AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

IN THIS ISSUE

Enclosed in this issue:
Four-page home care satisfaction survey

OCTOBER 2000

VOL. 6, NO. 10
(pages 109-120)

Patient satisfaction: Is your agency measuring and using it effectively?

Use these tips to help your patients help you improve care

When you gauge the success of your agency's efforts, clinical measures are always of paramount concern: How much do patients' conditions improve as a result of care? Now, another measure is gaining greater importance: How satisfied are patients with the care and other services you provide?

As agencies seek an answer to that question, they are spending more time and effort on patient satisfaction surveys, tailoring them to give a more complete and specific picture of patients' wants and needs.

Carol O. Long, PhD, RN, assistant professor in the College of Nursing at Arizona State University in Tempe, says interest in patient satisfaction surveys has skyrocketed in recent years. "I'd say probably six years ago, nobody cared a whole lot about it," says Long, who has studied patient satisfaction for the past decade. "But today, it's much more important. Now, it's considered a bona fide outcome measure."

One reason is financial: Insurance companies are increasingly looking to patient satisfaction results as a factor in awarding contracts. As interest evolves, agencies have begun to use good results from such surveys in their marketing efforts.

Tell us about your experiences with PPS

As *Homecare Quality Management* continues to follow the rollout of the prospective payment system, we want to know how PPS is affecting you. Were there aspects that caught you unprepared? Have you made quality improvements that have eased the transition? Do you have unanswered questions about the payment system?

Contact *HQM* writer Suzanne Koziatek at (618) 398-5555 or by e-mail at koziatek@intertek.net. We'll use your responses in a follow-up story later this year. ■

Bad patient satisfaction can affect referrals and word-of-mouth recommendations, Long says, citing the oft-used consumer statistic that a dissatisfied customer tells 10 people about his or her experience.

But, she says, the best agencies also look to patient surveys to fine-tune their care, identifying areas of weakness and acknowledging the efforts of staff who score well among their clients.

The recent attention to the Patient's Bill of Rights, requirements of the Medicare Conditions of Participation, and other quality improvement initiatives will only increase the importance of accurate patient satisfaction measurements, she adds.

At the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the new ORYX initiative requires accredited agencies to begin tracking different performance measurements. Among the measures that agencies can choose to track are those dealing with "patient perception of care," which is commonly gauged through satisfaction surveys.

Those patient perception measures are given equal weight with other measures of agencies' care, says **Sharon Sprenger**, RHIA, MPA, project director for core measure identification and evaluation in JCAHO's division of research.

"If I'm going to look at an organization, I really need to get a balanced picture," Sprenger says. "I need to look at things related to clinical care. I need to look at health status to see if people are functioning better after they get our services. And I'd also want to know something about the patients."

Surveying styles vary

However, as satisfaction surveys become more important, Long says not every agency is using them to their best effect. Poorly written surveys, or those that don't adequately encourage responses, won't tell an agency much about its operations. Because agencies use a wide variety of surveys — some building their own questionnaires, some relying on packaged ommercial surveys — it's hard to draw useful comparisons among them.

Those agencies that choose to use patient perception measures to meet their ORYX requirements must use a patient satisfaction tool offered by their performance measurement system, Sprenger says.

Long surveyed Arizona agencies a year ago and found a wide variety of patient satisfaction survey efforts. "Some agencies do it right on discharge, others while they are still on service," she says. "Some do a sampling, while others survey all patients that have used agency services. Some don't know whether it's the client who fills out the questionnaire or someone else in the family. All of those things may make a difference as far as what your final satisfaction scores are."

Home care itself has certain features that make it difficult to compare satisfaction with other health care providers, she says. "There's a lot of research that shows that continuity of care and interactions with staff are highly valued. In home care, where you are generally having the same person throughout your duration of illness, that can play more of an important role. The proficiency of clinicians can be important."

A patient in the home is expected to participate more in his or her own care, and that, too, can affect the relationships with caregivers and the satisfaction of the patient.

Front-line care staff aren't the only ones who can have an impact on patient attitudes. Billing, scheduling, and other interactions between the agency and the patient all can lead to client perceptions, both good and bad.

Long says these results must be considered in tandem with other outcomes measures. She notes, for example, that patients who are doing poorly can have high satisfaction with their care, while the opposite might also hold true — an unhappy client may be doing well medically.

"That's why it is important to examine how utilization rates, access to service, and other key clinical indicators may relate to patient satisfaction," she says.

