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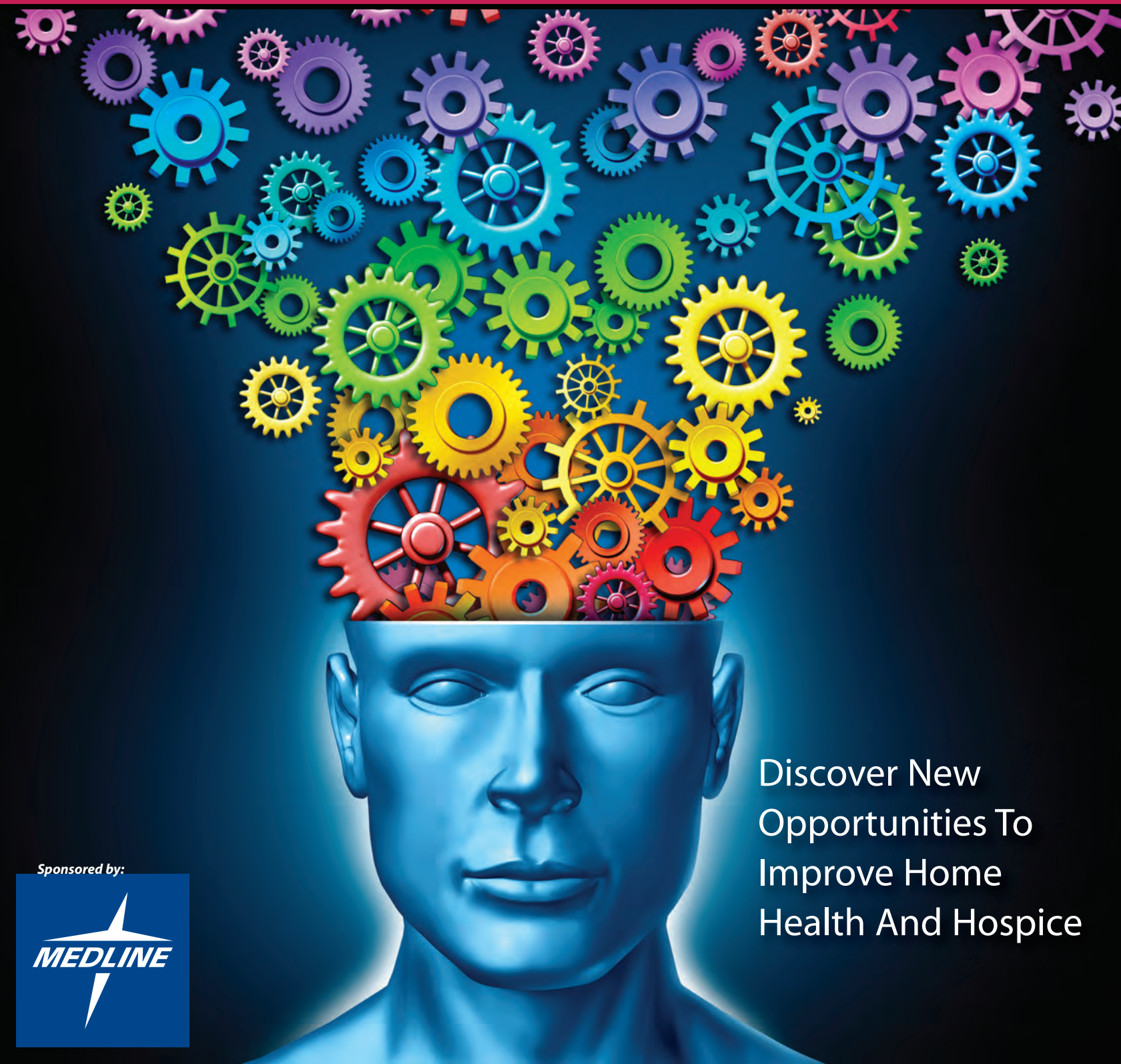

Discover New Opportunities To Improve Home Health And Hospice

Content

President's Letter

This year has brought a wave of changes to home health and hospice care. New trends present unique challenges and opportunities that drive different goals. I've spent a lot of time with agency owners, administrators, and clinicians just like you discussing the importance of managing staffing and supply costs; meeting and exceeding quality standards; preparing for the updated CMS rating system; reducing readmissions; expanding referrals; and successfully transitioning patients to their homes.

These challenges forge a path for creativity and innovation to improve Home Health and Hospice business models. This opens the door to developing new relationships with vendors that can offer solutions to create possibilities from problems.

