DME) support activities (repair/replace, etc.) are not part of clinical staff duties. More effective to hire non-clinical staff to take care of that work. RNs can focus on their clinical work. We don't have high turnover of RNs. This approach makes sense from clinician perspective.
14. Communication book: This book is kept at HHA office to log weekly comments and issues with the patient. The notes contain anything that is related to patient needs or concerns.

Clinical Team Meeting:
Tessie Lising (RN, Administrator/Director of Nursing)
Candice Calso (RN, Education/Telehealth Coordinator)
Marie Evelyn Go-Ebreo (RN, Nursing Supervisor)
Maria Gruezo (RN, Nursing Supervisor)
Philip Sangalang (RN, Charge Nurse)
Robert Constantino (RN, Visiting Nurse)
Ressie Krabacher (RPT, Visiting Therapist)

1. Assignment of primary nurse depends on address. RNs work primarily (but not exclusively) within that geographic area. There is consideration also given for RN specialty based on need of patient.
2. Primary nurse role is primary communicator with physician. If there are problems communicating with the physician, then coordinate with supervisor. This especially true if primary nurse is in the field cannot communicate with physician due to primary care nurse schedule of visits. Charge nurse is not necessarily supervisory nurse (one non-supervisory nurse shares rotation as charge nurse while awaiting supervisory credentials).
3. The DON serves as the 24-hr "on-call" nurse. Patient contact number for 24-hour service goes directly to her.
4. Full time primary nurses say their patient load is at the high end of 20-30 patients. Primary nurse choice is sometimes based on the patient preference (gender issues).
5. The primary nurse fills out form requesting other professionals and resources for their patients. The request goes to in-house administrative personnel who spread out the work and make assignments. These assignments are confirmed with supervisor and primary nurse. This information is also put in communication book and includes requests for lab work.
6. Primary nurses meet weekly (various days during week) with supervisor to review/discuss patients. Primary nurses now have regular (about quarterly) meetings that are training-oriented.
7. Focus committees: In addition to the acute care hospitalization risk committee that generated many of the actions described by the administrative team, other

committees focus on wounds, pain, falls, PT, home health aide needs, depression, infection (especially urinary tract infections (UTI)). These are multi-disciplinary teams with 2-5 members. HHA has two full-time HH aides; why only two? The Department of Aging in Illinois comes in and provides HH aide types of services and many patients have resident caregivers.

8. Clinical staff would describe response to P4P as "More of the same", with more emphasis on telehealth post-P4P.
9. Supervisors are available in office and meet with primary nurse to track/monitor patient progress and randomly call the patient. Supervisors do the patient recertification visits.
10. Clinical staff wants to be quality home health center. They noted importance/value of sharing with others regarding patients. This is done primarily through the communication folder. The supervisors and DON counseling the nurses on performance. Clinical care ideas can go to committees
11. Clinicians believe their assessment skills are getting to be higher quality. For PT only cases while the initial order may be for PT, supervisors and DON check to see if other services (e.g., social worker) are needed.
12. HHA is known for regular visits and personal approach with patients. They develop strong rapport with patients. Patients send cards and letters regarding nurses. The patients say they love their RN because the RN is compassionate, thorough, on-time, seems like family to them. Patients say "I can reach you if we need something". DON empowers RNs to do what is needed. The HHA works with some very meticulous physicians who have tried many HHAs, but they stay with them.
13. Clinical staff gets briefing quarterly on quality improvement (QI) measures. That's why they (clinical staff) stay because they have the tools they need and management support. Administration does take away non-clinical paperwork. The HHA emphasizes staff education—continuing education units (CEUs) and teleconferences, open-door forums; local conferences; OBQI information. HHA is on several list servers including from state to stay current with information. (Note: HHA did ask about the lack of updated information from Abt regarding the demonstration.)
14. Advice to other HHAs: Just do your job and stay patient-focused. Patients will recommend you to others.

4. Professional Home Health Advantage (IL)

Professional Home Health Advantage
Thursday, February 26, 2009

Management Team Meeting:
Eden Rachel P. Espina (RN, Administrator, Director of Nursing)
Antonio Espina, Jr. (Finance)
Rainelle Ranario (Accounts Manager)
Isidro Gonzales (Office Supervisor)

1. The HHA identified a problem with the number of patients going to hospital. HHA was discharging patient immediately when they go to hospital even for short stays (<24 hours) in hospital. HHA changed its policy to keep patient on books. This is now considered an ER visit (non-hospital admittance) during care episodes. Typically these are patients who were just admitted and in the first week go back to hospital. This practice of "holding open" the case was discussed at a Chicago area HHAs conference. Several HHAs discussed how they handle this situation in the manner adopted by "Professional".
2. Another frequent reason (non-first week patients) why patients were returning to hospital was because they ran out of medication and this was the easiest way for them to get their medications. When the patients were asked why they did not contact the HHA, their response was that they couldn't read the HHA's phone number on the "at home packet". HHA changed the font to a much larger size (24+) and the number of hospitalizations decreased and number of phone calls by patients to HHA increased.
3. The HHA primarily (almost exclusively) finds out about the hospitalization by asking the patient on the next regularly scheduled visit or a call to find out why they were not home for a scheduled visit. There is usually no feedback from hospital regarding the visit. Sometimes the patient goes without calling doctor.
4. HHA runs on a rather tight budget (CMS payments reconciled with cost of visits). If there is need for extra (unpaid) visits to patient, the DON (Director/Administrator) visits to stretch the patient care.
5. Patient materials: HHA provides a bright red folder with all patient information (includes thermometer) for the patient to keep at home. The HHA increased the fonts for phone number, etc. on front sticker which generated more phone calls from patients about their needs—medications, vitals ("not feeling well"), etc.
6. HHA does not use telehealth monitoring. They rely on telephone calls. HHA has received solicitations about pricing/features of telehealth. HHA's analysis of budget is that visiting is cheaper than telehealth. They do not think that patient understanding (or lack of understanding) was an issue in this decision.
7. Primary patient diagnoses are CHF, diabetes, stroke, Alzheimer's, and asthma.
8. HHA expressed a concern about the P4P demonstration and competitive nature of business. Their concern was about other HHAs that were not service oriented

(patient focused). This concern was based on reports from their patients that the patient had not received quality service from some prior (other) HHAs. When "Professional" asked the patients what they were taught about their condition, the patient reported that other HHAs just took their BP and leave. HHA doesn't see anything about what the patient was taught from patient records. The RNs at "Professional" emphasize teaching.