The response rate on surveys can vary widely depending upon the patient involved. Overall response rates, Long says, can be up to 80% to 85% for some agencies, which is considered quite successful. She says there are steps an agency can take to ensure more patients understand the survey and have an interest in returning it:

- **The survey's format.** It is important to consider the presentation and content of the form the patient must fill out. Is it too long? Does it adequately address all of the dimensions of care a patient is likely to encounter — nursing care, therapy visits, aides' services, billing, and scheduling?

Is it confusing? Long says many patients don't differentiate between the nurses and the other professionals who visit them. When asking about

specific care, a survey should describe the care involved, rather than just providing a label.

"Sometimes you have to clarify what those disciplines are," she says. For instance, "A question [should] ask about, 'the registered nurse — the nurse who came in to provide your teaching, take your vital signs, and report to your doctor.'"

She says a survey that is too long may turn off patients who feel they are too busy to participate, while a short, vague list of questions may lead a patient to believe it's not important enough to bother with.

Patients can provide a grade for each service — A, B, C, D, F — or can be asked to gauge their satisfaction on a scale from "very good" to "very poor," or "strongly agree" to "strongly disagree."

In addition to scored responses or rating scales, a patient should have the opportunity to discuss the care in his or her own words. Often, Long says, those comments will prove to be more useful than the simple satisfaction scale. The short answers will give you the "context of care."

She says it's important to give the client the opportunity to remain anonymous if he or she wishes or to leave a name and phone number for follow-up.

Long and **Diane Greeneich**, DNSc, RN, president and chief executive officer of Healthcare Systems Management Inc. in Goodyear, AZ, have developed a patient satisfaction survey called "HomeSat." **(A copy is inserted in this issue.)** The company also offers other patient satisfaction management services.

• **Invitations to participate.** It is also important to encourage the client to fill out the survey. That process can start with a self-addressed, stamped envelope, but it shouldn't end there, Long says. "What is the letter of introduction for the survey? Is there a special letter from the executive director that says, 'We really value your input?' People want to know that when they complete the survey, that someone will be reading it."

Long says successful invitation letters point out how the survey can help improve an agency's services.

• **Staff enthusiasm**. Staff play an important role in helping convince clients fill out the survey and send it in. In some agencies, Long says, the survey is included in the patient's admission packet. At the end of care, the nurse removes the survey and explains to the patient how important the feedback is to the agency.

"The nurse or therapist can say, 'Here is the survey. We're really interested in knowing what you think.' Bring it to their attention, along with the stamped envelope."

Reinforce to staff the importance of the information, pointing out the effect that good patient satisfaction results can have on contracts and referrals.

Long says it's also important to provide individual feedback to employees who are praised in the surveys. "Most nurses and therapists like to get the feedback," she says. "When positive feedback comes back, share it. When staff get accolades back to them from the home setting, it's good to bring that to their attention."

Using the data

Once the responses start coming in, what do you do with them? Long says that process needs to start before the surveys are distributed, recognizing that multiple analyses can and should be done.

"Before you send out any survey, you need to have a database, some kind of statistical tool with which to enter and evaluate the data," she says. "If you're not set up for that analysis, it's very difficult. I've seen agencies send out the surveys and then have to hand-tabulate the data. They don't know how to really analyze it once they have the data in place." Some agencies may use Microsoft Excel, SPSS, or SAS, which are more sophisticated data entry and analysis packages.

Most prepackaged surveys will analyze data the agency has gathered. The manager then needs to interpret the data, she says.

Long says agencies should know what kind of information they want — averages or mean scores, the range of scores, and information broken out for each discipline.

When reviewing the surveys, an agency should note any written comments that point to an immediate medical or legal problem and address them right away. Otherwise, Long says, the goal is to find trends, comparing results over time and looking for areas of weakness and strength. When a negative trend shows up, it's important to carefully analyze what may be causing it. Many agencies use control charts. "Like any other outcome measurement, you go back and look at the processes of care," Long says.

One factor that can affect results is a small sample size, in which outliers are more likely to skew the results. "You can't talk about 10 surveys when, generally, they say you should have 100 to look at," she says.

Another way of blunting the effect of outliers is to use median measurement, which is the point in the scale that has an equal number of higher and lower results.

Judicious use of both scored results and written comments can help an agency focus on a problem and fix it. At Hospice of the Valley in Phoenix, results from patient satisfaction surveys were used to support a decision to change pharmacy services, says quality/compliance officer **Madeline E. Wollmer**, RN.