The articles in this year's supplement are devoted to your tireless efforts to move forward in your business, both clinically and financially. Read this issue to:

- Learn about two resourceful organizations changing their business models and reaching their goals. The article, "How can Home Health Deliver More with Less?" showcases innovative ways to turn obstacles into opportunities. Presented are the details of how these agencies cost-effectively enhanced patient care and outcomes and met the demands of referral partners to reduce readmissions.
- Study an in-depth analysis of Venous Ulcer disease and its impact on your business and patients. The article, "Getting a Leg Up on Venous Ulcer Disease" has an interesting perspective on the assessment, cost, symptoms, and treatments of this prevalent clinical diagnosis in Home Care.
- Examine the phrase, never discharge in an article by Medline's Chief Nursing Officer, Martie Moore titled, "Never Discharge: Idealistic Dream or Obtainable Reality?" Find out what that means for patient transition and standardization of care.
- Discover a fresh web-based, real-time reporting tool that helps you prepare for the increased rigors of federal surveys being ramped up by the IMPACT Act and CMS Enhanced Enforcement. The article, "Are you Ready to Navigate the Changing Compliance Landscape?" highlights agencies facing potential survey deficiencies, the subsequent implications for their certification status, and how SMARTAUDIT™ helped avert heavy fines and potential financial hardship.

On behalf of everyone at Medline, thank you for the opportunity to be more than just a medical supplier, but a partner of choice to over 8,000 home health and hospice agencies nationwide. We look forward to hearing how we can help you by improving our service and your business.

Sincerely,

Michael Lee, President, Home Care
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How Can Home Health Deliver More with Less?

Article Contributors:
Charles McDonough, Administrative Director, WellSpan VNA Home Care in PA
Crystal Shepard, Agency Supervisor and DON, Willow Care in IL

Reducing healthcare costs while improving patient care is a common goal and a continuing challenge for the home health industry and the health system in general. There's certainly a lot of room for improvement. The United States has the most expensive healthcare system in the world, but is ranked last or near last on dimensions of access, efficiency and equity, according to The Commonwealth Fund's 2014 international healthcare review.[1]

In trying to improve our healthcare system, two major focus areas stand out with implications for homecare:

Preventing avoidable readmissions. An estimated 1,034,034 home health care patients were hospitalized in 2004. The national rate of unplanned hospital admissions for home health care patients has gradually increased from 27 percent in 2000 to 28 percent in 2006, and it is the only publicly reported home health care patient outcome that has never improved at the national level.[2]

The Briggs National Quality Improvement and Hospitalization Reduction Study[3] convened a panel of experts to identity best practice strategies that agencies should implement to prevent unplanned hospitalizations.

Recommended best practices included:

- Implementing a fall prevention program
- Front loading visits
- Management support
- 24-hour on-call nursing coverage
- Medication management
- Case management
- Patient/caregiver education
- Special support services
- Disease management
- Positive physician and hospital relationships
- Data-driven services
- Safety and risk assessment
- Telehealth

Standardization of care across the continuum. The aim of standardization is consistent quality patient care and cost savings to the system. The idea is that once a patient is discharged or leaves a health facility, he or she is given the same level of care, including clinical protocols and products at the next skilled nursing facility, rehab center, wound care clinic or their home. But, as Martie Moore explains in *Never*

Discharge: Idealistic Dream or Obtainable Reality? (included in this issue), establishing a standard level of care while transitioning locations is anything but easy. "One of the guiding principles underlying 'never discharge' is standardization of practice. This might be one of the most difficult areas to address within our delivery systems." She goes on to state, "This type of care would require networks of acute, home, long-term care and community-based settings to agree upon methods of communication, formularies, standards of practice and execution of care. It also would call into question our current structures of supply chain functions."

No doubt efforts to prevent readmissions and standardize care are significant challenges for homecare to tackle, especially when declining reimbursements demand agencies provide more with less. But there are home health agencies, working in creative ways with their medical supply partners, making great strides in these areas. Here are two examples:

Reducing Costs per Episode

Three years ago, WellSpan VNA Home Care, a non-profit agency serving central Pennsylvania, was looking for a supply partner that could meet their growing demands to improve overall operational efficiency, provide better patient care and help reduce their supply budget. The agency is part of WellSpan Health, a growing medical system that is acquiring surrounding hospitals and other healthcare entities, adding to the agency's already-expanding patient population.

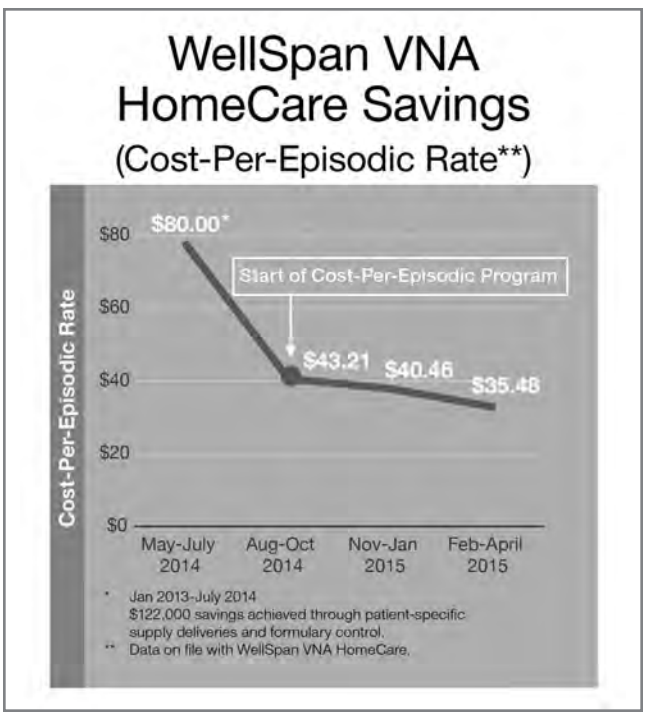
At the time, the agency's medical supply vendor was delivering products in bulk to the agency's office, where the nurse would pick the products and deliver them to the patient's home. Sometimes there was a 72-hour turnaround time from when the patient ordered the products to when they were finally delivered. Also, there was no product formulary and little control over the different types and brands of products being ordered for the various WellSpan entities. As a result, expenditures were increasing and they didn't have very efficient or advanced reporting tools to help get them under control.