9. HHA clinical staff includes seven RNs plus several others part-time and no LPNs. They have both full-time and part-time PTs; full-time OT. HHA believes there is a difference in performance of full-time vs. part-time personnel
10. QI information: HHA is aware of CASPER OBQI/M reports. These are posted prominently on the bulletin board for everyone to see. The HHA worked with the Illinois Foundation for Quality Health Care (IFQHC) on benchmarks and other initiatives. HHA received reports from them quarterly. The HHA reviewed HHC reports. The DON was involved in QA before she came to this HHA.
11. Patient assignment policies: Look at patient diagnoses first, then the available (and expertise of) nurses. DON opens all patient cases and assesses all aspects--bathing, social, pain. She case manages for week; then, she turns over the case to the primary nurse. This initial information about the case improves monitoring of case once you turned it over. DON will send in PT later if patient is in pain.
12. Training of RNs: Nurses come from hospitals. DON works one-on-one and will accompany new RNs on patient visit. HHA uses a simple "look around, observe, act on observation" approach with new RNs. This means more than just writing something down. Home health RNs do interventions. It takes a year for a hospital RN to understand the role of home health nurse.
13. HHA culture: If you do your job well, there is savings. Keeping patients out of the hospital is goal, in part because there is no Low Utilization Payment Adjustment (LUPA). Administrative staff monitors numbers of patient visits to ensure that HHA meets the minimum threshold required and doesn't exceed maximum. There is regular feedback within office. Administrative staff gives reminder calls to clinical personnel in all specialties.
14. Equipment supply costs: Catheters and DME equipment costs are monitored. Supplies, especially wound care costs, are focus. HHA will suggest/use less expensive product than ordered. Doctors are receptive if they know what that we know what we are doing.
15. HHA communication with RNs in field: HHA gets phone calls from nurses to supervisors/DON in office. RNs write visit notes in patient folder that stays with patient. The patients share these notes with doctors (some require that patient brings folder to doctor visits). This is not new with P4P.
16. HHA has no big advertising budget; but, community knows them and they get many family referrals.
17. Their patients are from inner city Chicago on the south and west sides. This population is 90/10 (black/Hispanic). The new Medicare Part D has added to work load.

18. Pay for Performance initiative: If incentive helps other HHA do quality work, then it is a good thing. HHA's expectation is to be involved. They really look at what is happening with patient. Reporting alone is not going to help the patient improve. HHA has tweaked the patterns of care that they have had in response to P4P rather than needing to establish new ones. The lack of feedback thus far about their P4P performance is confusing to them.
19. Administration's focus is to give clinical what they need to do their jobs. Some of non-clinical work often assigned to clinical people is done by non-clinical people. This gives clinical people more hands on time with patients. "Professional" supports nurses with drivers for reasons of safety and parking.
20. "Professional" is a family place. They are close knit with low turnover. Employees like it here and like each other. They have lunch together and are on a first name basis. They are cross trained and have done the jobs (or at least part) of others during absences.

Clinical Team Meeting:
Eden Rachel P. Espina (Administrator, Director of Nursing)
Sonia M. Aberilla (Agency supervisor)
Christina Sunaz (PT)
Barbara Zalewski (RN)
Emilia Baltazar (RN)
Cecilia Rosadia (RN)
Angeli T. Ramos (RN-supervisor)
Laarni Sapigao (RN)
Regina Brown Stephens (RN-supervisor)

1. HHA developed critical pathway for CHF patients. This is a step-by-step aid for helping patient stay at home rather than go to hospital. This was formulated by a focus group.
2. Another focus group was on why hospitalizations increased. This was a major problem including patients never call us. The doctors just send their patients to ER. The focus group did root cause analysis of the problem and what HHA can to do solve problems. Examples of solutions included making the phone contact font big enough, including the office phone, giving out cell phone number, and increasing office hours to 8AM-4:30PM plus providing an Urgent Care contact number where someone is always available. The results show that HHA is getting more phone calls especially from patients who live by themselves. The RNs fill pill boxes for them and have patient record taking medicines.
3. For patients suspected of being early Alzheimer patients, they do the "Mini Mental" as part of comprehensive assessment. They find the key indicator is slowing down or an error when there is a transition of 10 (e.g., 90-89).
4. RN work with depression patients: RNs and PTs have conversations about patient. HHA does not specifically work in teams. RNs/PTs (or other RNs) talk before

and after care. They write the information (observations) in the patient notes, but try not to use the word "depression".

5. Patient "red" packet: Patients take to doctors' offices. The doctors read and then write their notes and even orders. Some doctors require the folder. At least one doctor writes his goals and medication changes into the care notes.
6. RNs focus on medication reconciliation. They pre-fill daily pill boxes in presence of patient. They teach patient the skills needed to help with post-home health care transition. RNs do the same with insulin, i.e., pre-fill syringes and then hide the bottle. They review medications once a week to reduce surprises when new medications are listed.
7. Basic technology used with patients includes glucometer and pulse oximeter. RNs have cell phones contact with pharmacy and doctors while with patient. One example: the RN noticed extra Lasix in medicine cabinet. The pharmacy had been making regular delivery of drug without checking to see if patient needed additional dosages. The RN called pharmacy and told them don't send until notified.
8. RNs on wounds: They focus on what works. RNs will try a treatment for a week or two and monitor progress. The HHA seems to be taking aggressive approach with daily interventions during first week or two and then less frequent intervention. They report that they try to teach family to deal with wounds. HHA uses Gentle Heal (foam dressing) with four layer that can stay on for a week. RNs perform debridement of wounds in home. The HHA uses Technicare (a surgical (antibacterial) cleansing product) to reduce infections.
9. Care process: DON goes in first, then skilled RN. The nurse supervisor in office reviews charts and contacts PT/OT. Nurses' notes are done in field and filed at office. The supervisor coordinates the care among specialties. The supervisor does the recertification with an eye toward validating the primary RNs work with patient (also does random visits). The case (primary) nurse does the Resumption of Care (ROCs) assessment.
10. HHA takes a pro-active teaching/learning approach with patients. Patients are happy to see you and patients can tell difference in "Professional's" care versus other HHAs. RNs don't need to do all the paper work. RNs can control their schedule. They like the opportunity to follow through with patient ("you can take action"; "give us the tools and we are happy campers"). RNs see their job as ensuring communication with the doctor to plan and execute the care for the patient. There is more responsibility in being a home health nurse.
11. Examples of going "above and beyond":
    a. DON known to sing to the patient to "cheer them up";
    b. lots of teaching, especially diabetes. Hospitals do not do this; they say "Your home care nurse will tell you."

c. lots elderly caregiver should also be patients. We teach them to pre-fill water jar to monitor fluid intake and how to read can goods for sodium/sugar content;

d. strong patient focus and will take a little extra time to help the patient;

e. link in family with social worker as needed; and

f. everyone cares for patient and support is always available at the office.

12. PT identifies what patient needs are at Start of Care / Resumption of Care (SOC/ROC). PT sets the frequency of visit in conjunction with RN. They look at incorporating PT functions into daily at home activities. They emphasizes multiple modalities including stationary bike.

13. HHA is improvement-oriented and uses constructive peer review. There are random reviews including quarterly patient satisfaction follow-up. Patients like this and sometimes report the random calls from the HHA as "someone called to check on you" to the RN at their next visit.

14. HHA's concern that hospitals are discharging patients too soon. The patients are not well enough resulting in many short stays in home health care before rehospitalization (<3 day LOS). Hospitals will discharge patient after one diagnosis is addressed and then readmit them for another diagnosis.

15. Clinical support: We share experiences with our colleagues. We work with new nurses (or other RNs with HHA experience) to show them how home health is done here. The supervisors go out—not just in the office. The supervisor can cover for RN if there is double duty. The RNs can call case manager to monitor cases. There are many feedback loops both administrative and clinical. Example of support: The sending of the blood draw is done by non-clinical transport and this reduces RN burden.