Wollmer says staffers already had been complaining about problems with the pharmacy. Then, she says, complaints started showing up on surveys. "I won't tell you that it was the only reason we changed pharmacies, but when your customers begin to tell you there's a problem, then there really needs to be some action taken."

On the clinical side, Long points to a home health agency providing intravenous therapy, an environment in which the proficiency of nursing staff is especially important. She notes that if a nurse comes out to start IV therapy and has to make multiple attempts, it can cause difficulty for the patient.

"The nurse may have to call another nurse out, but by that time, she's done, say, 10 sticks," Long says. "Patients are pretty good at evaluating technical things. They can tell when a nurse knows what she's doing or doesn't know what she's doing. That can relate to scores that are not very favorable."

She says the agency can review the scores, making note of any written comments that explain the problem in more detail, and use them to make changes. "When you look at your data for the month and see, for example, 10 comments about IV therapy, and it appears that the nurses are not very proficient in administering IV therapy, you'd want to look at that and see what's going on. Is it the same nurse? Are they patients who are very old and are a difficult stick? What are the issues that seem to be affecting the satisfaction score?"

At Hospice of the Valley, survey results are handled differently depending on their content. A wholly positive review goes directly to the manager of the team caring for the client. Negative results are sent to Wollmer, who reviews them and assigns the team leader to call the family. In the case of hospice, families are usually sent satisfaction surveys after the patient's death.

Complaints are tracked by the team, with an eye toward emerging trends. As an example, she points to a recent increase in the number of complaints about the hospice's after-hours service. "The director of that department has had to respond to all of those [individual complaints], but now I have a whole quarter's worth of results," Wollmer says. "I will say, 'Here's the trend for the whole quarter. You need to examine what's going on in your department.'"

Wollmer says survey results also can serve as a powerful argument to staff that they should improve. "It's very helpful for the staff member to see the comments on a survey. It means more than anything else. It's very powerful to be able to say to a staff member, 'Here's what your patients have said about you.'"

Outside comparisons

Drawing comparisons with other agencies can be more problematic because of the different types of surveys used, as well as the difficulty of finding similar organizations with which to compare an agency.

One agency may deal with terminally ill patients, a factor that could have a serious effect on satisfaction rates. Another might have a higher population of elderly people or Medicaid patients, both of whom, Long says, are more likely to be satisfied with their care than other groups. Patients with higher incomes are often less likely to be satisfied.

"All of these kinds of things are usually not factored into those surveys," she says. "You wouldn't ask a person's income level in a survey. There are so many variables that enter into the process that you can't control for on a 10-item questionnaire."

What an agency gains in creating its own highly individualized survey, it may lose in benchmarking ability. For example, Hospice of the Valley is switching from a fairly detailed survey to one with fewer questions so it can benchmark its results nationally.

Wollmer admits that it's a trade-off, but notes that even on a more general survey form, there's room for customization. "We've tweaked it. We've added some questions that we wanted to ask. We just won't be able to benchmark those answers nationally."

Despite the hassle, you can glean useful information from comparing your agency with others, Long says. "There's some value in benchmarking, but you need to understand there are caveats and

Sources

- **Diane Greeneich,** President and CEO, Healthcare Systems Management Inc., 14820 W. Trevino Drive, Goodyear, AZ 85338. Telephone: (623) 536-9744. Fax: (623) 536-9745.
- **Carol O. Long**, Assistant Professor, College of Nursing, Arizona State University, P.O. Box 872602, Tempe, AZ 85287-2602. Telephone: (480) 965-7444. Fax: (480) 965-0212. E-mail: Carol.Long@asu.edu.
- **Sharon Sprenger**, Project Director, Core Measure Identification and Evaluation, Division of Research, JCAHO, 1 Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5968. Fax: (630) 792-4968. E-mail: ssprenger@jcaho.org
- **Madeline E. Wollmer,** Quality/Compliance Officer, Hospice of the Valley, 1510 E. Flower St., Phoenix AZ 85014. Telephone: (602) 530-6985. Fax: (602) 530-6904. E-mail: mwollmer@hov.org.

variables. Standardization is forthcoming, and benchmarking is inevitable. The greatest challenge, however, is to truly capture the essence of patient satisfaction in your surveys."

Reference

1. Long CO. *The Arizona Home Health Care and Hospice Survey, 1999. A Final Report.* Tempe, AZ: Arizona State University College of Nursing; 1999. ■

Pain management is agencywide goal

QI project seeks improved pain assessments

At a Missoula, MT, home health agency, the road to better pain management is being walked with careful, deliberate steps.

