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INSIDE

Special Report: Preparing for PPS

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New agency teaches all staff, disciplines how to be PPS-ready

Director offers tips on getting most out of OASIS assessment

When Athens (GA) Regional Home Health / Home Infusion opened its doors on Dec. 10, 1998, the home health industry was going through a very tough time. The interim payment system (IPS) had forced hundreds of agencies to close their doors, and Medicare reimbursement looked increasingly grim.

But since the Athens Regional Medical Center had been planning to open a home care agency for years and had to wait to receive state approval, its leaders were instead optimistic, believing that the home health agency opened at the perfect time. This new agency had the opportunity to hire and immediately train staff to work and think in terms of a prospective payment system (PPS) world. There were fewer old habits to break and fewer old attitudes to overcome, says **Carol Jelke**, RN, BBA, executive director of the agency, which serves five counties in northeastern Georgia. "We just decided that we would adopt the philosophy of PPS from day one," Jelke says. "We've been working toward that all along, even though we didn't know how it was going to play out when we opened."

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Staff focused on teaching independence

For instance, the agency's staff never were permitted to approach their jobs from a fee-for-service perspective. Rather than think of cases in terms of the number of visits they might require, nurses were encouraged to think in terms of providing a reasonable number of visits, working toward the goal of helping patients become independent.

That means there is much less emphasis on home health aide visits than what has been typical among home care agencies. Jelke reports that while a typical agency in 1998 or earlier might have 30% to 40% of

all visits being made by a home health aide, the Athens agency only had 9% to 10%.

"We never attempted to go down that road," she says. "From day one, we'd say, 'Does this home health aide and the scope of service she's going to provide really fall in line with the whole plan for this patient?'"

While nurses sometimes think of home health aide visits as being a way to help patients and families with increasingly difficult activities of daily living (ADLs), the new philosophy caused them to look at the negative side, which is that aide visits can increase a patient's dependency, Jelke says.

The agency also expects all physical therapists (PTs) to open new cases for patients who will receive only therapy visits. This saves unnecessary nursing time, and it only required educating PTs about the Outcome and Assessment Information Set (OASIS) and PPS, she adds.

Physical therapists serve as staff educators on how to perform the best functional assessment using OASIS. The agency started this type of education last year, and the benefit has been that chart reviews show nurses are consistent in how they assess functional limits.

"We've been doing a good job and it's been consistent over time," Jelke says.

In addition, nurses are taught to look at their productivity not in terms of the number of visits they make in a given day, but in terms of how well they can teach patients and caregivers to become independent of nursing care. So nursing visits at the Athens agency typically last 50-54 minutes, as opposed to the 30-36 minutes that is more common in the traditional agency, she explains.

"We spend the time doing a lot more teaching," Jelke says. "Some of the philosophy I've adopted and tried to communicate to nurses is that their patients and clients come out of the hospital ready to learn and wanting to learn. You should get most of your teaching done within the first three weeks of seeing them, when they're more willing."

Old way: Teach a little each visit

The old philosophy at some home care agencies was to teach a little bit on each visit; and so long as there was a skill involved, the agency would be reimbursed, she adds. "So you'd drag it out — but now you do it quickly, and ultimately, I think it's better for patients."

When the proposed rule came out during the agency's first year, Jelke began to look for specific ways she could improve staff education about PPS and the agency's potential reimbursement under PPS. Here's how she did that:

• **Assess patient profiles.** "First, we collect data by the patients [who were] discharged each month, and then we look at which home health-related group [HHRG] they fall into, and how many visits did we have to serve them," Jelke says.

After collecting the first data in December and January, Jelke determined that the staff needed to learn how to appropriately select diagnoses for patients. "We had a big program in mid-February, and we are now collecting data from February, March, April, and May, and we have so far seen a significant change in our groups of utilizations," she says.

C-2, C-3 ratings receive more reimbursement

• **Look for trends on OASIS assessments.** While diagnosis-related groups (DRGs) are driven by diagnosis, HHRGs are not, except for the diagnoses of neural, ortho, and diabetes. "We now have a payment system driven with information off the nursing assessment," Jelke explains.