To help reduce costs, streamline operations and provide enhanced distribution capabilities, WellSpan established a relationship with medical supplier Medline. The company immediately implemented its Patient Home Direct program, in which supplies are delivered directly to the patients' homes in patient-specific packages. As part of the transition to Medline, a supply formulary was developed in conjunction with Medline's clinical experts and WellSpan's nursing team. The formulary consisted of products based on WellSpan's patient demographics and diagnosis, which helped to significantly narrow down the selection of products.

Another way the agency improved efficiency was to order supplies using Medline's online ordering system. It was quicker and more accurate than their previous system and it gave them key ordering and usage data to better track and manage their expenditures.

The program went live in January 2013, when the supplies were shipped from Medline's distribution center in nearby Havre de Grace, MD and received by the patients usually within 24 hours of ordering. Since the nurses no longer had to worry about picking and delivering supplies, the agency immediately saw an increase in their productivity through making more patient visits.

Results



"Medline and our clinical team collaborated very closely to ensure we had the right supplies for the right people and to establish a program that also met our operational needs," said Charles McDonough, Administrative Director for WellSpan VNA Home Care. "In the first six months of starting the program we saved $80,000, including supply costs, mileage and the nurses' time going back and forth to deliver products to patients' homes."

During the next year, the agency saved an additional $42,000 by implementing more process improvements and refining the formulary and protocols. McDonough said they really "hit their stride" in August 2014 when he worked with Medline to develop a supply program based on a cost per episode of patient care.

"With higher reimbursement levels from commercial insurance or Medicare, everyone was going to a risk-based or value-based purchasing model. I wanted to get our supply costs from a per-order cost to a per-episode cost to reduce our spend even further," he said. "This will give us our biggest bang for our buck. I know what the government is giving us for our supplies and it's plus or minus what Medline is charging us. It really helped us get to a risk-sharing agreement between Medline and the VNA."

McDonough said the VNA was spending about $75 to $85 per episode before Medline. With Medline's risk-sharing program, the costs were reduced by 48 percent to approximately $43 per episode. Beginning in 2015, the rate was reduced another 18 percent to $35 per episode with tighter formulary controls and standardization of product and clinical protocols across all of its WellSpan entities.

"It can be really confusing for the patient and the clinician when the supplies used in the hospital are different than what the patient is being given in their home," said McDonough. "When you consider that the infection rate for wound care patients is a lot higher in the home than in the hospital, it is really important that there is continuity with product and clinical care when the patient transitions from the hospital to the home."

McDonough said that establishing a strict product formulary and care standards has been extremely successful as WellSpan acquires other hospitals and healthcare sites. "The same episodic rate and formulary can be implemented at the new sites, which help to manage our costs and at the same time provide consistent care across the system, which is really our ultimate goal."

Avoiding Readmissions with a Personal Touch

Like other managers of home care agencies around the country, Crystal Shepard, Agency Supervisor and DON for Willow Care in Plainfield, Ill., was feeling the pressure to increase the level of care with fewer financial and staffing resources.

A major goal to improving care at Willow Care is reducing avoidable hospital readmissions. But what makes this effort even more challenging is that hospitals in some cases are discharging patients when they may not be ready to come home. This is happening because hospitals are trying to reduce the length of a patient's stay in order to maximize government reimbursements. For Shepard this means her nurses are taking care of sicker patients and need to do everything they can to improve their health and keep them from returning to the hospital.

In an effort to reduce readmissions and improve overall care and efficiency, Willow Care began implementing an advanced patient monitoring system called Willow Connect. The service is not only a telehealth system to monitor a patient's vital signs from their home; it can serve as a personal assistant to help them with any of their daily needs. With a touch of a button, the patient is immediately connected to a trained professional through a cellular phone line.

The representatives are actually members of the SmartCare CST team, the service with which Medline partners to manage the system. To the patient and family members, however, they are an extension of Willow Care's staff. The phones are answered under the name of the home care agency to provide consistency and avoid confusion for the patients and families during the transition back to the home. Patients can contact Willow Connect as often as they like with questions that are health related, clinical or even social. By resolving issues over the phone, the patient doesn't have to go back to the hospital or even have a visit by an agency nurse.

"The biggest reasons for a patient to return to the hospital are 1: medication issues such as side effects or not understanding how to take them; and 2: failure to go to a follow-up doctor visit because they don't have a ride or forgot to go," said Shepard. "SmartCare can address both of these issues by proactively reaching out to the patient soon after discharge to make the follow-up appointment and arrange for the transportation or act as the gatekeeper to connect the patient with their care network."