Dianne Hansen, director of quality improvement for Partners in Home Care, says that as her agency copes with the prospective payment system and a host of other issues, slow and steady is the best way to work on improving pain management without overwhelming staff.

"You really don't want to try to accomplish this in a short time frame," she advises. "We've been at it almost a year, and we feel like we have a good handle on assessment. We're just beginning pharmaceutical intervention."

"You have to look at what you can realistically accomplish. At the same time, don't get so intimidated by the whole process that you don't begin. Just peck away at it, which is what we did. We'll probably still be working on it this time next year," she adds.

Luckily for Hansen, she has valuable resources at hand. Partners in Home Care has home care and hospice organizations under one roof, and some of the company's hospice nurses are well-versed in pain issues.

Pain as the fifth vital sign

Missoula also is the home of the Missoula Demonstration Project, an end-of-life initiative that is raising awareness of pain management issues, including teaching hospice agencies how to better assess and treat pain in their patients.

Partners became involved with the project through its hospice component, Hansen says. "They started working with some of our staff in hospice, including some of them in their training and planning. They had a task force called 'Pain as the Fifth Vital Sign,' whose major goal was to get facilities to incorporate pain assessment along with vital signs assessment."

She says that after participating in the demonstration project's training sessions, the agency began to try to institutionalize its pain management practices.

One of the strengths of Partners' program is that it treats pain management as an agencywide concern. Home health aides are taught to do basic assessments and report back to nurses. Social workers are expected to seek out possible psychosocial causes of pain. Therapists add nonpharmaceutical interventions such as positioning, therapeutic exercise, and massage.

"When we started, that was one of the goals, to treat pain management as an every-discipline issue," Hansen says. "It didn't belong to any one discipline or any one clinical staff person. Pain management is something that everyone is involved in."

Partners began its program by looking at what institutional standards were in place regarding pain assessment and pain management. "We're a home care agency that has home health, hospice, IV therapy, private duty, and a case management for the elderly Medicaid waiver program all under the same company," Hansen says. "And we're finding that each program addressed pain in its own separate way. There weren't any agencywide pain treatment standards."

Pain resource on the Internet

For more information about pain management, visit The Missoula Demonstration Project's "Pain as the Fifth Vital Sign" Web site at www.missouladem onstration.org/fifth_vital_sign.htm. It explains the project's work on pain education. ■

There were some programs within different disciplines. "Hospice had some policies; IV therapy had some policies on pain, but most of those were pump-related. We didn't really have any clear policies or procedures and standards," she says.

In assessing the clinical staff's skill and knowledge levels, the demonstration project already had laid the groundwork. Hansen says she found that while hospice nurses had a good understanding of pain management in general, home health nurses were less informed and more unsure about their knowledge.

"Home health nurses felt very inadequate in their knowledge level, and there were some nurses who just didn't understand really basic pain management," Hansen says.

There were other barriers to overcome. Documentation was inconsistent from program to program. Home health's older computerized documentation system had little flexibility to prompt nurses to ask pain-related questions.

Hansen says there was little comprehensive pain education, except for occasional inservicing. If nurses were unsure of their role, home health aides and social workers were even more in the dark about what they could do to help assess and manage pain.

With so many areas needing improvement, where do you start? For Hansen, the answer was obvious: pain assessment. "If you have a good assessment, even if that nurse doesn't know how to handle that pain situation, you can go from there," she says.

Throughout fall and early winter 1999, the agency devised a policy for pain assessment. They set forth standards that all staff must meet — to be able to assess pain's onset and duration, quality, location, and intensity.

Staffers in every discipline must know how to use a 10-point intensity scale to help patients determine the severity of pain. A pain assessment form was developed that could be used consistently throughout the different programs whenever a patient complains about pain.

In addition to intensity levels, the form includes descriptive words that can help patients describe their pain in detail. "It asks what medications have been tried in the past. Have they had any side effects? What effect does pain have on the patient's functioning?" Hansen explains. "We ask what is the patient's present pain level? What is their worst pain level? What is their best pain level? What is their goal?"

Wherever possible, Hansen says, the agency added cues in the computerized documentation that prompts nurses to ask about pain. The agency also created logs that patients could use to track their own pain. The logs help nurses document ongoing pain assessment in their clinical notes.