This is why staff education is so crucial. If nurses are consistently making mistakes on the OASIS tool, or if they are overlooking certain patient problems, then the agency will not be reimbursed for all that it is entitled to receive. And a lot of those decisions involve ADLs, such as whether the patient can dress or bathe.

The agency discovered through audits that its nurses were consistently and accurately assessing patients' functional status. But the audits spotlighted discrepancies in how nurses assessed the clinical dimension indicators. For example, by examining the answers to the OASIS questions related to scoring the clinical dimension as a whole, it was determined the staff had assigned a C-0, which means there is little or no problem on a particular indicator, to 32% of patients. Nurses gave a C-1 rating to another 30% of patients. At C-2, there was an average of 17%, and the C-3 rating received 21%.

Now, PPS will pay agencies slightly more for patients who receive the higher ratings of C-2 and C-3, because this means the patient has more clinical deficits and likely will need more skilled care. So if nurses are under-reporting clinical problems, this could cost the agency money, Jelke explains.

• **Educate staff on ways to improve assessment.** Once Jelke identified that clinical assessment could be a problem for nurses, she developed some educational material and held an inservice to teach

nurses how to better assess patients.

For example, a nurse might ask a patient, "Do you have a lot of pain?" And the patient, who is old and expects that pain is part of being old and therefore believes it does no good to complain, may answer, "Oh no, I'm OK." So, the nurse would check the 0 box on the pain indicator / MO420.

But suppose the truth is that the patient is in pain, even considerable pain, and just doesn't want to appear to be complaining about it. Assuming that for many patients this might be the case, the nurse could assess this indicator in a more thorough way. The nurse could say to the patient: "Let me see you get up from your chair and try to walk over to here." Then, the nurse could observe the patient to see if the patient ignores the request or grimaces when slowly trying to stand and walk. Those would be indication that the patient is experiencing some pain.

Also, nurses could closely examine all of the patient's medications to see if there are any painkillers or anti-inflammatories that may indicate the patient is in pain. "We look at how they are having these pain medications refilled," Jelke says, "and we try to talk with them about activities they are not doing anymore and why they are not doing them, because this could be the result of pain."

These are strategies the agency uses to dig for the truth on the clinical indicators. "You're not asking these questions to just get a higher score, but these questions can help us to be better clinicians," she says.

Jelke took each of the OASIS items that are included in the PPS payment determination and wrote some strategies for making sure the assessment is complete. Then she handed them out to staff as part of the inservice. For instance, one page of the handout has the title, "OASIS Item (MO488)" at the top. Below, it reads, "Status of Most Problematic (Observable) Surgical Wound: 1 — Fully granulating; 2 —Early / partial granulation; 3 — Not healing; NA — No observable surgical wound.

The page also includes the definition of the intent of the question, and a PPS calculation impact as to how many points are given for each box.

Box gives nurses reminders on 485 impact

Jelke wrote a "485 Impact" box that gives nurses reminders, such as "Do not forget to identify supplies to be used in the care of the wound," and "Be specific on the wound treatment."

Below that she has a box stating the "Impact of answers on need for other services." Finally, there are boxes listing "Response-Specific Instructions," and "Strategies to obtain and collect accurate data and responses."

Under the latter box for surgical wounds, it reads, "Inspect each surgical wound to determine its status. Based on this information and that from the health history, use clinical reasoning to determine the most problematic (observable) stasis ulcer."

The final box item is a list of time points when the item is completed. In the surgical wound item's case, those would be at the start of care, resumption of care, follow-up, and discharge from the agency — not to an inpatient facility.

The additional staff education on the clinical dimension had a striking impact. Chart reviews showed that after the education, the percentage of patients who fit into the C-0 category was 18.5%; in C-1, the number fell slightly to 27%; C-2 rose to 27%, and C-3 stayed about the same at 22%.

- **Show staff how to be cost-efficient.**

"It's not only cutting costs, it's changing a philosophy," Jelke says. "You have to do this because these payments are not great, and it will be extremely challenging to at least break even under PPS."