Shepard said another example of SmartCare's benefits is for physical therapy. Patients can't go through therapy when they are in pain, so they must take medication before the therapist arrives at their house. The patient often forgets to take their medication, which delays therapy for 30 minutes or more until the medication has had time to take effect. With SmartCare, the therapist can instruct the system to call the patient to remind them to take their medication before the therapy begins, so the patient is ready to go when the therapist arrives.

Results

In the first year of using SmartCare, 88 Willow Home Care patients have used the system. There were approximately 30 avoided readmissions, which may have resulted in significant savings to the health system (see accompanying chart), and improved patient satisfaction.

Readmission Reduction Savings

	2 Day Scenario		7 Day Scenario	
Willow Home Care				
Avoided Readmissions	30		Avoided Readmissions	30
Patients on Service	88		Patients on Service	88
2 Day Costs Prevented	$128,380*		7 Day Costs Prevented	$420,580*
Current Monthly Program Cost	-$17,600		Current Monthly Program Cost	-$17,600
	88 Patients x $40 x 5 months			***88 Patients x $40 x 5 months***
Savings to Program	**$110,780**		Savings to Program	**$402,980**

If All Avoided Readmissions Had Resulted in EMS Transport and a 2- or 7-Day Hospital Stay.

*Based on an average cost of a one-day hospital stay of $2,157.
Source: Kaiser Family Foundation, http://kff.org/other/state-indicator/expenses-per-inpatient-day/

"Our referral sources (the local hospitals) really like to hear how Willow Connect can prevent readmissions and keep patients out of the hospital," said Shepard. "Prior to Willow Connect, our readmission rates were above the national average for both the ER and the hospital and now we are down to the national average. Our goal is get our rates even lower."

The agency staff has also saved significant time by having SmartCare take 93 percent of all the calls. The accompanying chart shows that only seven percent of all the calls to Willow Connect resulted in a nurse intervention. The majority of the other calls were directed to the patient's contact network (42 percent)—such as a physician or family member – or the callers were satisfied with a conversation with the SmartCare professional (19 percent) for non-emergencies like ordering a meal or arranging transportation.

Most Common Outcomes

Willow Home Care	
Intervention with Patient's Contact Network*	42%
Social Reassurance**	19%
Intervention with Patient	18%
Intervention with Nurse	7%
Emergency Services Dispatched	1%

* Patient's Contact Network includes stakeholders such as PCP, pharmacist, DME, family members, MCO, and other parties.

**Social Reassurance is characterized as general non-emergent call interactions with the Care Center (e.g., patient looking to talk to someone)

Shepard also said that another great advantage of the system is how quickly it can be set up. "With everything a nurse does in the initial visit with a new patient, including head-to-toe assessments and capturing key information, setting up SmartCare takes just a few minutes," she said. "The nurse takes the device to the patient's house and sets it up through a wireless cellular service. Once a connection is made, a SmartCare representative will call the patient to get all the vital personal information and conduct a training session with the patient, family and caregiver."

Resources:

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Getting a Leg Up on Venous Leg Ulcers

Patients with venous ulcers can be challenging to manage in the home care setting. Despite the general perception that pressure ulcers are the most common chronic wounds, lower extremity venous ulcers are actually more widespread. Venous disease affects 5% to 8% of the global population[5], with up to 3% of all adults over age 60 suffering from a venous leg ulcer[8]. These ulcers account for 70% to 90% of all lower extremity wounds with an annual incidence rate of 2.5 million, making them the most common chronic wound. In turn, this costs an estimated 2.5 to 3.5 billion dollars annually in the United States[2] and the cost of treatment to homecare as high as $27,500/ulcer[8].

Venous hypertension is the hallmark sign of venous disease and can be caused by a variety of factors such as incompetent valves, calf muscle pump failure, immobility, or hereditary conditions affecting the veins of the lower legs. The increased intraluminal pressure in the veins and capillaries leads to increased capillary permeability allowing blood, inflammatory cytokines, and protein rich plasma into the tissues. Venous hypertension eventually results in permanent damage to the veins of the lower leg and the disease process chronic venous insufficiency, or venous stasis disease. Studies have shown that on average, a patient will develop a venous ulcer within 13 years after onset of the disease[8].

Risk factors for the development of chronic venous insufficiency include history of vascular surgery, varicose veins, DVT, thrombophilia, obesity, multiple pregnancies, severe trauma to the lower leg, smoking, advanced age, calf muscle pump failure, and occupations requiring long periods of sitting or standing, such as healthcare professionals and long-haul truck drivers[5,8,4].

Venous Ulcer disease can affect many components of a homecare agency's core business, such as HHCAHPS, readmission rates, clinical performance, patient outcomes, and overall financial episodic health. Comparing clinical data is one thing; comparing clinical data with a financial aspect is completely different. Today, the homecare industry must look for vendors to be resources and experts in helping manage the most difficult of wounds, especially as length of stay trends within the acute care and long term care segments is declining. The use of reporting tools, such as Smart*Supply*™ by Strategic Healthcare Programs (SHP), helps to review both clinical and supply cost data which can reveal important facts on wound cost and subsequent clinical guidance in wound eradication.