5. Unison Home Health Care (CT)

Unison Home Health Care
3/11/09

Management Team Meeting:
Kathleen Sierakowski (RN, Administrator/CEO)
Richard Binkowski (Business Manager/CFO)
Holly Ducot (RN, Clinical Supervisor)
Lynn Taylor (RN, Clinical Supervisor)

1. Administrator (who is an RN) makes the decisions. She makes decisions about who to accept or not accept (are they appropriate at this time for home health). We often take those patients who have called everyone else and been rejected because our name begins with "U". Costs for patient care were an issue, especially for wound care costs.
2. They believe they receive a higher percent of wound care patient referrals than other offices within area. We are known for our approach to decubitis problems. They use a combination of treatments and look to coordinate care. For difficult patients, nurses do an evaluation of patient needs even before discharge from hospital or nursing home to see if home care is appropriate, and if the patient/family is willing to accept our team approach. They make an effort at coordination of care. They have had very good success with wound/ulcer patients. An outside nursing consultant stated that our most of our patients were at a high acuity level after she reviewed our records.
3. In CT there are clinical supervisors. HHA director doesn't need to have clinical license. They believe decisions will be made differently where director is business person vs. clinical person. This impacts decisions about care giving—who to accept. They believe that business people look financials as potential costs by visit vs. by episode overall costs. This approach is short sighted. What will produce the best outcome for patient, e.g., first week visits maybe high—but then they can back off. HHA is often in contact with primary doc to suggest alternatives within care plan.
4. Wounds new treatments—new products, e.g., "Silver" dressing with anti-infection helps reduce visits. The "wet to dry" approach--while doctors like this, it is not the best for healing the wound. HHA personnel suggest new dressing alternatives to doctors. Some alternatives are associated with diabetes. In-service training given by Medical Director, wound care specialist consultant, and industry representatives on topic. Wounds are not new diagnoses but can be complicated by other illnesses. Clinical supervisor conducts the discussions with doctors on alternatives.
5. The HHA is already doing measurement of every wound in their comprehensive assessment (Briggs form). They ordered new OASIS forms just before previous OASIS change and could not return (upset by Briggs).

6. They make extensive of a holistic approach to treatment. They use a team approach with diagnoses, meals, patient vital signs, insulin pen, and skin care. They work closely with the aide, but there are lots of external realities. They (agency and state) are experiencing a nursing shortage (RNs). Many of their RNs are part-time, including the clinical supervisor; 4 RNs other office as well as LPN 1 needed in each office. Homecare regulations don't allow LPNs to do SOC/ROC. Typically, the case is opened by team nursing with supervisor or PT if PT only. Referral source is about 20% from hospital and 80% from nursing homes, community care group homes, and directly from doctors (small percent). The percentage varies by office. Many hospitals have their own HHA.
7. Many of their clients were clients of other HHAs that had either failed to help or were "put out" by HHA saying that the patient was not capable of being helped in home care setting.
8. At a Marketing meeting a Waterbury hospital said that our HHA in Waterbury "would take anything—and if they won't take them, they are not ready for home health." The same is true about the Middletown office. The HHA has few marketing artifacts. Most of the marketing is done face-to-face. The HHA develops relationships and gets referrals that way. They will take whatever is sent (and seem proud that they are willing to do this). The RN sees the patient the day of discharge as opposed to day after discharge. Both patient and HHA view this as a big positive.
9. Caregiver behavior during early days of care can be strange.
10. Quality not big focus at the HHA. They emphasize the principles of nursing standards and that is the way things are to be done at the HHA. They believe that they already have been doing these quality activities and that this is old hat. "We have been doing this for years." We get our feedback from surveyors in state and can't figure out how they are making their comments. The comments will sometimes be contradictory depending who you will be talking with from the state.
11. OBQM reports have been best resource for agency. However, the data are not current enough. The most helpful feedback is often from MD's or case managers who cite higher quality of care from Unison staff compared with other agencies.
12. Example of quality of care and making a difference where other agencies have failed: Unison got a patient what had a foot ulcer for 15 years. The plan of care focused on the patient's recovery from a hip fracture. Unison staff got the foot ulcer healed as well. They believe that some doctors are using bad practices.
13. HHA has a patient focus and care about patients.
14. Find that they get lack of quality information from various external organizations, e.g., QIOs. Qualidyme in CT QIO said HHA has terrible outcomes. However, when the HHA looks at HHC results and OBQI reports, they don't look bad. CT factors in Title 19 patients (psychiatric) into the computations. While these patients may be stable, they get worse due to aging (not skilled care to skilled care) and lower improvement rates.

15. Long-term care people often have two or three significant co-morbidities (blind, respiratory, CHF, med changes) that influence the outcomes. Often something else happens after different the patient has been discharged from hospital or nursing home. Other treatments including giving B-12 shot monthly for multiple years or monthly change of foli-catheter.
16. HHA provides constant mentoring of new RNs. They do lots of visits together. New RNs shadow other nurses until they feel able to go solo. This varies by nurse. Always new RNs spend their first week in office, then they shadow the better nurses. Watch what the home health nurse does and visit with clinical supervisor (all three offices). Most have no home care experience. It takes a good year (more than 6 months and less than 3 years) to become a good home health nurse. Supervisor will give them a couple of cases but stay on top of them for 6 months. RNs new to home health don't understand the case management piece. They need to have a plan to get them (their patient) to the next visit not just to the next shift. There is support available from clinical supervisor and multiple disciplines. All report back to supervisors for about 2 years.
17. Example of how patient and family focused the HHA is: Diabetes and wounds sometimes need to involve several family members. This requires lots of teaching and is a big issue for all concerned with the patient's care. HHA staff met with daughter, son, and doctor. They re-wrote the care directions in the speaking language of caregiver. All of the follow-up meetings (and PT and OT activities) were written down in the spoken language. Bottom line: the wound healed.
18. Communication log in house is another example of involvement. Each specialist writes notes in the communication log. Sometimes different companions of the patient also write notes. There was a daily food long for a diabetic patient. Unfortunately, the son (the caregiver) is non-compliant with nutrition. HHA's policy is to treat as individual—do what you need to do. The patient was under the care of other agency that could not handle the case, e.g., the patient was found unconscious on floor. The patient was not safe at home if they could not figure out how to control the food. The plan of care centered around the patient's meals.
19. HHA uses a formalized team/multidiscipline approach, meeting on a case-by case basis. They are very clear about putting patients on notice about what are the patient is going to be responsible for and assign accountability. At the meetings the RNs identify care plans disease processes and generate a check list of must do's. These are much more than just the parameters. For all patients: when do we notify doctor? How many pounds weight gain? We are very specific how we measure pulse-oxygen values and weight. Supervisor's job to monitor and notify doctor. No standing orders; the parameters are patient specific and by diagnosis;
20. HHA uses a "low tech, high care" approach to quality. HHA nurses are not interested in using technology. There is no telehealth monitoring. They see this as being worried about documentation of what is happening rather than quality of care given to patient. An initiative may result from different types of management. HHA focuses on getting a real "get a feel for the patient" not just the patient's numbers.

21. HHA began looking at care episodes at discharge. Why did some items (outcomes) not improve? They interviewed primary care nurse or PT about why no change—ambulation especially.
22. Supervisors do some recertification visits—and some openings. They will do validation of OASIS assessment by either simultaneous or very near-time visit and then check/compare answers.
23. Nurses and PT check different boxes on SOC/ROC especially for ambulation. There has been a more formalized interdisciplinary approach since P4P. The PTs fill out forms and send to RNs. Example of difference between the two disciplines: Assistive devices used as supporting ambulation rather than redesign the house with adaptive devices that can be found this in some houses. RNs were marking down just because the devices were in the house even if they were never used by the patient.
24. Uses an accounting wizard (local individual) to monitor visits and types of visits. The accountant matches visits to doctor order. This improves the documentation. The care plan is key. Most calls may result in an extra visit.
25. Advice to others: Follow standards of care. Just do it (provide quality care) and let everything fall where it may. The outcomes will happen. Cost should not be the first consideration. Give the patient what you need to be successful, but watch your costs. The HHA uses home health aides—but provides no homemaker services. They hire home health aide for personal care while the patient is on skilled care. Many other local HHAs were paying RNs per "visit" rather than hourly with benefits pay. Unison has always paid hourly with benefits, not "per visit". The HHA believes that the "per visit" payment of staff encourages less follow up and case management activities. There are 5 people to do the administrative tasks. Records and billing are very efficient which lowers overhead. This allows for added visits to patient by paying with lower overhead. This leads to more referrals from these patients. Rather than look at activities from an individual accounting perspective, here, we look at the patient holistically rather than at particular task.