This means the staff must work hard at encouraging caregivers and patients to do more for themselves earlier in their home care treatment. This will be the most important way to cut visits and still maintain quality, Jelke says.

For instance, nurses need to teach families and patients that the home care agency isn't the answer to all of their problems, but is only there to guide them to independence.

"The biggest thing is you have to help your staff understand and appreciate that they are the skilled caregiver, and their role is to deliver a skill — not to become the caregiver for the patient," Jelke says.

Another important strategy is to provide total case management, including bringing in social workers when needed, or keeping in close contact with the patient's physician. That way, the agency

SOURCE

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can recommend medication, social service referrals, and other changes when they might help a patient make faster and better improvements.

"You have to be tight in case management," Jelke says. "You can't let those visits get away, and you can't delay taking action."

The agency's staff have become so efficient in care that when Jelke did a preliminary PPS analysis to see what the agency might have been paid under PPS, vs. IPS, she found that the agency would have received more reimbursement under PPS. ■

AL agency runs trial benchmarking for PPS

Key to staying afloat is attention to efficiency

While waiting for the final rule on the prospective payment system (PPS) for home care agencies, some Alabama agencies took a preliminary benchmarking comparison of how they would fare under PPS as it was set up in the proposed rule, published late last year.

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Decatur (AL) General Home Health Services studied PPS reimbursement for all of its patients from October 1999 to February 2000, says **Jimmie Galbreath**, RN, MSN, director of the rural, hospital-based agency that covers 10 counties in northern Alabama.

Galbreath benchmarked the agency's findings with the same data from other agencies that were part of a study established by Health Group of Alabama in Madison.

The PPS study proved helpful. It reinforced the agency's trend of encouraging staff to make the most of each visit while at the same time reducing the overall number of visits, he says.

Strategic wound care

Agency managers also learned that the agency would have some reimbursement problems with certain complicated wound care cases because they were very costly, and PPS reimbursement will not fully cover the cost of supply material, Galbreath says.

Being a public, not-for-profit agency means Decatur General Home Health will continue to see those types of patients and perhaps even be referred more of them in coming years. But the preliminary PPS information will help the agency set up strategies to reduce the costs of those cases, Galbreath says.

"We may not always want to do the newest, most modern way of providing wound care treatment," he adds. "We may want to resort to what's tried and proven, and what will work with the least costly supplies and still achieve a good outcome."

Galbreath offers these tips on how to run a preliminary PPS reimbursement study and how to use the information:

• **Use a PPS tool and adapt it.** Decatur General Home Health used a standard PPS tool and modified it so the agency could obtain some additional information. "We wanted to break down the information about why we were completing the PPS study, and whether it was for the start of care or research or an intervening event," Galbreath says.

The tool should be tied to the OASIS assessment to make it simpler to collect data. "We took the OASIS questions that were identifiers that affected PPS scoring or the home health-related group [HHRG] and determined what our HHRG would be for each patient," he adds.

Everyone involved with the Health Group of Alabama study used the same tool, which enabled them to determine clinical and functional service utilization. The tool also provided a case mix weight on each patient, which would be combined with the proposed formula for PPS reimbursement in this way: Take the HHRG formula, add case mix weight, multiply by metropolitan statistical area number or rural area code, then factor in wage index weight. This equals total PPS reimbursement.

"We included in our tool the amount of therapy hours because with PPS reimbursement, therapy is not inclusive unless you have eight hours or 10 visits or more," Galbreath explains.

He says they also compared the start-of-care projected number of visits to the actual number, noting differences for specific care plans with both new and ongoing patients.

• **Compare reimbursement projection with current situation.** Once you have the data, it's simple to see which cases will result in a budget deficit and which will provide ample reimbursement under PPS.

"Overall we came out . . . close to even with what we're getting reimbursed now and what we

would be reimbursed under PPS," Galbreath says. "In some scenarios, we [would receive] less than we receive now, and in others we would receive more."

Galbreath also compared Decatur General Home Health's results with two other hospital-based home care agencies, and found that Decatur General's overall average reimbursement per patient was better than the other two agencies.