See page 8 for details of a recent patient case study of an agency that purchases supplies from Medline Industries, identified with the assistance of SHP in a Smart*Supply*™ report.

The data analytics that point to areas for clinical improvement typically can lead to financial improvement as well. In this example, supply spend was nearly 40% below NRS reimbursement. This is a great number. However, could the patient have been better managed to avoid wound infection and deteriorating status? Should supply spend have been more to reduce clinician visits? Would more advanced dressings promote better healing and thus potentially avoid infection and emergent care? The agency caring for the above patient has an excellent record for very low emergent care cases resulting from deteriorating wound status, which takes proper training and dedication to quality. As we understand more about venous ulcer disease and other difficult wound treatment, it is imperative for home health clinicians to realize the disease process and how to best manage all facets of care.

Episode History:

SOC: 11/21/14 for patient with venous ulcer disease.
Recert: 1/19/15
Recert: 3/20/15
Tf: 3/26/15 (Reason was EC for Wound Infection/Deteriorating Wound Status)
ROC: 4/19/15 (24 days in hospital)
Tf: 5/6/15 (Reason was EC for Wound Infection/Deteriorating Wound Status)
ROC: 5/12/15 (6 days in hospital)
Recert: 5/18/15

Supply Reimbursement:

11/21/14 – 1/18/15:.....$328.82
1/19/15 – 3/19/15:.....$328.82
3/20/15 – 5/17/15:.....$328.82
5/18/15 – CURRENT:.....$328.82

Supply Spend: $809 was the total supply spend for the 4 episodes of care through June, 2015.

Visits:

11/21/14 – 1/18/15:..... 6 Therapy, 28 Total
1/19/15 – 3/19/15:..... 0 Therapy, 17 Total
3/20/15 – 5/17/15:..... 0 Therapy, 13 Total
5/18/15 – CURRENT:..... Open Episode

Management in the Home

Management of a patient with venous leg ulcers in their home includes comprehensive assessment and treatment.

- A patient assessment reveals the causative and contributing factors, clinical signs and symptoms, in order to differentiate the underlying etiology of the ulcer.
- A physical examination of the lower extremities should be performed to assess skin condition, temperature, color, sensation, capillary refill, edema and the presence or absence of pedal pulses. However, studies show the presence or absence of a pulse is not a reliable indicator to determine adequate perfusion or the presence of peripheral arterial disease[9].
- A vascular assessment should be conducted to verify the patient's perfusion status, as up to 25% of patients will have some level of coexisting arterial insufficiency[5]. An ankle-brachial index (ABI) is a simple, non-invasive diagnostic test that can be performed in the home and has been shown to reliably predict the presence or absence of peripheral arterial disease. ABIs should be performed and documented on all patients with venous leg ulcers before initiating compression therapy[9]. An ABI of 0.8 to 1.3 indicates adequate arterial blood flow and is usually considered safe for therapeutic compression. An ABI below 0.8 indicates some level of arterial insufficiency and requires further vascular assessment.
- A comprehensive wound assessment should be routinely performed and findings documented to describe the location, size, wound edges, tissue type, and amount in the wound bed, characteristics and volume of exudate, condition of periwound skin, odor and signs of infection[9].
- Treatment of a patient with a venous leg ulcer relies on addressing the underlying disease process with a three step approach: compression, ambulation, and limb elevation[1,9,2]. Compression is the cornerstone of treatment because consistent use of compression speeds healing and can prevent or prolong the return of venous ulcers[9]. There is a variety of compression bandaging systems available. Those providing graduated compression of 35-40mmHg (beginning at the ankle) are the most effective[9].

Selecting an Appropriate Compression Bandage System

Selecting an appropriate compression bandaging system is based on the patient's perfusion status, tolerance of compression, comfort, and mobility. The use of an Unna boot, an inelastic bandage designed to support the calf muscle during ambulation, is commonly used in home care. However, it may not provide effective therapeutic compression for sedentary patients. For sedentary patients, an elastic compression bandaging system may deliver better management of chronic venous insufficiency and lead to improved healing outcomes.

In addition, newer, two layer bandaging systems offer many advantages over traditional multilayer systems. Two layer systems are cooler, more comfortable, and provide a lower, less bulky profile. Moreover, they decrease nursing application time and promote more consistent application of therapeutic compression. The ability to comfortably wear a shoe is a substantial advantage, enabling more effective ambulation and exercise of the calf muscle pump.

(continued on page 10)

HARD-TO-HEAL HAS MET ITS MATCH.