<u>Clinical Team Meeting:</u>
Kathy Sierakowski (RN, Administrator/CEO)
Sue Killy (MSW)
Denise Laline (RN)
Holly Ducot (RN, Clinical Supervisor)
Vivian Douhart (RN)

1. General note: I noticed message on records file "No orders go in charts unsigned or with MD signature date later than 21 days of original order!" Also I noticed letter from family of patient thanking Unison for the care given to the family member. This message was posted at the entry way to the break-room that included the bathroom—high traffic area.

2. Clinicians take a very patient-centered approach to interventions. They liked the opportunity for one-on-one time with patients, meeting the families, and seeing how they live. Clinicians see many opportunity for teaching as part of what they do—"don't wear high heel clogs when you have diabetes or ambulation problems" (laughter). Work to encourage the patients (and caregivers) to change, but this is an older population who are rather set in their ways.
3. Supervisors help primary care RNs and LPNs to improve their paperwork. Recertification is done by RNs and nursing supervisor. These are easier to do if you know the patients. Initially we (other clinical members) are introduced to the patient by the primary care nurse.
4. About 10% or so of patients have bad experience with other agencies. We work like a team. RN will call in SW if there is a need. Team approach gives patient a good comfort level. Typically we work on getting everyone together (on board) early. The supervisor is very supportive.
5. Wounds: We often are dealing with chronic wounds. The focus group described situations where they have healed the wound and the patient was discharged, only to have the patient need treatment at a later point in time to heal/close the same wound that had deteriorated. Treatments of wounds are similar to nursing homes and hospitals, but the patient's bedding is different. Working with wound patients can get frustrating if patient is not cooperative, i.e., not compliance about elevation, not scratching, and diet. Unison does not have too many wound patients at this time (have had high wound census in past). Because many patients are two or more diagnosis, this creates a number of alternative approaches to try to close/heal wounds. Every patient is different and will require an individualized approach.
6. Depression: This is especially true after heart attacks. We focus of getting the patient to look at what have they done in the past. We build on their strengths. "Here is how we can help you get better." We get them involved in the community. Some patients are concerned about medication. They want to hide it and there is fear on their part. They worry about getting forgetful. We encourage them especially in assisted living settings.
7. About 1/3 of patients in assisted living situation. This can be problem for HHAs. The assisted living site tries to get patient discharge even if HHA believes patient is not ready for discharge. Unison reports that the assisted living staff frequently will interfere in patient POC, and will give incorrect "Medicare" information to patient. Also, there is an issue about the types of care given by assisted living aides vs. HHA aides.
8. Quality measures: The clinical staff seem relatively unaware what these (formal QMs) are. Their comments focus on patient feedback about the care provided by clinicians. OBQI/OBQM data are distributed to clinical supervisors at bi-weekly supervisor meeting. It is the clinical supervisor's responsibility to work with staff concerning outcomes. Unison has a "Home Health Aide of the Month" certificate presented to outstanding aides.

9. Examples of quality measures from clinician's perspective are patient comfort (controlled pain, decreased dyspnea, increased endurance/ambulation, decreased confusion, etc.), progress wound healing, meeting the patient goals matched against plan of care (POC). Clinicians are focused on needs of patient and not on formal CMS quality measures.
10. Unison does send out post-care survey. They hear from families and post letters (see my introductory note on this section). These let them know how they are doing. A patient died recently and family recognized the quality of Unison's care in the obituary.
11. Clinicians were concerned that doctors saying "go to the emergency room" seems to be on the rise. This is especially true when the primary care doctor is not around and other doctors on call are. They report that even if they looked at the patients first and report change condition to the doctor, the doctor sends the patient to the ER. Hospitals will answer "Was patient admitted to hospital?" if asked but do not volunteer information. By HHA policy, if out of home in hospital/ER, HHA will transfer patient after 23.5 hours.
12. The primary care physician loses control of patient when the hospitalists (hospital doctors / staff) take over. The hospitalists start from scratch (tests, information gathering) and then call primary physician. The primary physician is often unaware patient in hospital until we notify the physician.
13. Clinicians report in daily (typically at the end of the day) to insure continuity of care provided. They regularly check with each other, especially with other nurses and then call supervisor. This (where Unison is located) is a somewhat rural area and the clinician can get lost finding patients.
14. Use of technology: HHA does pace maker checks and uses glucometers, life alerts, Pulse Oximeter Oxygen Saturation (SpO2); vents, and respirator. They have heard about telemonitoring of patient vital signs, but believe that older folks would be intimidated by these devices. There is some use of electronic medical trays (with beeps and reminder messages), but these are not always covered costs. Medical trays are a personal (private) pay item. Sometimes HHA can get CAM (CT state agency—Department of Mental Health and Addiction Services?) to pay for this for needy patients. They have patients that they see everyday with diabetes. HHA makes use of insulin "pens" to instruct self administration of insulin.
15. Unison makes use of multi-disciplinary teams. Philosophy is to have all the players (clinical disciplines) in place to meet all if the patient's needs. They coordinate the effort both by phone and by face-to-face meetings. They take a holistic approach to patients.
16. Administrator has hospice experience and has applied that interdisciplinary approach to home care. The teamwork is both formal and informal. Sometimes everyone who is involved with a patient happens to be in office at the same time, and they share ideas about how things are going and what needs to be done next. Clinical team described the office as having strong communication.

17. Green folders (HHA information folder) and communication folder is kept in everyone's home. Everyone can write in folders as required. Also, some patients have progress charts toward goals in home. All nursing staff have parameters for all clients that are updated often by supervisor. Communication also done via email to clinical professional staff. Each nurse is given agency cell phone on hire to facilitate communication.
18. Additional examples of patient focus care: Clinical staff at Unison have patients describe what is going on with them. They focus on patient's coping skills. The elderly feel that depression is a sign of weakness. Nurse calls the doctor and asks for social work order, then social worker can go visit patient. The patients will bring their notes and weights to doctor office visits. Some doctors are requiring patients to bring their medication list. Nursing staff will fax list of vital sign, weight range or fasting blood sugar ranges, etc. to MD prior to patient MD visit.
19. Clinical philosophy: Do what we are supposed to do. We do our best. When we are stuck, we just call each other. Focus on patient and see if what we are doing is making a difference. There is an advantage of being a small agency. We follow-up with the patient. If we need an extra visit when there is a problem, we adjust. If visit is necessary, we are flexible and if the patient needs it, we do it. Communication with home health aide is also very valuable.
20. Note: Clinical staff was unaware of the HHA's participation in P4P. They seemed pleased that they were part of the "treatment" group, but were unaware until the focus group of their HHA's participation. The administrator said this was "by design". The intent was to insure incorporation of improvements in delivery of care as part of the on-going agency culture, not just for the time of project.