A detailed reimbursement comparison will highlight which areas are the most costly to an agency. This is how Galbreath found out that certain types of wound care would be financial losers. Knowing these details can help quality managers and administrators make decisions that will improve costs and efficiency.

A penny saved

Some agencies may choose to stop providing certain specialized services because the reimbursement is not adequate. But others may choose to continue to provide the services, but find ways to cut costs, such as using less expensive supplies that have the same outcomes, or improving caregiver / patient education so that nursing visits may be reduced.

Hospital-based agencies may decide to write off the losses on certain home care patients because home care still is less expensive than keeping the patients admitted in the hospital, which may be the only other option at times.

• **Make staff and protocol changes to reduce costs.** One certain change under PPS is that cash flow will change, and this might signal the need for a revamped billing process, Galbreath says.

"It depends on the mechanisms you have in place within your specific agency in order to be able to do timely billing," he says. "I think home care agencies will have to get away from the old hat of monthly billing, and there will have to be some sort of billing at least weekly, if not daily, because of the cash flow."

The sooner an agency bills Medicare, the faster the agency will be reimbursed. It won't make good fiscal sense to wait until the end of the month to send in a batch of bills, when that means an agency may be short of cash for several weeks of that month. "In our scenario, I'm looking at the option of daily — if not weekly — billing," Galbreath says. "Now, we do billing twice to three times a month."

Also, he plans to make those changes without hiring new staff, sticking to a motto of "reduced reimbursement, increased responsibilities."

The agency also has made a number of other cost-cutting changes, including restructuring its office staff so that each employee has specific, multitask job functions in preparation for PPS. Although there have been no layoffs, the agency has eliminated some positions through attrition, Galbreath says.

Clinical staff have been working on providing only the number of visits that are necessary for any specific patient. For example, some agencies might send a home health aide or personal care attendant to bathe a patient six days a week, Galbreath says. "We have found we're as effective at bathing a patient three days a week, because this allows the patient and family to take some responsibility and not lose all of their independence." ■

SOURCE

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JCAHO's new standards inspire patient pain guide

GA agency puts pain management on fast track

Advantage Home Health in Savannah, GA, has wasted no time in revising the way staff assess and help manage patients' problems with pain.

The new pain management standards, added to the accreditation manual for home care by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL, call pain assessment the "fifth vital sign." Advantage Home Health now requires nurses and therapists to assess patient pain at every visit, says **Deborah Jennings**, RN, quality manager / coordinator of the agency, which serves six counties in coastal Georgia.

"I think the nurses see the sense in the requirement," she says. "They said that many times before; they would ask patients about pain, but didn't document it if patients say they don't have any pain."

Now, they must document the patient's

(Continued on page 79)

Pain management teaching guide can help meet JCAHO standards

Advantage Home Health in Savannah, GA, has devised a three-page patient guide to pain management. The guide is handed out to each patient at admission, and lets patients know what their rights are with regard to their pain.

The tool also discusses ways to relieve pain, side effects of pain medication, and other barriers to managing pain successfully. The teaching guide meets the patient education requirements of the new pain management section of the accreditation manual of the Joint Commission on Accreditation on Healthcare Organizations in Oakbrook Terrace, IL. Here is a look at the Advantage Home Health patient education guide on pain management:

Pain Management - A Patient Guide

Dear Patient or Caregiver:
The nurse will teach you about pain control. Then you can use this Teaching Guide as a reminder.
Your nurse is _____.
The phone number is _____.

