Supporting Organizational Culture Translates to High Performance

Austin Medical Center demonstrates how supporting its organizational culture helps improve outcomes

Often, well-intended process improvements are followed by gradual breakdown, no matter how sound the process or how well-supported by the staff. A new process is more likely to be sustainable when the process itself is improved and related support systems and management processes are aligned with the change. The experience of Austin Medical Center (AMC), located in Austin, Minnesota, demonstrates that building and supporting an organizational culture focused on leadership, teamwork, and care coordination is essential to making process improvements stick.

Ruth Crabtree, AMC home care and hospice nurse manager, attributes AMC’s superior rates for acute care hospitalization and oral medication management to a committed interdisciplinary staff and multiple strategies. These strategies are designed to improve patient care, including an improved communication system, standardized organization-wide processes and tools, and technology.

Motivated staff members, whose goal is to provide quality care to their clients, are enthused about learning and implementing effective new processes at AMC. According to Ruth, “The credit really goes to the staff. You can put the plan out there for them, but they are the ones who have to implement the changes. I really have an excellent staff.” Leadership and decision making are a team effort at AMC. Ruth says, “Leadership comes from within. It just gets stronger as we continue to work together. We have all worked together as a team to get there.”

AMC’s electronic peer-to-peer recognition program, called the Great Place, provides an incentive for employees to recognize each other. Employees can send an electronic thank you or recognition card to their peers. Those who are recognized by coworkers are entered into a drawing for “perk” points. If they win, they can use the points to purchase gifts. As manager, Ruth has used the program to recognize staff for their efforts to improve the agency’s outcome measures.

AMC is a comprehensive medical system with organization-wide processes and initiatives. Technology has evolved over the years and has significantly improved communication and coordination of care. Home health has had an electronic record system since 1997. Nurses use notebook computers on visits and have electronic access to hospital and clinic records. Within the last year, they have had immediate access to physicians via direct messaging using a wireless connection.

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In addition, computer-based education on the SBAR (Situation, Background, Assessment, Recommendation) communication model and education of OASIS elements has improved the consistent application of home care practices and protocols.

The following strategies and AMC-wide programs have positively impacted home health outcomes, particularly acute care hospitalization:

- Participation in the AMC-wide falls prevention program
- Medication reconciliation with direct messaging between physicians and nurses for comparison of medications in the home to those on the client’s clinic list, and updates on how clients are really using their medications
- Increased use of therapies for evaluation and education of medication management and home safety, including suggestions for equipment or techniques, and triggers for referral
- Increased client education on nebulizer and meter dose inhaler cleaning and correct use, along with printed materials
- Standardized phone calling and emergency care plans as part of the agency’s front-loaded visits
- Increased attention to vaccinations for influenza and pneumococcal disease, assessing at admission, using the electronic health record for better documentation, staff education, and collaborating with AMC’s infection control nurse

Through leadership, teamwork, and standardized processes of care, AMC demonstrates how supporting its positive organizational culture leads to improved processes of care and outcomes for its clients.

December 2006 Rates for Home Health Improvement in Acute Care Hospitalization and Management of Oral Medications

The tables to the right compare national, state, and Minnesota Collaborative rates for improvement in acute care hospitalization and management of oral medications for the period December 2004 through December 2006. The rates show us that we do have work to do in Minnesota on both these measures and that we are making progress.

For information on your agency’s rates for these measures or for best practices to improve these measures, contact Stratis Health. Our goal is for every Minnesota agency to improve their rates for these measures.

Home Health Quality Improvement Campaign: Don’t be left behind!