6. Visiting Nurses of the Lower Valley (CT)

Visiting Nurses of the Lower Valley (CT)
(03/11/09)

Management Team Meeting:
Priscilla Munro (PhD, Executive Director)
Phyllis Sedlock (RN, Director of Nursing)
Mary Beth Sebbins (RN, QI/Supervisor)
Rich Viscardi (CFO)
Maureen Hebert (Administration Supervisor)

1. Differences/Changes since the beginning of the Demonstration project: HHA has increased OT for dyspnea patients. They now use an emergent care self-triage (Green/Yellow/Red light) by providing patient with patient-specific parameters to monitor self (hard copy example). These are across all parameters and the customize this for the patient based on the doctors information. HHA began this about a year ago.
2. The self-monitoring triage idea came from QIO Qualadyme. Kathy Roby (from the QIO) provided monthly improvement programs/newsletters for HHAs. The triage idea came out of that program.
3. Falls prevention began more than a year ago, but has been re-emphasized. Fall risk using a standardized form for each patient. Do pre- analysis and post-fall evaluation if one occurs.
4. View the role of home health aide as important to success—especially for monitoring progress of patient. Visiting Nurses will score each patient to see what the home health aide need is based on OASIS items. They use their own formal scoring. If there is a need for home health aide, Visiting Nurses will contact both doctor and patient.
5. Visiting Nurses look at Adverse Events and OBQI results to monitor quality. They monitor patients at least weekly and more regularly by morning calls from primary care nurses to supervisory nurses. Visiting Nurses view themselves as a very small organization (census of about 110 Medicare). They have about a 50 mile radius in a relatively rustic setting with only one town of any size (12,000 pop.) in the area. Service is to 13 towns/villages (about 2000 - 6500 people per town/village) on both sides of river. Supervisors review plan for day and review of yesterday with the primary care nurses. The facility (a remodeled bank building) is a geographic center point and a crossroad. Lots of cell phone and voice mail interactions with primary care nurses.
6. Primary care nurses use an electronic OASIS/comprehensive assessment. There are three different people at the office (medical coder, DON, QI supervisor) who perform various elements of a quality review. The DON audits more formally about 10 assessments per month.
7. The agency case mix has become more complex. Wound, respiratory, heart, diabetes (not that much more) were mentioned as notable changes in last year.

About 1/3rd of patients are over 85. Visiting Nurse do have a steady population of orthopedic need patients.

8. Specialty changes in the past year: HHA has increased PT and OT utilization in the last year. Utilize these specialties as early intervention agents, especially at the beginning of care episodes. PT and OT personnel often called on for additional fall risk assessment. Visiting Nurses has dietician and social worker available. Nutrition consultation is often used especially for diabetes patients.
9. PT intervention at the beginning of episode is a conscious effort to prevent re-hospitalization; Visiting Nurses perspective is that the more eyes on the patient at beginning the better chance you have of preventing re-hospitalization and getting pacing of the overall intervention correct.
10. RNs and PT (manager) will open case (SOC). They make an assessment and can recommend home health aide and OT. Clinical staff focuses on pain and wounds. The nurse supervisor will be contacted for expansion of rehabilitation focus. DON and nurse supervisor have much contact with PTs and OT.
11. Visiting Nurses has lots of longevity among its FTE RNs. They are very seasoned home care professionals. Their experience and expertise sets them apart for other HHAs in the area (especially the hospital-based ones). It takes time for RNs to learn about all of community resources. Most of per diem RNs are new. It takes about six months of training to become an effective home health RN. The paperwork (completing the electronic OASIS/comprehensive assessment) "kills" them at first. Visiting Nurses currently has about 2.2 FTE RNs and need another 1.0 FTE. They back fill with per diem, but it takes about 5 "bodies" at about ½ time each to meet their need.
12. RN training: New RN orientation is about 10 hours. RNs will usually spend some time with each of the "back office" people within the organization to get an understanding of what these folks do and how it relates to their job in the field. Senior nurse supervisor shows how to do OASIS and charting. New RNs realize that we (DON, QI supervisor) are auditing records of these folks. New RNs shadow one of the nurses for about a week or so. Then, clinical supervisor goes out for first visits and then conducts reviews/debrief. Being computer savvy makes a difference (younger RNs do better than older RNs). Visiting Nurses does a fair amount of medication administration-only for some patients.
13. Visiting Nurses does no telehealth with patients (triage and personal parameters works for them). Other use of technology includes electronic OASIS/comprehensive assessment and use of Misys / All-scripts (software applications) which allows for an integrated system of data collection and billing. Visiting Nurses has used this system for about seven years (beta site).
14. We don't market. Visiting Nurses (or variations) has been around for 90 years. Physician community is stable so Visiting Nurses have established long term relationships with these doctors and medical director (geriatrician) is very influential in the community and beyond. He is also medical director of Gentiva (Rodney Hornbake). Visiting Nurses is active in the community. They visit

senior centers once a month. Visiting Nurses provides lots of support for community actions (health check ups and shots). Their patients are very savvy about health care delivery. Some patients get major surgical/internal medicine care even as far away as New York City (NYC). Visiting Nurses get referrals from NYC (Hospital for Special Surgery) and from Danbury, CT. They describe their patient population as very literate population who have resources. Visiting Nurses had interns from Yale last year and medical students from University of Connecticut. They receive town monies for medically indigent folks in the community and to conduct clinics. Visiting Nurses (through a foundation) award scholarships for local community students to enter health care with preference nursing. Visiting Nurses has a volunteer program where volunteers drive patients to doctor/bank/grocery.

15. Medical coder does internal data quality check. They can check more warnings now, especially for patients with respiratory issues. This creates an immediate feedback loop for primary care RNs.
16. Visiting Nurses' mission is to serve everyone. They will be there for everyone regardless of ability to pay. Visiting Nurses has a separate foundation to help raise funds as well as the town grant. They have had lean times in the past, but things are better now. Revenues exceed expenses. Claims are sent out quickly now (use of the integrated system) and there is a "critical mass" of patients and staff.
17. Dually eligible patients are very difficult in CT. The billing system for Medicaid in CT was described as "Byzantine".
18. Wound patients are about 5 to <10% of patients. Patient census is about 110. Visiting Nurses tries to emphasize education of both RNs and family for wound care. They have no wound care specialist, but have had local consultant who is knowledgeable of national issues work with them. HHA has no exact formulary for wound care products. They focus on patient progress. Local doctors often leave specific treatment (materials) up to Visiting Nurses. They try to move from daily visits to a few times per week using a variety of wound products based on individual needs. There is no general wound protocol.
19. Secret of success: Visiting Nurses has been very successful in recruitment of professional and administrative staff.
20. Visiting Nurses is very concerned about patients in residential care facilities (psychiatric "retirement homes" and assisted living facilities) where medication administration is an issue. They serve two facilities with a total of about 20 patients who have psychotropic drugs administered daily. The challenge is with schizophrenic patients who are supervised daily by many individuals who provided unskilled services. When these schizophrenic patients have emergent care need (toothache example), Visiting Nurses has no control of these patients going to the local emergency clinic. The same is true with doctors, especially with psychiatrists, suddenly sending their patients off to the hospital. The Visiting Nurses' ER visit rates are very high comparatively. Many of these patients are Title 19 people and transportation can be an issue also.

