Ms. Chaffee met with the VNAA Operational Best Practices Work Group and responded to questions prepared by the group

1. **Mission:** Please describe the philosophy of your home health agency that contributes to your quality strategy?

Porchlight’s quality improvement journey began about 6 years ago. The agency was using an EMR where there were a lot of ‘work-arounds.’ They recognized that they needed a tool that could be programed to include all of the quality and compliance requirements and to support quality improvement. The agency switched to Homecare Homebase (HCHB) as the agency-wide EMR tool. Having a more comprehensive and functional medical record has been major contribution to their quality initiative. The EMR streamlined information management and workflow. It gave the managers the technology needed to manage.

Porchlight is a ‘patient-centered care organization.’ This has implications on how issues are prioritized. The patient is the center of care. Individuals who interact directly with patients – therapists, social workers, HHAs, and other workers are the second line; office staff are the third line. “Our mission is guided by a tradition of patient-centered care combined with clinical and technological excellence. We are dedicated to providing the highest quality services, with compassion, & respect, to our communities and home –based patients.”

2. **Data:** How do you capture performance data for internal evaluation?

The agency uses Strategic Healthcare Programs (SHP) for data analytics. (An example of an alternative vendor includes HH Gold) There are several dashboards in this tool to manage payment, clinical metrics, and regulatory requirements. Their data management process:

- Review data biweekly as team, and supervisors review it daily with SHP
- Clinical managers meet with clinicians weekly or biweekly with report card data from SHP and set improvement goals. This is labor intensive but pays off because clinicians can improve individual performance. It also improves staff retention.
- Communicate with frontline staff weekly at team meetings at each branch. QI staff person does 10-15 minute education each week based on performance and need for improvement.
- Board members get the information quarterly with outcomes from SHP and information on quality processes.
4. **Star-related QI:** Do you have any quality initiatives specifically focused on improving reportable measures:

Porchlight has implemented a number of standard processes to improve quality, and monitors to ensure that these interventions are achieving the desired goals.

**Timely initiation of care**
- All referrals seen within 24 hours. Depending on acuity, Porchlight may have an evening on call RN go out and may evaluate the patient for telemonitoring;
- If they can’t get out, they do a ‘telephone visit’ e.g. talk with the patient to see if it’s okay
- Customer service is key – they feel that it trickles into patient perception of other aspects of care

**Clinical measures**
- Porchlight is part of the VNANE clinically integrated network. They have adopted specific pathways of care that are integrated into the EMR. Clinicians then must ask questions and provide care using the same process and flow. For example, all CHF patients get frontloading of visits and telemonitoring even if it is a secondary or third level diagnosis
- Sometimes patients don’t want telemonitoring. In this case Porchlight provides education that using the telemonitoring will help the patient stay out of the hospital by doing preventive maintenance.
- The agency also conducts regular review of data with SHP to make sure they are not letting things fall through the gaps.
- Porchlight has a nurse practitioner (NP) available who can see patients in decompensation if the patient’s physician can’t see them same day. This is an important aspect of meeting clinical quality metrics, particularly readmission / ER use.

**CAHPS**
- Many aspects of their program relate to improving the patient experience of care. For example the phone call to see if the agency is meeting expectations is key.
- The agency carries out specific training of home health aides to ensure they are meeting needs because they have a major influence on patient experience

**Readmission / ER use**
- The nurse practitioner program is a major initiative to reduce hospital use.
- Telemonitoring gives the agency heads up on patients who may be at risk of rehospitalization
- Use of private pay supplemental services also contributes to readmission reduction. Patients who do not have a remaining Medicare benefit can often be transitioned to the private pay side.

5. **QI- Process changes:** To implement your QI, did you evaluate clinical and/or administrative workflows to ensure that they contribute to high performance? Did you redesign or change any workflows to better support high performance?

- The agency was able to streamline workflow through the EMR. They recognized that there is a cascade impact if any team member does not carry out required aspects of the care and
documentation process. Work impacts people downstream e.g. visit frequency must be written in so it can be scheduled. This is an order driven system in which each task leads to the next process step, and is quality checked as it is entered.

- The system is configured with prompts and hard stops so that staff realizes they need to complete certain aspects before moving on. For example, notes have to be written and completed by the PCN so that the next visit can be scheduled. The tool improves timeliness and quality of documentation.
- Redesign of the EMR impacts performance outputs – the patient record documents each quality measure and facilitates the process to ensure that the agency meets its goals.

6. **QI – data collection changes**: Did you make changes to your EMR or other record-keeping to collect data to better support performance improvement?

   - This was a very important aspect of performance improvement. The EMR capability and the functions they programmed in have helped provide a systematic approach to inputting data, which enables them to look at outputs and identify areas for improvement.

7. **QI – Training and Sustainability**: What is your basic training approach related to quality? Is there any training specific to reportable measures, e.g. training staff on implementing approaches that result in better performance on measure?

   - Each week the supervisor and clinician discuss patients and measures relating to those patients. The agency also does new skills training e.g. Oasis C1 on a regular basis

8. **Employee Engagement**: How do you engage employees to help them support your 5 star approach?

   - Employee professionalism very important in driving patient perception. Porchlight’s program to review data at the individual and organization level helps to make employees engaged and accountable. Training is another important aspect. Employees may be trained on overall competencies, or on specific issues needing remediation based on their individual performance.

9. **Patient Engagement**: how do you communicate with patients about quality or purposefully interact with patients with the intention of improving quality scores?

