HIM's Impact on Enhancing Data Quality and Integrity in the Home Health Setting

by Johnna M. Ervin, RRA

Home health care is not a new concept, but it is definitely an evolving one. The roots of the home care industry go back to the Visiting Nurse Associations, which appeared in the US in the late 1880s. The early Visiting Nurse Associations were charitable organizations that primarily served the urban poor.

Yet it was not until 1965 and the creation of the Medicare program that home care providers began to receive a steady source of revenue. Federal funding of home care not only helped existing Visiting Nurse Associations, but also triggered the establishment of many new home health agencies.

The next impetus to home care's steady growth was the emergence of the competitive managed care systems of the 1990s. New forces accelerated the need for more effective data and information management in home care. Prospective payment's focus on reducing the length of stay, changing consumer attitudes, and creating new standards and regulations has contributed to this recent evolution. In response, home health agencies began seeking the assistance of health information managers to create mechanisms that would effectively capture, store, and analyze data for their specific needs.

But establishing these mechanisms has been a very frustrating task at times. With no previous experience in managing health information in home health settings, both health information managers and home health agencies were often unsure of the expected information management outcomes. Like many of my HIM peers, I was not sure exactly what contributions I could make as a health information manager when I entered the home health field. However, in a short time it became very clear just how I could contribute to the management of patient and agency information. My principal duties as operations manager are to provide case management advice and supervision for coding and documentation accuracy, to convert raw data into meaningful information, and to provide education and training for diagnosis-specific documentation techniques. These duties are fulfilled by thorough, detailed record review.

A large portion of a home health agency's responsibility is to be able to provide current, valid information to the various healthcare providers involved in a patient's care. Continual monitoring of the patient's clinical record is imperative to assuring that information is complete and current.

Upon admission, a detailed review of the patient's history and current condition is accomplished by looking at the referral form, hospital records, initial nursing assessment, medication profile, and admission note. Each area includes information that is vital to ensuring that a patient's condition is thoroughly documented and subsequent goals and orders are in alignment with diagnoses, recent procedures, and medications. This information assures that appropriate services are provided in accordance with the patient's needs and builds a database of information for subsequent review.

After that, ongoing record reviews monitor completeness and consistency, which can target problem areas for improvement. Findings from these record reviews generally determine which quality improvement projects are necessary. For example, it was recently noted in my facility that home health aide assignment sheets were not being updated appropriately as physician orders changed. A team, comprising skilled nurses, the home health aide supervisor, and several home health aides, was created to improve the situation. Since the assignment form and current policy have been reviewed and found to be sufficient, the team is currently detailing the procedure to identify the problem areas and determine appropriate, workable solutions.

The interdisciplinary team approach focuses on quality efforts and creates an incentive for the entire health team to work together in achieving desired patient outcomes. The clinical documentation in the home health record demonstrates this collaboration in the format of team meetings, conferences, or other team activities and communications. This documentation must be reviewed continually for continuity and accuracy.

To monitor these efforts, follow up record review is performed each time a patient's needs change. This takes place within the facility with each new diagnosis; each time a patient receives a new medication or change in current medication(s); and when recertification papers are prepared. Diagnosis codes are reviewed every time a patient has had an inpatient stay, as well as at recertification.

It is essential to review all information pertaining to the patient. For example, medications can help identify an existing condition for which the patient is under physician supervision--because even when the disease is controlled by medication, conditions like these still play an important role in the patient's overall condition.

A qualitative record review looks at many of the same areas that the traditional inpatient setting does (e.g., signatures, dates, and record completeness). However, there are many additional areas in home health records that must be reviewed, including the comparison of the following: documentation to orders and assignment sheets, care provided according to ordered frequency and duration, documentation of homebound status, and medical necessity based on skilled need. Clinical visit notes are designed to give a clear, precise picture of the patient's continual status. The documentation must also communicate the specific care provided and the patient's response to that care.

On August 5, 1997, President Clinton signed into law the Balanced Budget Act of 1997 (Public Law 105-33). This new law will bring significant changes to the Medicare and Medicaid programs. Among the new revisions is the implementation of a prospective payment system (PPS) for home health services by October 1, 1999. Much like DRGs in the inpatient setting, the home health community must prepare for prospective payment. As these changes evolve, there will be a higher demand for the skills health information managers possess. To aid in a smooth transition from cost reimbursement to prospective payment in the home care field, health information managers should provide expertise in coding, documentation, and information management. It is also important that health information managers understand rules and regulations and develop effective compliance programs.

On March 10, 1997, the Health Care Financing Administration (HCFA) published a proposal that would require the use of the Outcome Assessment Information Set (OASIS) developed by the Center for Health Care Policy Research (CHPR), in its revision to Medicare's home health Conditions of Participation. The intent of the proposal is to establish a mechanism for home care quality monitoring that will evolve into an outcome-oriented, data driven, patient-centered system. Ultimately, OASIS may become the foundation for a home health prospective payment system. Currently, it is being evaluated as part of a national demonstration project, scheduled to conclude in 1999.

Health information managers have the knowledge and expertise needed in the home healthcare field. Detailed record review, education, and coding expertise are currently in demand as the industry moves from cost reimbursement to prospective payment. It is time to meet the challenge of assuring that the home health record accurately describes the nursing process, is based on the plan of care, and facilitates movement toward achieving patient-centered goals and positive outcomes.

Johnna M. Ervin *is the operations manager, The Caring Connection, Wewoka, OK*

Article Citation:
Ervin, Johnna M. "HIM's Impact on Enhancing Data Quality and Integrity in the Home Health Setting." *Journal of AHIMA* 69, no. 1 (1998): 48-49.