Clinical Team Meeting:
Priscilla Munro (PhD, Executive Director)
Phyllis Sedlock (RN, Director of Nursing)
Chris Albert (PT, PT Manager)
Angela L. Paholski (OT)
Christine Schumalke (RN)

1. Note: Clinical folks entered the management conversation at different points due to scheduling issues with patients. I tried to move/collect all of their comments here.
2. PT manager entered the conversation. He is a PT and runs a PT services company. Visiting Nurses contracts about 90% (or more) of their PT work through this company. The company has a strong reputation for excellent work.
3. RNs are older nurses. This is helpful for pulling together the POC which is the responsibility of the primary care RN. POC is reviewed by the supervisor. There is special attention to the projected total number of visits. Visiting Nurses makes an effort to front load these visits.
4. RNs make extensive use of the patient folder that contains the patient contact information with Visiting Nurses. They use big letters for primary nurse names and contact numbers. The primary nurse focuses on learning capabilities of patient and caregivers. Also, they focus on where patients are in pain management and set plan for the patients. All individuals interacting with the patient can read and place notes in the patient folder. PTs write their notes separate form. Then, the PT manager transfers this information electronically to Visiting Nurses. This allows for monitoring of progress by PT manager and by clinical supervisors.
5. The number of repeat patients tells us we are doing well. Visiting Nurses gets neighbors/family referrals which is another measure of success. Another measure is the internal monitoring of information and staff feedback. Patient feedback about quality of service via personal communication is very strong measure.
6. Professional staff is very respectful of patients ("our way"). Professional staff appreciates the opportunity for continuing education, e.g., wounds.
7. Physical therapy is utilized more and is more aggressive now (recently) than before (five years ago). Therapy begins even before the patient gets out of hospital. The therapy is delivered a lot faster and has been effective in improving health of patients more quickly.
8. Each discipline has better understanding of what the other disciplines do. This is a result of the team approach and communication. There is much more sharing of information and skill sets. The supporting disciplines form a more cohesive unit. PTs are told "you don't need to do everything and you don't need to do it all yourself—they see PT/OT (as well as nutrition, social work) as a team). This lets PT/OTs spend more one-on-one time with patients.
9. Clinical philosophy: "I am effecting a change; I am not taking care of the patient." This is true even down the home health aide level. They are not giving

bath, but helping patient progress to independent bathing. They are motivated to see the results by promoting independence. "I am a cheerleader to help you get better." The clinicians need to do it with a sense of humor. The ability of the patient to take a joke or make a joke with us a great assessment tool regarding where they are both physically and mentally. If patients are happier, they are more willing to do what you are asking them to do. Visiting Nurses tries hard to involve the family members to see how they could support the recovery/improvement process.

10. Clinicians view themselves as facilitating patient healing. They emphasized a multifaceted understanding of helping a patient. There was a very strong focus on the patient. "Use your personality motivate them (the patient) to want to be better."
11. Clinicians cited communication both internal and external with Visiting Nurses as important to success. "We are smaller and that helps us understand what everyone in the organization does." Another clinician stated that "this does not create barriers to cross-company communication—it facilitates the opportunities for communication."
12. Clinicians expressed concerns about working for too large an agency. In a bigger agency they (different clinician groups—RNs, PTs/OTs, etc.) would not see how everything works together. One clinician who worked for another larger agency indicated that s/he didn't know how things work. "You get into silos quickly in large organizations." Clinicians and management believed that there was a need for a critical mass (of patients and staff). They couldn't put a number on what that is. If an HHA is too small, that can be a problem because you are always "living on the edge". Cross training is good for business and morale. As the administrator stated, "Everyone here can wash the windows."
13. Personal note: This was the most articulate group of clinicians (could see both the big picture and immediate care delivery perspective) of the six HHAs visited.
14. Note: The clinical staff was unaware (by design per the director) of the HHA's involvement in the P4P demonstration. They seemed unfazed by the news during our focus group discussion.

7. CareSouth / Advantage Home Health Care (GA)

CareSouth/Advantage Home Health Care
Brunswick, GA
April 28, 2009

Management Team Meeting:
Mary Miller (RN, Regional CQIS)
Kathy B. Tyre (RN, Administrator)
Birgit Carreras (RN, Regional Vice President)
Betty Chokos (RN, Regional Staff Development Specialist)
Candie Tyson (RN, Patient Care Coordinator)
Diane Scott (RN, Patient Care Coordinator)
Liz Crosby (RN, Assistant Administrator)

1. We thought we would participate because we thought we could learn something new. We have been thinking about and preparing for P4P for 5-6 years now, got started when we first started hearing about it. We partnered with the Georgia Medical Care Foundation (GMCF) to look at best practices for Urinary Incontinence, management of oral meds, and to decrease acute care hospitalizations, etc. We follow the best practices that GMCF put out and track them using chart audit tools. When the P4P demonstration started, we thought it was a natural fit because of our preparations.
2. Falls risk and hospitalization risk tools are incorporated into admission documentation. We have teaching packets for diabetic patients. We focus on management of oral meds and have worked on medication simplification for patients with > 8 meds and screen patients' medications using the Beers criteria. We presented this work to the hospital QI committee and they were very impressed.
3. We have a balanced scorecard for the three agencies that is generated quarterly and shared with all staff. This shows our data compared to benchmarks for goals of service, people, efficiency, access, and effectiveness. We benchmark internally (3 agencies: Brunswick, Hinesville, and Savannah) and against national norms. The report includes outcomes (OCS), human resources (HR) data, referrals received vs. those converted to admissions, patient satisfaction, and average number of visits/patient (efficiency). Outcomes are those that we anticipate may ultimately be used in a P4P system.
4. Staff development includes information on continuous quality improvement (CQI). Have been doing CQI for many years. It's integrated [into our normal work patterns]. We have patients that look at the Home Health Compare website and sometimes patients come to us from other agencies because they look up our outcomes.
5. We use outcomes for marketing. In addition to helping with referrals, it makes the physician's assistant (PAs) and MDs aware of what we look at for outcomes and keeps them on the same track—so they can look at similar outcomes.

6. We have a diverse patient population, but no pediatrics or maternity. There are lots of wound patients. We do palliative care. Payer mix is approximately 74% Medicare and 2% Medicaid and 23.5% private pay. There is a large migrant population here. We use telephones that provide translation when language barrier exists (blue phones). We have a very diverse population because of living in a port city. Additionally, there are military bases in area and the migrant population mentioned previously.
7. Case mix reports shows 42% of patients with surgical wounds. Our staff development nurse has an intensive knowledge of wound care. The Regional Staff Development Specialist (Betty) does training and investigates new products. She also consults for field staff and will go out to see patients if needed. All new employees have to participate in a wound assessment class and do a 4 hour rotation in a wound and hyperbaric treatment clinic. A new notebook [of wound care protocols] is in development and will be distributed to all staff.
8. We use PtCT/Meditech on laptops for clinical charting. All staff including therapists and aides uses the laptops. All staff members are provided with cellular phones, pulse oximeters, and glucometers. Nurses carry PT/INR analyzers. We are working with a consultant from Auburn University who is looking at the technology we have to help us to maximize uses for the data we collect. We are looking into upgrading phones to use to take photos of wounds, and technology to electronically send orders to MD/electronic signatures. We are also looking at purchasing portable scanner/copiers for staff.
9. We have 34 telehealth units (Well-at-Home) across the three agencies; 11 at CareSouth/Advantage in Brunswick. We have calculated a ROI for them and [by using them], we are reducing hospital rates. We began using them mostly for the CHF patients but now use them for patients who are at high risk for hospitalizations. We also have a telephone call program for patients that can't handle the telehealth units. If we assess a patient at high risk for hospitalization, we call in between visits and check on their symptoms, weights, to make sure they took their medications, etc.
10. We are paperless except for the forms requiring signature (consent forms and signed copies of MD orders). The surveyors have gotten used to doing surveys this way. We had a deficiency-free survey last year.
11. We front-load visits in the first three weeks for patients at high risk for hospitalization.
12. We use "Situation, Background, Assessment, and Recommendation" (SBAR) forms for communication with physician via fax. We marketed this concept to the MDs and they have been very receptive. This helps minimize back and forth phone calls.
13. Staff retention is very high at 93% across the three agencies. We had staffing needs for PT, but put together a recruitment/retention strategy and now we have 4 full-time therapists. Being fully staffed definitely affects our outcomes

[positively]. We have a heavy rehabilitation emphasis—on OT as well. If a patient has activities of daily living (ADL) problems, they get an aide and an OT.