What is pain?
Pain is an unpleasant sensation caused by different stimulations of the sensory nerve endings.
What are your patient rights in relation to pain?
• That your reports of pain will be believed.
• To receive information about pain and how your pain can be relieved.
• Agency staff who are committed to pain prevention and management.
• Agency staff who will respond quickly to your reports of pain.
• Best pain control possible.
• Pain medication information for drugs ordered by your doctor (side effects, precautions).
What are your responsibilities in relation to your pain control?
• Ask the nurse what to expect regarding your pain and pain management.
• Discuss pain relief options with your nurse.
• Work with the nurse to develop a pain management plan.
• Ask for pain relief when pain first begins.
• Help the nurse assess your pain.
• Tell the nurse if your pain is not relieved.
• Tell the nurse about any worries you have about taking pain medications.
What will the nurse need to know about your pain?
• Frequency (how often it occurs);
• Location (where it occurs);
• Duration (how long it lasts);
• Intensity (describe the pain on a scale of 0-10; 0 = no pain; 10 = worst possible pain);
• Character (use your own words to describe the pain);
• Things you do that help you get rid of the pain;
• Things you do that make the pain worse;
• Effects of pain on your daily life (appetite, sleep, emotions, activities, etc.).
What are some barriers to managing pain?
• Not understanding the pain.
• Thinking pain cannot be relieved.
• Thinking pain is a normal part of the disease and should be present.
• Thinking that you are not a good patient if you have pain.
• Thinking that medicine causes addiction.
• Not being able to afford to pay for pain medicine.
• Side effects of pain medicine are too hard to manage.
• Hard time getting pain medicine refills.
• Hard time telling others about your pain.
Please tell the nurse if any of those barriers (or others) are true for you so that we can help you overcome them.

What are some other ways to relieve pain, in addition to my medicine?

- Relaxation (deep-breathing exercises, abdominal breathing, with or without calming music in the background);
- Distraction (watching nonstressful or comedy TV, listening to peaceful music or recordings, such as waterfalls, ocean sounds, or other environmental sounds that are relaxing to you);
- TENS (transcutaneous electrical nerve stimulation). This can be ordered by your doctor. It can be obtained from your medical equipment supplier.
- Massage (with medicated cream or ointment as ordered by your doctor, or with your favorite lotion);
- Heat (check with your doctor or nurse to be sure that wet or dry heat will not make the pain worse or cause problems with other ailments that you may have);
- Cold (check with your doctor or nurse to be sure that cold will not cause problems with other ailments that you may have).

What are some of the side effects of pain medication and how can they be controlled?

1. Nausea/Vomiting
   - other medicines can be ordered to control or prevent this;
   - check to see if you should avoid taking the pain medicine on an empty stomach;
   - increase your fiber intake;
   - increase your fluid intake;
   - abdominal massage — rub from right to left across the upper abdomen and down the left side for 2-4 minutes;
   - using a mild laxative, suppository, or enema as ordered by your doctor;
   - the nurse can teach you or a caregiver how to do digital stimulation if this will not aggravate any other ailment you may have.
2. Sedation
   - drinking coffee or other caffeinated beverages — if this will not aggravate any other ailment you may have;
   - having the doctor adjust the dose for daytime use, or having the doctor order two different medicines — one for mild pain and one for severe pain.
3. Diarrhea
   - other medicines can be ordered to control or prevent this;
   - decrease your fiber intake;
   - must still drink plenty of fluids to prevent dehydration.

What is your goal for your pain management? Tell the nurse or write it out on the lines provided:

_____

_____

_____

Please use the pain management log to keep track of your pain. Share it with the nurse when she or he visits.

Source: Advantage Home Health, Savannah, GA.

(Continued from page 77)

response to a pain scale of 0-10 with 0 representing no pain, and 10 representing the worst pain imaginable. Staff enter the pain rating in their laptop computers.

The agency also has a new patient teaching guide on pain management. It's placed in patients' admission packets and handed out to each patient. **(See Advantage's patient teaching on pain management, p. 78 and above.)**

Other changes included holding a 40-minute inservice for nurses and therapists on pain management and the Joint Commission standards.

"We went over the pain management tool and how you use it and when you use it," she says.

There was no inservice for home health aides because they are required only to report when patients say they are experiencing pain, and that requirement has not changed.

Jennings made changes to two agency tools that will help her monitor how well the staff are doing with pain management and assessment. The first change was to the agency's admission audit form. She added an item: "Pain is assessed & documented?"

Chart auditors will check nursing documentation to make sure that they have assessed patients' pain properly. If the first audits turn up problems, Jennings says she might add another and more specific pain assessment indicator to the audit tool.