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Wound Management

Management of a venous leg ulcer presents unique challenges such as preventing and handling Periwound maceration and skin breakdown. These are typically associated with the high levels of exudate and destructive matrix metalloproteinases (MMPs). Periwound maceration has been shown to delay healing, but the use of a cyanoacrylate liquid skin protectant may prevent its occurrence and facilitate faster wound closure[3]. Super absorbent polymer dressings and rapid wicking fiber products that may be used under compression are essential tools in any formulary for the effective management of exudate and periwound skin damage. A small, single center study showed Chitosan based dressings also reduce Periwound maceration and facilitate increased healing compared to a CMC dressing in patients with bilateral venous leg ulcers[6]. Medical grade Manuka honey dressings may also be useful in promoting autolytic debridement of slough in venous ulcers and can be utilized under compression bandages.

Patient Education

Patient and caregiver education is arguably the most important component of managing a venous leg ulcer. To promote acceptance and adherence to the care plan, patient education regarding the disease process of chronic venous insufficiency is essential. Patients should be instructed on the importance of compression bandages to promote wound healing and the use of ongoing, life-long compression to prevent edema and venous ulcer recurrence. It is important to understand that Antiembolism stockings are designed to prevent venous thromboembolism (VTE), and should not be relied on for the management of edema associated with chronic venous insufficiency[9]. Patients should be encouraged to participate in physical activity as tolerated, to utilize their calf muscle pump, and to elevate their legs above the level of the heart several times a day. These activities facilitate the reduction of venous congestion and hypertension.

We know that venous ulcers heal slowly, recurring in up to 76% of patients[7]. Subsequent pain and significant morbidity accompany these wounds, adversely affecting health-related quality of life[7]. A sound understanding of the underlying disease process, systemic factors affecting healing, and evidence-based treatment is essential in achieving optimal clinical and financial outcomes when managing a patient with venous ulcers in the home. The future of wound care treatment will be more developed around the disease process, and following various guide-lines that best meet the patient's goals. One of the biggest challenges Medline sees in its understanding of countless patient records is realizing that the top 10% of patient census typically accounts for 30-50% of overall supply costs for all patients. How can we impact those patients? What wound diagnoses comprise that population? And what of the next 10% of the overall patient census – how can we collaborate clinically and with strong data to reduces the overall cost per episode, inclusive of supply costs, nurse visits, acute care admissions, and overall labor associated with the patient care under the episode?

Resources:

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NEVER DISCHARGE:
Idealistic Dream or Obtainable Reality?

Author: Martie Moore, Chief Nursing Officer, Medline Industries

In May of 2015, a large group of healthcare leaders comprised of nursing and medical officers providing services in hospital systems across the USA convened to discuss the current state of the healthcare industry and the emerging new models of delivery systems throughout the nation. The meeting, a summit hosted by The Advisory Board, a global research, technology and consulting firm, highlighted best practices for readmission strategies and standardization in practice. During the course of the discussion, a simple statement was infused into the dialogue: "Never discharge." The awkward silence that ensued seconds afterwards spoke volumes about how healthcare leaders struggle with the concept of continuation of care. The bias of episodic care has deep roots and duplicates itself silently, at times without conscious acknowledgement.

To understand why "never discharge" created tension within the room, we have to understand the meaning of discharge. The definition of the word discharge is "to unload, or relieve ones burden." When you ask healthcare providers if they "unload" their patients upon discharge, they are rightfully offended. Yet in essence, the way the current healthcare system is designed, that is what happens. We center our thinking on the acute care system, which "discharges" their patients back to home, skilled facilities, rehab and other settings of care. If you hold the definition of "discharge," patients or consumers are unloaded. Hence why the room became quiet and reflective when asked if we could create a system of never discharging.

Not surprisingly, in the mix of this discussion are consumers who feel they are swept up in the vortex of a fragmented system. They assume that care transitions are well coordinated, that critical data points and key information about their healthcare is transferred from one setting to another. They assume that the delivery system will ease their way and support them in this bewildering world of changing health status. When they realize how much is dependent upon them to assure coordination of their own or their loved ones' healthcare, they many times feel

overwhelmed and lost in the maze of episodic care. When they realize they have been "unloaded," their emotions of bewilderment, frustration and anger emerge. They are shocked at the fragmentation of the delivery system. Consumers are now channeling their emotions into advocacy and pushing for radical changes within healthcare.

The concept of "never discharge" sounds good to consumers. They want to have their healthcare be seamless and effortless. Are they idealistic dreamers or realists? Maybe a little of both, but they are the consumers and they will communicate with their purchasing power.

The influx of clinics in retail settings exemplifies this in action. On Mother's Day this year, one retail provider had 10,000 visits across its settings. This same retail provider is rapidly hitting the 25 million visit mark since opening its clinics. Within weeks, they will be launching an electronic medical record (EMR) that has connectivity to the consumer's primary care provider. They openly see themselves as partners in co-management of chronic diseases. They are actively partnering with large Integrated Delivery Networks (IDN) to create seamless streams of care, all while developing the concept of never discharging.