14. We notified staff that we were participating in the project. Then we found out we were in the control group so we pretty much forgot about it. [EDITOR NOTE: This agency was known as St. Joseph's / Candler Home Healthcare, Inc. at the beginning of the P4P Demonstration and was assigned originally to the "treatment" condition according to the listing provided by Abt Associates, Inc. on 02/11/09.] These changes we made are not really in response to participation in the 2 year demonstration. We have had this focus on quality for a long time. We work on staff needs, those aspects of care affecting our patient population, new treatments and ideas, and chart audit findings as part of the staff development process. We have weekly and informal staff meetings/case conferences. We publish a monthly intra-agency newsletter "Smart News" and sometimes use that forum to reinforce clinical topics covered in staff meeting. We post all kinds of information (i.e., audit results, patient satisfaction survey results, etc.) in the bathroom. We have storyboards of our QI studies.
15. Our patient care coordinators are clinical experts who provide support to field staff and do visits if needed.
16. We emphasize close monitoring of quality data: tracking outcomes, clinical record audits, satisfaction data, etc. We also listen closely for issues that are identified informally—phone conversations, etc.
17. We audit every SOC/ROC, recertification and discharge. We manually audit the records and track findings monthly. We follow up with the field staff monthly if problems are identified. We track all the Joint Commission for the Accreditation of Hospitals Organization (JCAHO) regulations and the National Patient Safety Goals. At times, clinicians participate in clinical record review.
18. Participation in the P4P demonstration has had no financial impacts. We already had processes in place. We believe that if you process your data and make changes early for potential problems, you will save money.
19. The only information we got about the P4P demonstration was the introductory letter. No comments on P4P materials.

<u>Clinical Team Meeting</u>:
Loretta Mitchell (RN)
Terri Rozier (RN)
Anna Hennen (RN)
Jeff Turk (PT)
Ginger Luke (PT)
Mary Hanson (OTR)
Management staff participated as well

1. The P4P demonstration participation was announced at a staff meeting. We first thought it might be a lot more work/documentation for us. But that isn't the case.

We just went on with our jobs. We had pretty much forgotten about it until we heard you were coming. It hasn't affected the way we do our jobs or our patients.

2. We focus on outcomes: The Regional CQIS (Mary) has a packet of best practices that we use. There's a big focus on patient/family participation [e.g., for avoiding re-hospitalization].
3. An RN goes out to do the first visit, even for a therapy-only case. Our staff members work together as a team. RNs identify therapy needs and vice versa. Frequencies are set up for patients and we can identify high-risk populations [using hosp. risk tool.]
4. We use technology (laptops, cell phones, etc.) [that are provided by the agency]. I don't know how we did our jobs before. The phones are helpful in coordinating patient care, allow for impromptu care conferences, etc. The laptops help by allowing us to see what happened in previous visits, vital sign trends, etc. It has improved our care. Pathways prompt you to document everything and cue your clinical interventions. You can't overlook anything. The laptops provide more guidance for care.
5. We document toward goals. We have to document patient teaching and discharge planning, and progress toward goals on every visit. Teaching on safety, diet, care management, etc. Our visits are very focused.
6. We have access to resources like teaching tools. We use the Zone Tool guides to help patients identify symptoms and how to respond. The teaching guides for patients are very simple and use a lot of pictures. These are left in the patient's home for their reference.
7. We front-load visits for high-risk patients. It does affect outcomes. We customize our care to the patient needs—sometimes the high-priority problems are education/problem-solving (e.g., how to I get to the bathroom safely), and we focus on those problems up-front.
8. At staff meetings, we get an update on chart audits, updates on QI programs, scorecard reports. The reports: state reports, OCS reports, satisfaction reports are also put in mailboxes, in bathrooms, etc. It helps to know the comparisons/benchmarks. GA Medical Care Foundation named us the best agency in GA twice—we even got a trophy!
9. We have a very strong management team. They work very hard and are experts. We have high-quality employees. We take a lot of pride in the work we do and want to excel. There is very little staff turnover.
10. The focus here is on patient care. We do the right thing even if it's not the best financial [choice]. This company lets you do your best job. They provide us with the equipment and resources. We can set up resources for patients for long-term needs.
11. All disciplines work together to meet patient needs.

12. We see lots of CABG patients, knee and hip replacements, wounds. We have a very focused pathway for pressure ulcer patients. Use a variety of dressings: Dakins, duoderm, wound vacuums, silver, Kaldostat, honey, hydrophera blue.
13. We've been working on hospital risk for 2-3 years. We use the Morse scale for falls risk. For patients with more than 8 medications, we have medication simplification protocols. Because, if the patient is on more than 8 medications, they are less likely to be compliant. The nurses do the medication regimen review, then contact the MD for every patient.
14. SBAR is working well. It helps to keep track of the communication. Faxing the SBAR is easier than calling and you don't have to worry about return calls when you are in another patient's home.
15. Concerns about P4P system: We hear of other agencies with outcomes that go from low to very high in a short period of time. We wonder if they are "cooking books." GA is a Certificate of Need (CON) state---outcomes should be part of a decision to award a CON. We would like to know how much time is spent in the home for each type of assessment on average. We estimate but this is really unknown. Our average productivity is 5.5. (required productivity is 7.2). We would like benchmark results for this from other agencies—and it should take into account if the agency is computerized or not. We would like to see outcome findings for agencies with different productivity expectations.
16. Would be nice to see infection rates included with other outcomes.

8. Maury Regional Home Health (TN)

Maury Regional Home Health
Columbia, TN
June 2, 2009

Management Team Meeting:
Debbie Bratton (RN, Director)
Freda Bennett (RN, PI/Education Coordinator)
Cheryl Morrison (I.S./Business Manager)
Rosemary Edmonds (RN, Clinical Director)
Sharon Foster (RN, Care Manager)
(NOTE: due to scheduling issues this meeting was actually held after the Clinical Team Meeting. In all other site visits, the Management Team Meeting occurred first, followed by the Clinical Team Meeting.)