SOURCE

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The second change was to the patient satisfaction tool and the patient satisfaction telephone surveys. The customer satisfaction survey now has a question that asks, "Did we help with your pain control?" The same question is asked during the random telephone surveys conducted of discharged patients, Jennings says. ■

Medication management requires 'holistic' approach

How do drugs affect patients' lives?

Good medication management of home health patients involves more than monitoring to ensure pills are being taken on schedule. In these days of complex illnesses and multidrug regimens, agencies need to learn how a patient copes with drug-taking routines, side effects, and the other consequences of medication. They also need to help patients work through the obstacles to good drug-taking habits and advocate for patients with physicians who may not realize the drug burden a patient is under.

"It's really about incorporating the medication into the patients' lifestyle," says **Deborah Wendt,** RN, PhD, CS, associate professor of nursing at the College of Mount St. Joseph in Cincinnati. "If they can't incorporate it into their lifestyle, they don't take it."

Wendt says agencies should approach medication management holistically — looking at all of the factors that bear on a patient's decision whether to take pills as prescribed — as well as interventions that can help. The stakes are high, particularly for elderly patients who are taking multiple drugs.

Research shows that for every dollar spent treating a disease with medication, another dollar goes to treat morbidity and mortality linked to the misuse of medication, says **Luann J. Capone**, RN, MPA, vice president of quality management for Parkside Care Corp., a home health agency in Chardon, OH.

Many patients often must cope with up to 16 or 17 medications a day, often prescribed by a scattered group of physicians who don't know about each other. Some use multiple pharmacies, so pharmacists may not be able to catch duplicate prescriptions or drug interaction risks.

As patients develop side effects to their drugs, more drugs are prescribed to cope with the side effects. "The problem is getting worse, because the medications are getting much more complex," Capone says. "As much testing as is done before a product goes on the market, there's a lot of interactions and other things that aren't tested."

In addition, there are patient compliance issues ranging from forgetfulness to patients simply refusing to take medications they don't like. Keeping up with the complex web of drugs and their effects on the patient is a heavy load for a home health nurse already burdened by documentation and other requirements.

On the bright side, teaching patients how to handle their drugs intelligently can make the difference between the patient's staying at home and requiring more intensive care.

Obstacles to proper medication use

What keeps patients from taking their medication properly? Although the classic excuse is forgetfulness, those who work with patients and study their behavior say the process is usually more complicated.

Wendt, who interviewed a number of elderly patients about their medication use, says she's found two distinct phases when a patient begins taking a drug for the first time. During the first stage, which she calls a "testing" period, a patient will see how a drug fits in with his or her lifestyle. If it proves to be too much of an inconvenience or causes unpleasant side effects, a patient might abruptly stop taking it.

"They might say something like, 'This just doesn't work in my body,' and sometimes they would stop their medication after one dose," Wendt says. "Or the requirements for taking it might be too disruptive.

"For example, one pill . . . said you couldn't eat or lie down for half an hour after you took it, and it had to be taken in the morning. That disrupted [the patients'] morning routine, so they just stopped taking it."

In other cases, side effects such as increased urination or impotence would lead a patient to stop.

If patients continued to take the drug through this testing phase, their responses to new side effects or other problems were different. In those cases, patients usually would continue to take the drug while going to the physician to ask about the problem. Wendt says the patients she interviewed viewed compliance differently than health care professionals would. If a woman delayed a dose because she had plans for the afternoon, but did take the dose later, she would view that as being compliant. And patients were likely to listen to people who weren't health professionals, who might advise them to try an herbal remedy or even stop their medication entirely.

"In one case, a woman who took about eight drugs one day stopped taking them all because she started believing they were making her sick, and her husband agreed with her," Wendt says. "So, on the advice of the husband, she stopped everything. When the doctor found out, the doctor said she had to take it, so she restarted it."

Many who work with elderly patients taking multiple drugs say that financial considerations are a factor in whether they're able to take their medication as prescribed. "Cost is a big issue," says **Patricia A. Nester**, MSN, RN, assistant professor of nursing at Westchester (PA) University, who trains student nurses in performing home health medication assessments. "[Patients are] willing to say, 'I just can't afford this.'"