One of the guiding principles underlying "never discharge" is standardization of practice. This might be one of the most difficult areas to address within our delivery systems. Case in point, three major influencers of readmissions to acute care are: falls, pressure ulcers and the infectious disease diagnosis of *Clostridium difficile (C. diff)*. Here is what we know. According to the CDC, *C. diff* caused almost half a million infections among patients in the United States in a single year. Twenty-two percent of patients who develop at least one new pressure ulcer during their hospital stay will be readmitted within 30 days. Falls and injuries associated with falls consume $55 billion dollars annually in healthcare dollars. Between settings of acute, long term, home care, physician offices and assisted living, there is no agreed upon, utilized and measured standardization of practice to address these three influencers, let alone acute and chronic diseases. Each setting determines what its practice should be and changes the plan of care accordingly when the consumer presents to them for care.

Let's take this example further. Imagine an elderly woman with a history of long-term steroid usage who is malnourished from poor appetite has had several episodes of skin tears with healing. Her long-term care setting has worked hard to moisturizer her skin on a regularly scheduled basis. They have addressed her incontinence issues to keep urine and fecal matter away from her skin. They have developed a dietary plan, increasing her protein intake to help with skin health and wound healing. They have a solid plan of care and are measuring their care through assessment of her skin. She is admitted to the hospital for pneumonia. With standardization of practice and "never discharge," the plan of care for skin health, medications, products and actions would move with her virtually to the acute care setting. Any adjustments made to her care are based upon the need to adjust to *her* symptoms, not the hospital's practices, medications, products and rituals, highlighting that there is no variation between care settings. This type of care would require networks of acute, home, long-term care and community-based settings to agree upon methods of communication, formularies, standards of practice and execution of care. It also would call into question our current structures of supply chain functions.

When presented with this concept, several CEOs claimed that this was truly idealistic and they didn't believe it would happen in their lifetime. When pushed further on why, they became perplexed, and finally one brave executive stated, "It is overwhelming to even think about where to start." Interestingly enough, that is the same feeling that consumers who become patients also feel: overwhelmed with the current system that they must navigate.

"Never discharge" is not idealistic; it is obtainable and can be a new reality. It takes courage to cut the invisible rubber bands that snap all of us back into old patterns of behaviors and practice. We have to take the first step and acknowledge that the hospital is not the center of the care system. The hospital has a *placeholder* in care, but it stands equally to the placeholder of other care settings. Once we are able to look at the delivery system as equal, we can then frame a new view into focus, a view that standardizes and reduces variation across care settings; that has the consumer moving seamlessly through the system, no longer overwhelmed, bewildered or frustrated, and that never "discharges or unloads" those who are entrusting their health and well-being.

Are You Ready To Navigate The Changing Compliance Landscape?

Article Contributors: Mary Mitchell, Director of Quality, VNA Health at Home, Inc. in CT; Meredith Ferreira, Administrator, All Point Care in CT; Laurie Rockwell, Director of Quality Management and Education and Compliance Officer, VNA Community Healthcare, Inc. in CT

Today, home care is facing increasingly tighter regulatory scrutiny. Failed surveys are more common, and fines and penalties can add up for agencies that find themselves out of compliance. Why this stricter enforcement of the laws? In part it's a result of the Centers for Medicare and Medicaid Services' (CMS) new Home Health Conditions of Participation (HH CoPs). Home health and hospice agencies must meet the HH CoPs in order to participate in the Medicare program, and if they fail, risk receiving penalties ranging from fines and sanctions to full program termination.

By imposing harsher rules and tighter scrutiny, CMS is also putting "fraudsters on notice" that it will use all available tools to combat fraud, waste and abuse in the government healthcare programs – Medicare, Medicaid and Children's Health Insurance Program. CMS stated that, rather than continuing its historical method of "pay and chase," it is choosing a more preemptive approach to prevent fraud and abuse in certain high-risk areas, including home health.[1]

Agencies are subject to fines ranging from $250 to $10,000 per day for a failed survey or audit due to non-compliance. These fees do not include consulting fees that can run into the thousands of dollars for a directed plan of correction. In addition to fines, the time and resources spent to maintain accurate record reviews, stay current with regulations and prepare for state audits can be considerable.[2]

What can agencies do to keep up with constant regulatory changes and survey deficiencies? They can implement tools that that will help standardize processes and assist with survey-readiness. One of those new tools is called SMARTAUDIT™[3], a web-based compliance system to help home health and hospice agencies navigate and stay current with the regulatory environment.

A New Alternative to Ensure Complete and Accurate Record Reviews

"Prior to using SMARTAUDIT, we were using a paper system for our record reviews," said Mary Mitchell, Director of Quality for VNA Health at Home, Inc. in Watertown, CT. "It was time consuming and the reporting methodology antiquated."

Mitchell said that using a web-based system, which systematically guides the user through the record review, is far more efficient. "SMARTAUDIT's reports tell us not only how compliant an individual patient record is from a percentage standpoint – 80%, 90%, etc. – but more importantly in what areas it is not," she said. "We can then drill down in the record, read comments, analyze processes, determine where staff education is needed and develop a plan of correction."

Meredith Ferreira, Administrator at All Point Care in Cheshire, CT., said that SMARTAUDIT works really well for her because she oversees a smaller agency that does not have the dedicated staff to manage record reviews.