1. We decided to participate in the project because we figured, "Why not?" We already were looking closely at outcomes. We informed the hospital but didn't really need their permission. We got a letter from Abt but haven't really gotten any more information. We haven't accessed the Web site.
2. Participation hasn't really affected us. Outcomes have always been high on our list of things to pay attention to. Some things have changed but it's been more an evolution vs. changes made in response to demonstration participation.
3. Over the past year, there have been some changes to get leaner and more focused. Case conferences now specifically look at progress toward goals. Staff call the care manager at days 15, 30, 45, etc. after admission to monitor progress and discuss goals and the plan of care, determine if service intensity is still appropriate, etc. Patients are not discharged until the clinical staff has had communication with the care manager.
4. For monthly conferences, everyone gets into teams and discusses patients. Because we work in geographic teams, mostly the same team sees a patient, although if not then the team member goes to meet with another team to discuss those patients.
5. Therapists have really worked on clearly documenting progress toward goals throughout the episode of care.
6. We focus heavily on OASIS education. We have an individual specifically devoted to OASIS data accuracy/data quality. This is really helpful.
7. Outcomes are discussed in staff meetings. We audit 100% of charts for patients who do not meeting outcomes for improvement. When doing this, we can often find trends and areas to improve.
8. We use the SHP system which checks all OASIS data and sends daily alerts that we follow up on.

9. There is a SEEK-team (internal improvement team that uses the Plan, Do, Check, Act (PDCA) methodology) looking at acute care hospitalizations. The risk assessment is performed on admission and if the patient scores at a certain level, the social worker contacts them 3 times per week until discharge, unless the patient requests not to be called. This helps us identify if there is a need for additional clinical visits or phone consultation.
10. We looked at pain and did multiple in-services on pain assessment and pain interventions. We monitor those outcomes closely. We looked at dyspnea and provided in-services. We are doing the timed "get up and go" assessments. We do falls risk assessments. The Braden assessment for pressure ulcer risk is on every visit note.
11. We have a wound nurse, so get a lot of wound patients. We get a lot of the TennCare (State of Tennessee equivalent of Medicaid) patients that others won't take (about 10% or so TennCare). TennCare will only approve a few visits. We also see a lot of Medicare managed care patients. This is reflected in our outcomes. We see a lot of self-pay patients.
12. The OASIS question on surgical wounds is not great; you can't show improvement with port-a-catheter patients.
13. The outcome of incontinence is difficult to improve. These patients are older and we generally don't see them for very long.
14. We get dinged for scheduled surgeries. This shouldn't count as an acute care hospitalization outcome.
15. We are a lean office team. There is very little administrative turnover.
16. We have a lot of longevity on the clinical team; little turnover. They are really good and listen a lot. They are very interested in providing good care. It's a give-give situation between management and field staff.
17. From a business management perspective, we are always looking at ways to do things more efficiently. We will be changing our payment system to a per visit payment for our staff (instead of full-time, etc.). Currently productivity is 28 visits/week and we will be going to 30 visits/week. But the visits are weighted (i.e., SOC counts as 2) and they will be getting visit credit for staff meetings, etc. We are also looking at providing incentives that tie into our goals for outcomes and satisfaction. So if we meet the goals, the team can get the incentive. We are also looking at individual staff incentives for outcomes [can track this with SHP]. The details aren't figured out yet; it's a work in progress.
18. OASIS completion and correctness is one of 10 key job responsibilities used for performance appraisals. Donna (the OASIS coordinator) reviews and does the follow up to track performance. We also look at timeliness of response to her questions and follow up.
19. We hope to implement a telehealth program. This will be easier if Medicare will pay for these services. The hospital is very interested, too.

20. Our staff members have pulse oximeters, digital cameras, cell phones, and laptops with wireless capabilities. We are looking at investing in PT/INR monitors. The wireless functionality has really improved their ability to access and submit information in a timely manner.
21. We use outcomes as a marketing tool, and show comparisons to competitors. The outcomes are shared with the hospital QI team.
22. Anytime we can, we send staff to training/in-services or let attend webinars, etc.
23. We do extensive OASIS training for all new staff. They all have a copy of Chapter 8 and other OASIS materials. We stay on top of updates, Questions and Answers, etc. The OASIS coordinator (Donna) goes out with them on the first visit and does an assessment, too, so that they can compare and discuss OASIS responses.
24. If we were to get incentive payments, haven't really thought about what we would do with it. Maybe put it back into the agency as a receivable, maybe share with staff.

Clinical Team Meeting: (NOTE: This meeting occurred first during the visit.)
Sharon Kimmel (PT)
Monty Lewis (PT)
Henry Canaman (PT)
Angela Harden (RN)
Jessica Gingrey (RN)
Debbie Bratton (RN, Director)

1. We learned we were participating when an announcement was made. Wondered how it would affect me (Henry). We have some concerns that OASIS questions don't allow you to show improvement, particularly the functional items.
2. Participation in the demonstration has not really affected our practice. We have always had a quality program, looked at outcomes and OASIS, etc.
3. For quality improvement programs, we have in-services and [management staff] really point out what we are striving for. For example, we are really focused on acute care hospitalizations. We front load visits. We do a risk assessment on every admission and if the score is greater than 6, then the patients are called daily to several times a week. We try to stay ahead of problems to prevent hospitalizations. We have a SEEK-team (a PDCA team) working on [preventable] hospitalizations. We believe that a fair number of rehospitalizations are due to premature discharge or lack of preparation for hospital discharge. The hospital QI committee is interested, too.
4. We aren't doing telehealth yet, but hope to soon.
5. We focus on improving functional scores, like ambulation, transferring, etc.
6. There is open communication between/among care team members. We use cell phones, [secure] email. We use McKesson Electronic Health Records on laptops, which were implemented in 2000. Wireless functionality was implemented

recently. These [tools] are really helpful when preparing to see patients. You can see the latest visit, notes in the case communication section, etc. We use the phone a lot.

7. We have monthly staff meetings, where we discuss outcomes and OASIS items. Case conferences are held via phone with the case manager for every patient at day 15, 30, 45, etc. Then, we have monthly interdisciplinary conferences.
8. We have ongoing QI projects: The SEEK-team for hospitalization, a "Strive for Excellence" committee that looks at patient satisfaction outcomes.
9. People here are very attentive to detail. All the OASIS data are checked and there's a lot of communication/follow-up if there are discrepancies or questions. There is a quality manager and an OASIS manager. We use SHP, which pulls data from McKesson and flags potential problems. The data are broken down in different ways, including by clinician, case manager, etc.
10. There is a heavy focus on doing training and in-services. If we are doing poorly in a particular area, training/education is provided.
11. There are high expectations. They [management] don't skimp anywhere. There are good people that work well together (office and field staff). They take care of things, provide support to field staff. They try to address problems proactively. Managers go out with staff to see the interactions with patients. Staff members here go above and beyond.
12. People are very organized here. The focus is on high-quality, compassionate care.
13. We have an orthopedic surgeon who wants to use us exclusively for total knees and hips. We use CHF and COPD pathways. We had a SEEK-team that developed materials for patient care education. We used to work with the TN QIO, but not any longer because the person we worked with there left. We used the "red, yellow, green" system for teaching patients when to call the MD that the QIO was using. We had some success with this approach.
14. We see lots of wounds, lots of wound vacuums. We have a certified wound nurse, now retired but who still works several days/week. She helps us manage pressure ulcers, with preventive measures, etc. We struggled a little with wound outcomes, but we probably accept more wounds and the worst wounds. We work with TennCare (no Medicaid in TN) who limits the number of visits and you can't really see improvement. There's a problem, too, with the surgical wound questions because port-a-catheters are considered surgical wounds but they never close so it looks like an unhealed wound. We see a lot of peripherally inserted central catheter (PICC) lines, do total parenteral nutrition (TPN), etc.
15. There is a lot of competition here (other home care agencies).
16. We don't really want to focus on participation in the P4P project, want to look at outcomes as always. The hospital is very quality driven, and is working on a Baldridge award. They already won a state quality award. The quality focus is at all levels of the organization.