More than 100 Minnesota home health agencies have already signed up to participate in this FREE national campaign to optimize performance with free resources, networking and benchmarking data. The Minnesota HomeCare Association and Stratis Health strongly encourage all agencies to sign up. Participating agencies receive monthly emails with free agency-specific data, tools, guidelines, success stories, and best practice education materials to support improving the quality of care measured by reducing avoidable hospitalizations. **No data collection is required. It’s easy to sign up, and you are only committing to view the materials sent to you to determine what would be of help to your agency.** For more information, go to: www.homehealthquality.org, or contact Stratis Health at: 1-877-STRATIS.
For Which Patients Do You Collect Federal OASIS Data?

By Pat Nelson, RN, OASIS Coordinator
Minnesota Department of Health (MDH)

OBQI measures are calculated from OASIS data, so it is important to make certain that OASIS data are collected and submitted for appropriate clients.

Inclusion of the data for clients that do not meet the definition for skilled services may have an impact on the quality measure rates.

OASIS data collection is required for all Medicare/Medicaid patients receiving skilled services. OASIS is excluded for:

- Patients under 18 years of age, regardless of payer source
- Patients receiving pre- and post-partum maternity services, regardless of payer source

The following sources provide clarifying information regarding when OASIS data collection is required:

Information Bulletin 03-2 on the MDH website addresses the definition of skilled services for Medicare and non-Medicare patients according to the Home Health Agency (HHA) Manual (CMS HM-11). The bulletin can be found at: [http://www.health.state.mn.us/divs/fpc/profinfo/ib03_2.htm](http://www.health.state.mn.us/divs/fpc/profinfo/ib03_2.htm)

The Patient Classification Table is a helpful tool that identifies when a patient requires OASIS data collection, a comprehensive assessment, or both. The table can be found at: [http://www.cms.hhs.gov/OASIS/Downloads/patientclassificationtable.pdf](http://www.cms.hhs.gov/OASIS/Downloads/patientclassificationtable.pdf)

The State Operations Manual (SOM) at Section 2202 – Outcome and Assessment Information Set (OASIS) Requirements states when OASIS data collection applies. MDH recommends the section be read in its entirety for complete understanding. The SOM states in part:

“2202.8C (page 193)……..3. Transmission of OASIS Data
.....NOTE: CMS requires the encoding and transmission of OASIS information only on patients who are receiving Medicare/Medicaid benefits. This means that for patients with payer source (1) Medicare (traditional fee-for-service), (2) Medicare (HMO/Managed Care), (3) Medicaid (traditional fee-for-service), or (4) Medicaid (HMO/Managed Care) on OASIS item M0150, the HHA must collect, encode and transmit all required OASIS information to the state agency. If Medicare/Medicaid is contributing to the payment of the patient’s episode of care, the patient is considered a Medicare/Medicaid patient. The payer source for services provided as part of a Medicaid waiver or home and community-based waiver program by a Medicare-approved HHA is coded as (3) Medicaid (traditional fee-for-service) at item M0150.”

For non-Medicare/non-Medicaid patients (patients with only pay sources other than M0150 response 1, 2, 3, or 4), the HHA is not required to assess and collect OASIS as part of the comprehensive assessment and agency medical record........Non-Medicare/non-Medicaid payer sources include private insurance, private HMO/Managed Care, self pay, programs funded under the Act: for example, Title III, V, XX, or other Government programs. [http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf](http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf)

Based on Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, data collection for non-Medicare/non-Medicaid (private pay) patients was temporarily suspended. This is noted in the S & C letter 04-12, which is found at: [http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter04-12.pdf](http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter04-12.pdf)

Pat Nelson served as an HFE Nurse Specialist in the MDH Survey and Compliance Program from 1989 to 1995; a Special Investigator with the Office of Health Facility Complaints from 1995 – 2005; and a Registered Nurse Senior in the Case Mix Review Program since 2005. In August 2006, Pat assumed the duties of the OASIS Coordinator and remains with the Case Mix Review Program.

For more information, go to [oasis@health.state.mn.us](mailto:oasis@health.state.mn.us)
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Did you miss an issue? OBQI Update is available on the Stratis Health website, at www.stratishealth.org, under Publications and Press.

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