   - In week 1, the agency designates a QI person call every patient to discuss services. Typically this is a clinician supervisor. The call is based on “Are we meeting your expectations.” This is very valuable to uncovering issues and helping to turn around patient perceptions. Patients are very appreciative of call and the personal touch. There is so much technology now; the actual person and voice are appreciated.
   - One recurrent issue that the agency has to manage is financing of home care. There has been a major culture change in home care that not all patients and families understand. There are now significant co-pays; patients are often surprised or unhappy about having to pay. The agency may find out that the patient expects something that they are not getting. They may also learn about individual clinician performance issues. The personal phone call provides the chance to discuss financing issues and options with the patient/caregivers proactively so that there are no surprises.
• Patients also expect daily home health aides because that was common a decade ago – not routine now. Porchlight sees the call as an opportunity to educate the patient on the home health process in general, manage expectations, and help the patient finds ways to have needs / expectations met (even if it not necessarily with services provided by Porchlight).
• The call is in addition to the supervision/ observation that the agency routinely does.

10. **Costs**: What are the costs associated with being a 5 star organization? Is it more costly to achieve this level of performance?

• Costs are in time: more phone calls, more data review.
• It is relatively costly to designate clinical supervisors to make the check in phone calls, but the agency believes it is an important part of their process.
• The agency is not yet seeing changes in referral patterns or increased business as a direct result of high star ratings. The leadership believes this investment in performance will pay off over time.

11. **Accountability / Reporting**: Do you report on your performance to purchasers other than CMS, for example, insurers or hospitals? Do you expect more demand for this going forward?

• Yes! The agency looks at outcomes measures by physician practice and facility to show to these customers. The practices are surprised that VNA has the data and to see their own numbers
• Also report regionally to VNANE to show HHA outcomes performance by region
• Insurers are very pleased with data driven approach and the ability to track outcomes by region. Insurers also like VNAs using standardized, transparent clinical pathways.

12. **Barriers**: What would you identify as your greatest barriers to achieving sustained high performance? Were your QI changes designed to specifically address barriers?

• Staff turnover can be a barrier: retirement, mergers, etc. clinicians may not want to change practice when these transitions occur. Need to educate resistant staff on the why and how.

13. **Sustainability**: What actions do you take to sustain engagement and high performance over time?

• Sustainability is a product of ongoing training, communication of managers with clinicians, and having systems in place such as the EMR. For example, the QI calls still have to be made and sustained.
• They also focus on putting systems in place to sustain clinical improvements. For this they try to engage nurse practitioners and make sure they offer patients the full continuum of care.
• Porchlight has clinical staff plus homemakers, aides, and private duty. They make these staff available to patients as private pay. Staff ensures that patients know they can keep the nurse / HHA after their case is closed if they private pay. Patients like this continuity.

14. **Replicability**: What tools, resources or approaches would you specifically recommend to peers to assist them in improving performance on Star Ratings?

• In this case the Homecare Homebase (HCHB) EMR has been very important. The tool ensures more consistency across staff members and encourages the quality review on the front end.
The quality indicators must be addressed on the front end of the workload, rather than being generated retrospectively.

- SHP reporting is also a key element. SHP has a flexible reporting system that enables them to identify the reports they need overall and for specific quality improvement initiatives. This is key to understanding quality and for identifying training needs.
- Availability of the nurse practitioner to see urgent cases off hours has also been an important piece of their initiative to reduce emergency care and readmission.
- Having a continuum of home care services such as the private pay business is an essential part of the continuum.

Discussion

Q: What tools have been used to standardize clinical care and are they available?
A: The collaboratively developed VNANE pathways have been very important in standardizing clinical care. These are available to VNANE members, which is a regional membership organization. The pathways have also been a major starting source for VNAA’s Blueprint pathways.

Q: Does the contracted nurse practitioner already have an agreement with a physician supervisor?
A: No – this was something that they had to work out in order to get the nurse practitioner program up and running. The agency’s supervising physician did not want to be the supervisor. Local physicians were concerned that they would use business to the NP and were initially reluctant to collaborate. Porchlight had to educate the local practices that the NP would augment their care on evenings and weekends, prevent hospitalizations – and wouldn’t take their business. The NP got affiliated with a local practice and works there 3 days a week, at the VNA 2 days a week. This has been a major factor in preventing rehospitalizations and also in getting the docs to accept the program.

Q: Do agency nurses accept telemonitoring? It has been challenging for some agencies to incorporate this practice into appropriate cases.
A: Yes, they are very open with the nurses that this is an important revenue source and that it enables the patient to be safe when it is not cost effective to visit every day. Also it is helpful to engage the patient. This may become increasingly important as more Medicaid patients are using home care, and have very restricted reimbursement. They have been setting the telemonitoring up using IT staff and HHA’s are being trained.

Q: Is intake centralized?
A: The agency has an intake nurse in each office. Allscripts and Curespan portals from the hospitals will deliver some intakes electronically. They are looking into using HCHB as the intake management system. This may enable them to verify that necessary documentation and elements are in place using the EMR. The ability of the EMR to manage and flag information on the front end saves time on re-work at the back end if information is missing.

Q: Are clinical pathways integrated with HCHB?
A: Yes – HCHB can be customized with both clinical and social services information. For example, it can be a tool to identify social needs: low income patients can be connected with federal programs. Then they have HCHB flag need for automatic referral to the social worker. This helps to ensure patient gets connected with everything they need. Similarly each element of the clinical pathway is part of HCHB pathway. Not all agencies can do this depending on the EMR they use. Having this tool helps Porchlight standardize care.