

Data Analysis System May Not Sound Exciting, But Patient Outcomes, Bottom Line Can Be Thrilling

On October 1, 2000, without asking for it, nurses and physical therapists found themselves controlling the cash flow of Medicare-certified agencies subject to Home Health Prospective Payment. Today, from the start of care OASIS to subsequent assessments, decisions made by professionals with two letters after their name, not three, largely drive agency income and expense.

CFOs and CPAs are often relegated to recording, not controlling, financial consequences of clinical decisions made by RNs and PTs. Some agencies, however, have learned to restore balance. The artistic way these agencies derive meaning from data is worth a look, especially as home care barrels headlong toward another new era, pay-for-performance.

One such agency, Baptist Home Health Care, a component of Jacksonville, Florida's Baptist Health System, discovered a treasure buried in patient data with help from an outcomes, benchmark and web-based data analysis company, Strategic Healthcare Programs (SHP) of Santa Barbara, California. SHP's analysis systems allow Baptist to design process changes based on better-understood data. Changes implemented so far have led to bottom line and patient outcomes improvements.

According to Clinical Services Manager Michelle Robertson, when SHP data identifies specific areas in need of improvement, clinical care education and alterations in documentation and protocols can be quickly designed and applied. For example, from December, 2004 to November 2005, Baptist increased its rate of surgical wound improvement by 11% and improved wound status, a Medicare Home Health Compare measurement, by 9%.

Gleaning clues from SHP reports, Robertson offered another example, Baptist discovered a wound care issue that could be traced to documentation practices rather than clinical effectiveness. Without a uniform definition of what is or is not a wound, documentation occasionally caused a patient's condition to appear on paper to worsen when it was actually improving. "What might happen," she explained, "is that the nurse or therapist at discharge would see four wounds where the clinician who did the start of care assessment had seen one. Once the data showed us the source of the problem, we created a custom education program around a standard definition of a wound, defined standards for what should be recorded at start of care and at discharge, and thus fixed the problem."

Regulatory Compliance Manager Maureen Last added that Baptist also takes advantage of SHP's customizable report filtering, creating reports specific to

particular diagnosis groups. "We can look separately at each diagnosis group and understand our outcomes in greater detail," she said. "If we notice that one diagnosis is reporting outcomes significantly worse than average, SHP allows us to drill down further, all the way down to an individual chart, if need be, to find out why. We may find that one nurse makes the same error with every patient. Sometimes we discover a misunderstanding of one OASIS question by several nurses. It enables us to target training to a particular nurse or documentation item."

Robertson cites timeliness as SHP's premier advantage. "CMS risk-adjusted benchmarks displayed at Home Health Compare are useful," she said, "but they are always three or more months behind. Making clinical practice or agency policy adjustments that long after the fact makes it almost impossible to know which adjustments may have caused a specific positive effect. SHP data, she explained, provides the same CMS risk-adjusted benchmarks in minutes instead of months. "It applies those benchmarks to our own case mix," Robertson continued, "which is derived from the 23 primary OASIS M0 questions. It factors in other demographic data such as who a patient lives with, what level of support they enjoy from family, friends and neighbors, and then adjusts for our service area."

Simple process encourages frequent use

OASIS files are uploaded to SHP before being sent to the state. Immediately, an OASIS error report is available on the SHP web site. Any discrepancies between the assessment and plan of care discovered can be identified and edited before the state receives the file, eliminating rejections and delays. The system also compares new assessments with each patient's previous episode assessments and sends an instant alert if it discovers inconsistencies.

Once changes have been made, Baptist staff sends the OASIS file to the state, confident it will go through without incident. Visit frequencies, outcomes, rehospitalizations, fall reports and other benchmarks are then compared with averages from SHP's 1,000+ participating agencies and their millions of patient records. Sometimes the focus will be on a set of HHRGs or clinical pathways; at other times the practice of frontloading visits or excessive rehospitalizations will be highlighted.

At this level of complexity and with all these features, Robertson is often asked whether SHP use requires a great deal of training. She laughs, "My 9-year old could do it."