"We don't have a department that just handles record reviews, so SMARTAUDIT makes us more efficient and is great at catching crucial errors," said Ferreira. "For instance, all of our records were missing an important form in the admissions section, but we wouldn't have known about it if our report didn't indicate this error. By catching this deficiency we could put a plan of correction in place so that all of our nurses included that form going forward. This action prevented the auditors from finding what could have been a major error and an expensive citation."

Ferreira also said that the system is extremely easy to use and requires virtually no training. "SMARTAUDIT is an intuitive system that moves you through the documents very easily until you've completed the entire audit. When we first started using the tool, I simply showed my clinical supervisors how to get into the system and they were off and running without a lot of upfront training."

Identify Areas of Weakness to Develop Targeted Action Plans

Laurie Rockwell, Director of Quality Management and Education, and Compliance Officer at VNA Community Healthcare, Inc. based in Connecticut, finds the color-coded reports useful in identifying areas in need of improvement.

"Once the data is uploaded, the system automatically generates useful reports and dashboards that show you exactly where you stand with your compliance efforts – green means you're in compliance, yellow says you have a potential negative trend and red means you're not prepared," said Rockwell. "The system also shows you exactly

which records did not meet the standard under review. Once the reports are generated, we implement process improvement and then track our progress in the following quarters."

For instance, Rockwell said SMARTAUDIT specifically highlighted that her agency was deficient in the area of documentation of supervision of a home health aide. "The reports showed that we were falling below our benchmarks. We then drilled down further in the records and read comments and learned why we weren't at our desired levels. This evaluation led to the development of a specific plan of correction to improve our documentation."

Maintain Compliance and Avoid Penalties

"For us, the main benefit of SMARTAUDIT is that it tells us where we are – and are not – in compliance with state regulations," said Ferreira. "At a quick glance I can see where our trouble areas are and develop a plan of action to correct them. What also is very helpful is that the system is organized in the same way that the CMS surveyors audit our agency for conditions of participation, which helps us stay on track so we fulfill our CoPs and achieve a deficiency-free survey."

Last year, Ferreira said a quarterly report from SMARTAUDIT flagged a potentially large problem for her agency. "The report showed our medication reconciliation was running in the yellow, which signaled that I needed to look into that before it became a major issue," she explained. "So when we had our audit, I showed the auditors our plan of correction and that we were on track to fix it.

"SMARTAUDIT is really a compliance readiness tool," Ferreira continued. "If you are keying in accurate data and getting 100% compliance, you should get the same results when the state auditors review your documentation. The system is also updated with my state's latest regulations, so I am confident that we are remaining current with our compliance efforts."

Reduce Administration Time

Because it is a web-based tool, SMARTAUDIT creates reports instantly with real-time data to help agencies analyze and monitor their compliance status quickly and easily.

"I can pull up any section, like nursing supervision or timeliness of orders, and see how we're doing," said Ferreira. "Within minutes I have the entire year's worth of results in an easy-to-understand report with graphs and charts, which can be inserted in an annual report for our senior leadership. With our old paper system, this project would have taken hours and kept our staff from focusing on other important activities."

Performing focused audits (or reviews) is another area where a web-based tool helps agencies save time and provide comprehensive data. A focused audit allows the agency to select specific questions within the full audit to drill down on at-risk areas that have fallen below acceptable levels and perform the following tasks:

- Review the documentation of care by a specific discipline such as one or more therapies by selecting only those queries.
- Peer review.
- Monitor the progress of a post-survey plan of correction by selecting only those queries related to the citations.
- Assess an individual within an audit staff for a specific focused audit.

"When we were using a paper system, performing a focused review would take weeks and really stretch our staff time and financial resources," said Rockwell. "With SMARTAUDIT, the focused audit tool has saved us a considerable amount of staff time and helps us to identify specific individuals who might need additional education or supervision and quickly develop an effective plan of correction."

Savings with SmartAudit

(Based on reports from beta sites)

Task	Without SmartAudit	With SmartAudit	Savings*
Quality Management Auditing (average time per audit)	45 minutes	20 minutes	$40 per record
QM Quarterly Reports	8 hours	Less than one minute	$960/Quarter; $4,000/Annually
Focused Staff Remediation (on areas of deficiency)	$1,020 (based on team of 10 clinicians at $90/hr plus QM at $120/hr)	$210 (identify single staff nurse as root cause: $90/hr and QM $120/hr)	$810 (per remediation occurrence)
Plan of Correction (following unfavorable survey)	$60,000 (10 hours per week for 6-8 weeks)	$4,000 (creation of focused audit tool in 15 minutes, $30, and chart audits in 4 hours for 8 weeks, $3,840)	$56,000

*based on $120/hr for Quality Management Time

Resources:

1. http://www.nahc.org/news/why-a-check-up-on-your-home-health-compliance-plan-is-a-good-idea/
2. As reported to Qualidigm (the developers of SMARTAUDIT) by providers
3. SMARTAUDIT is developed and trademarked by Qualidigm and exclusively marketed and distributed by Medline.

MEDLINE

"When you're finished entering records, it allows rapid collation of information for a quick, detailed review and compliance analysis."

— Mary Mitchell, RN, BS,
Director of Quality,
VNA Health at Home, Inc.

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