Sturgis Home Health Success Story

The following success story was submitted by Bruce Hoem, Director of Sturgis Home Health, a rural South Dakota home health agency. Through the implementation of their agency's plan of action on *Improvement in Use of Phone*, Sturgis Home Health watched their targeted outcome rate improve from 27.5% in July 2003 (POA implementation date) to 40.9% in February 2004 (CASPER report data).

**Plan for Improvement**

Our plan of action has been for remediation. Looking at all of our risk-adjusted outcomes, it was quite obvious to us that our clients had a considerable deficit when compared to the national reference. In fact, *Improvement in Phone Use* was our worst outcome. After examining all of the other outcomes, we decided to try and improve this outcome as we felt (because of the rural nature of our service) that it is very important that our home health clients be able to use a telephone. Our second choice for a POA was *Improvement in Confusion Frequency*, but we decided to hold any POA on that outcome until we had first discovered why we were experiencing such a low outcome with ability to use the phone. *Improvement in Confusion Frequency* will be implemented in a POA in April of 2004.

Basically, our plan to improve this outcome was twofold. First, thoroughly study MO770, the phone outcome OASIS number, to make sure that we all agreed on what MO770 was asking. Next, we wanted a plan of action that would get to the heart of the matter, so to speak, and change the outcome for our clients as quickly as possible. We certainly wanted to look better on that outcome to our peers and to SDFMC, but, more importantly, we did not want a client to be unable to use the phone when there might be something we could do to enable him or her to do so. We seemed so significantly low in this outcome that we felt we had no choice but to thoroughly examine it.

**Implement Plan Interventions**

The first thing we wanted to do was help the entire home health and rehab staff understand the OBQI process. To do this, we decided to make the process more visual. Fortunately, we had a large wall in a conference room just perfect for diagramming the entire process from beginning to end, from one side of the room to the other. This enabled all of the staff to clearly see where we were starting and where we intended to go. So, on the far left there is a square on the wall that says, "Interpret OBQI Reports," then, after that, the next square says, "Select Target Outcome," the next says, "Do Process of Care Investigation," and it continues on across the wall, following the process steps as presented in our OBQI Training Manual.

Under each heading is what we have designed to fulfill that particular step. For example, under "Write Best Clinical Practices," we wrote all our best clinical practices regarding M0770, improvement in phone use.
We then created a team to evaluate, interpret, and develop guidelines on appropriate responses to MO770. This team was multidisciplinary including PT, OT, social work, nursing as well as office staff. Noticeably missing is speech therapy, and since we do not presently have a speech therapist, it was decided we could utilize the OT more than ST, but that we could always have an adjunct ST through the speech therapy services we have access to through Rapid City Regional Hospital.

The next intervention action was for the entire staff to be educated on what the above committee felt was the appropriate way to interpret MO770. After that, the next intervention was development of our agency’s phone use assessment tool. This tool was initially designed by another multidisciplinary committee and underwent three revisions as we used it and discovered where changes or improvements needed to be made. It did not begin life as the perfect tool, and perhaps it is still not perfect, but we certainly developed it into a very serviceable tool that now seems to do the job we need it to do.

The next intervention action was another in-service for the staff, by the Director, on the overall POA, the best practices, and the assessment tool. To be sure that everybody was on the same page, a month later the Patient Care Manager did another in-service on how we had agreed, as a team, to interpret MO770.

**Findings or Results Following Implementation of Best Practices**

We have five client-focused actions listed under our best clinical practices. The first four are centered around the phone assessment tool, and the last one is finance based (i.e., does client not have a payer source for a special piece of equipment that cannot otherwise be provided). When looking at our best practices and our intervention actions together, the importance of our telephone assessment tool became very clear. That explains why it went through three modifications as we began using it with our clients. We submitted our POA in July of 2004, and by September we were evaluating our POA to see how well we were doing what we said we would do with the best clinical practices. Our first discovery was that not all clients were being assessed with our tool.

Next, with that same audit, we learned that of those that were being assessed with the tool, not all of them were being referred for follow-up as was indicated in one of the best practices. So, it was back to the drawing board to revise the tool to make it more user-friendly and then re-educate the staff on how to use the tool as well as what to do when the tool revealed a client deficit.

It became the duty of the PCM to specifically monitor the scoring of MO770 to see if the assessment tool was indicated and to see if proper occupational therapy referrals were made. With the next audit in October of 2003 we saw an improvement in the number of Medicare clients with whom the phone assessment was actually used. This was most probably due to the re-education we did and also because we revised the phone use assessment tool to make it more user-friendly. Through that audit, we also discovered that there seemed to be some confusion among the PT/RN staff on how to make an OT referral based upon their assessment findings as well as confusion among the OT staff on how to show that they responded to the referral given to them. For this reason we once again revised the phone assessment tool so that the referral
procedure was clear to all disciplines (including the needed response from OT). Since then we have steadily been making improvements.

Response to Findings

Most of our responses to findings are included in the section immediately above. However, I would add that there is one other response that we have decided we need to do. This additional response is actually something that more appropriately falls under a best practice. It is also something we will pay more attention to when we begin our next POA. Next time we will spend more time with the clients explaining why we are doing the OBQI POA in the first place. I mean, we certainly do take time to explain it, but with our next project I would want to write something up (in large, easy to read type) that explains to the client what we are really trying to achieve with our project.

I would also like to add that we found out that it is very important that we take the time to specifically look at our intervention actions from time to time just to be sure nothing is being left out. One of our PCMs discovered, after we were really going strong with the POA, that we were omitting something written in the intervention actions. We had stated we would review every patient who qualified for the phone assessment tool at the next case conference yet we were not doing this. Instead, we were talking about those patients in general as we discussed the POA or OBQI at various meetings. We quickly fixed that by listing individual patient reviews on our weekly home health meeting agendas.

Future Goals

1. Continue with current POA as a viable project through at least August of 2004. After that, continue to use the assessment tool and monitor this outcome accordingly until such time as we, as an agency, feel we have made as much impact as is reasonably possible.

2. Look for correlations with this outcome and other outcomes that may be related such as those dealing with anxiety or emergent care.

3. Work on another POA.