Assessment first

All agree that a comprehensive, detailed medication assessment is the first and most important step in managing a patient's medications. Nester and **Michele L. Tucker**, MS, RN, also an assistant professor of nursing at Westchester, are developing a medication assessment tool that elicits copious detail on a patient's drug-taking habits.

"What we found sometimes is students would assume they had completed the assessment when they hadn't even come close," Tucker says. "They would ask general questions such as, 'Are you having any problems taking your medications?' That assumes that an elderly person would understand they were having a problem."

Even experienced nurses often don't fill out forms as completely as they should, Capone says. "They're not careful about getting the doses, they're not careful about getting the stop dates, they're not careful about documentation," she says, adding that careful documentation habits will lead to more careful medication monitoring.

This is also the time for nurses to learn as much as they can about other factors that can affect medication use — patients' attitudes toward medicine, their learning ability, who gives them medical advice, and their financial situation. All those, Wendt says, play a part in determining how well a patient can stick to a drug regimen.

"People can know what they're supposed to take, but they don't do it because of these other factors — their activities, advice they get from people, cost, etc.," she says. "You need to sit down and work on incorporating [medication] into their lives, so you can get the compliance you're looking for," she advises.

Assertive follow-up

Armed with information about the medication, the agency should follow up with physicians and pharmacists as needed. Capone says the goal isn't just to prevent duplicate prescriptions or interactions, but to act as an advocate if the patient has too large a medication burden.

"I think nurses need to be more assertive with physicians and say, 'I can get [the patient] to take five medications appropriately; I think that's realistic, but there's no way we're going to be able to get them to take these 12 medications,'" she says.

Nester notes that a patient who is having trouble with a medication might simply choose not to take it, unless he or she is encouraged to talk to the physician about alternatives. And as valuable and important as the initial assessment is, it is worth little if there are changes to the patient's status that the agency doesn't know about.

Those changes can come at virtually any time. As Wendt notes, patients may stop taking the drugs if they encounter problems. Other changes may be ordered by the physician or by other health professionals.

"What we found was if you don't keep up, people might not think to tell you the new over-the-counter they've got," Tucker says. "They may not think to tell you they saw another physician, or they went to the ER, or they went to the urgent care center and now they've got something else. So we found a need for continuing review both of their inventory of meds and of their usage."

Capone says other surprises can come up simply because a patient forgets about a medication they were taking. She advises agencies to roll with the punches. "It is not unusual to think you have a very clear picture of the medications and the vitamins, and whatever else they have in the

home; and you go back in a day or two and they say there's something they forgot to tell you about," she says. "Expect that you're going to be thrown a curveball," and as a professional, you have to go with the flow, she adds.

Obviously, the bulk of agencies' medication management work lies in the area of patient education. Again, that education should take into account all the ways in which the patient's life and medication affect each other:

• If a patient is illiterate or doesn't understand English well, he or she should receive more simplified teaching materials or those written in their own language.

• If the number of pills is confusing, they should be taught strategies for keeping track of their medications — the use of pill boxes, charts, or cueing devices such as television shows or positioning nighttime drugs on a bedside table.

• If finances are a problem, agencies should provide information on financial assistance programs that target medication.

Teaching time

Capone suggests structuring the visits so that a set portion of time, perhaps at the end of the visit, is reserved for teaching. "If you sit down, maybe in the last 10 minutes of the visit, and say, 'OK, this is our teaching time,' then the patient knows that this must be really important if this person, who is so busy, is setting aside time to teach me this medication," she says.

Wendt says that among some of the patients she interviewed, there were references to home health nurses "drilling" them — repeatedly asking them to describe what drugs they were taking and when they should take them. And although it sounds like a military technique, patients said it really helped them, she says.

Capone notes that careful documentation of the patient's education prevents subjects from being missed. It's particularly important in agencies where a patient doesn't see the same nurse each visit. Under OASIS, she points out, some agencies hand a case off from an initial admissions nurse to other nurses for follow-up visits.

"There's going to be room for inefficiencies, poor teaching, and missed opportunities for continuity in teaching if there's not a structure in place," Capone says. "There needs to be a form that can be carried all the way through . . . so the [new] nurse knows where the other one left off, and the approach they're taking."

At Parkside, the agency developed new documents that gave nurses more room to describe their teaching activities.

Encourage good habits

Capone and others say patients shouldn't just be learning about their own drug schedule, but about good medication habits that can help them in the long run. Among those habits:

• Using only one pharmacy, so the pharmacist can catch interaction risks or duplicate prescriptions (often, if one doctor prescribes a brand name and another the generic form, the patient doesn't realize it's the same drug).

• Keeping a comprehensive list of all drugs

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taken and their dosages that can be taken to each medical appointment so physicians know the full range of a patient's medication use. Capone's agency creates a form on heavy card stock for patients; Tucker and Nester's students used "medication passports" created by a drug company.

• Using up prescriptions such as antibiotics, and throwing away others when they are no longer needed.

• Telling health professionals about any herbal or over-the-counter medications they are taking.

• Going to a nurse or physician with side effects, rather than simply stopping the drug.

Wendt says many of the patients she talked to were grateful for the careful instruction they got from home health nurses. One woman she interviewed had developed an elaborate system for dealing with her 15 medications. She used multiple pill boxes, a notebook detailing her drugs that she kept with her medications in case she was taken to the hospital, and a binder of pharmacy information sheets on all her medications. "She had her drugs delivered, had been with the same pharmacy for 20 years, and often talked to them on the phone," she says. "She was just so coordinated in handling it.

"When she first came home from the hospital, she had home health nurses for three months, and . . . said she was very grateful for that. She said it took three months of them drilling her for her to learn about it," Wendt says. But the hard work paid off: "After that, when she was placed on new medications, she said it wasn't that hard." ■

Performing that initial assessment

Know your patients' drugs, lifestyle

When an agency first takes on a patient, it must conduct a thorough medication assessment to learn about the patient's inventory of medications, drug-taking habits, and any obstacles to proper medication management.

Some facets of a good assessment:

• **Details, details, details.** Start with a comprehensive list of all the drugs a patient is taking. Include the dosages, medication schedule, prescribing physicians, and the symptom or ailment for which each drug is being taken.

• **Are all of the drugs clearly labeled?** Does the dosage ordered by the physician match the instructions on the bottle? What is the stop date for each drug? Ask the patient to bring out all the pills that he or she has in the house, including leftover drugs from previous prescriptions.

• **Self-prescribed medication.** Ask to see all over-the-counter medication, vitamins, and herbal remedies the patient is taking. Note how often those drugs are being taken and why. Don't forget herbal teas and tinctures, which the patient may not consider as drugs.

• **Lifestyle issues.** Does the patient smoke? Drink alcohol? Drink coffee or sodas containing caffeine? All can interact with medications.

• **Drug-taking schedule.** Ask the patient to describe in detail the routine used in taking medication. Where are the drugs stored? Are they kept in the original containers or put in other pill boxes?

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• **When does the patient take each drug?** Often, patients don't take doses strictly by the clock, but by landmarks in their day, such as during breakfast, or after an afternoon nap. Compare the schedule described by the patient with the prescribed schedule.

• **Side effects, interactions.** Nurses should ask about any symptoms patients may be experiencing. Ask about specific symptoms related to the drugs being taken, but also generally about any physical changes since the medication began.

• **Patient attitudes.** Does the patient believe the medication meets his or her health care needs? Does the patient feel that the medicine is unnecessary, or express an unrealistic expectation about the medication?

• **Who is in charge of the medication?** Is it the patient? A particular caregiver? This is particularly important when a patient has multiple informal caregivers.

• **Good medication management practices.** Does the patient use the same pharmacy for all prescriptions? Do different physicians know what each other are prescribing? Does the patient have a list showing all the drugs being taken that can be shown to each physician?

• **Learning ability.** Does the patient speak and understand English? Can he or she read? Would the patient be better served by drug information that relies more on pictures? Thorough investigation at the earliest assessment will make it easier to monitor and manage the patient's medication throughout the length of their care. And continued revision of the assessment will keep their records current. ■

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■