Staff education pays off

The agency used several methods to educate staff, including inservices, a self-instructional unit, and a skills fair, where staffers could model a good pain assessment. Most of the educational work was done by March 2000, Hansen says. Based on a short audit comparing this year's charts with those completed before the training, the project already is producing results.

"The results are looking really good," she says. "As far as whether they're recording location and intensity and quality and that kind of thing, those numbers look much better than they did from charts about a year ago. [Before,] we were addressing it only 20%, 30%, 40% of the time, and now we're addressing it 80% to 90% of the time."

The only area where improvement hasn't been as dramatic has been in recording patients' goals regarding pain. Hansen says she'll follow up with more chart audits later this year.

In beginning to train the staff on pain interventions, Hansen says she didn't want to bombard them with an overwhelming amount of information. Instead, the agency is developing guidelines that nurses can use to cope with different types of commonly reported pain.

As a backup, the nurses can consult with a committee made up of the agency pharmacist and a number of hospice nurses, Hansen says. If a patient reports mild pain, agency nurses have two or three things to recommend. "For severe pain, these are the oral drugs to begin with. You try that, and monitor the patient's pain over successive days. If they're having trouble managing it, [the nurse] could go to the consulting group to

try to determine why that regimen isn't working and make recommendations on some other possible therapies."

The nurses also get information on nondrug therapies to use in conjunction with pharmaceutical options. They are advised on symptom control, such as recommending laxatives when a physician prescribes opiates.

Hansen hopes the guidelines — and the consulting team approach — will take some of the burden off the pharmacist, who is currently fielding a lot of calls from nurses who aren't sure what to do. As the nurses become more comfortable with the basics, they'll learn more about pain management, such as converting from one medication to another.

"They've sort of had that training before, but they don't feel comfortable enough with it," Hansen says.

Patients, doctors need help, too

Nurses and other staff aren't the only ones who need more education on pain issues, Hansen says. For some patients, thinking and communicating in terms of a 10-point intensity scale is difficult. "Even though they can see it, it's hard for them to put a finger on what their level of pain is," she says. "So you have to do a lot of work with them in making them comfortable using that kind of a scale. That's probably been the biggest thing we've come across."

Eventually, she'd like to have a special educational packet that can be given to every patient who reports pain as a problem, and she says some physicians are just beginning to understand the importance of pain management. "A lot of them still prescribe regimens that are totally ineffective."

She says future educational sessions will deal with how to talk to physicians about recommendations for pain management. Hansen says the secret — no surprise — goes back to a good pain assessment. "You have to have your assessment data to back up what you're trying to recommend." ■

Source

- **Dianne Hansen**, Director of Quality Improvement, Partners in Home Care Inc., 500 N. Higgins Ave., Suite 201, Missoula, MT 59802. Telephone: (406) 728-8848. Fax: (406) 327-3727. E-mail: hansend@pihc.usa.com.

OASIS skills critical for data integrity

Agency targets three areas for improvement

Donaldson Home Health of Lebanon, TN, has made this the year of improving quality and compliance with the Outcome and Assessment Information Set (OASIS).

The agency collects data on 20 indicators from the OASIS tool, including the five deemed necessary for the ORYX initiative by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL. The indicators include OASIS data on pain, dyspnea, ambulation, management of oral medications, and discharges to an inpatient facility.

"This gives us a well-rounded picture of outcomes and a sense of what's going on with medications," says **Liz Lovvorn**, RN, CPHQ, quality improvement (QI) nurse for the agency, which is part of the University Medical Center of Lebanon, TN. However, in order to obtain the best data for QI comparisons, the agency needed to make sure the staff knew how to interpret OASIS questions and collect the most accurate data.

"Last year, we realized we were concerned about the data collection processes," Lovvorn says. "We decided we needed to divide the QI project into three components, and these 20 indicators are a part of that."

Here are the three parts of the QI project:

❑ **Education:** Employees took a pretest on OASIS, which helped Lovvorn identify problem areas. "We gave them examples and definitions, and the way clinicians responded to that, we realized we absolutely had a problem," she says. "We . . . developed a pretest for data entry folks as well, picking out specific indicators from OASIS and the basic principles."

The test fit on one page, and employees were allowed to take it home, with instructions to return it within a few weeks. Lovvorn estimates the test should have taken them no more than 10 to 15 minutes to complete.

Here are some test question examples:

• We have __ days to complete the OASIS discharge assessment. *(The answer is two.)*

• The data we are collecting and entering into the state's database will be used for:

A. partially driving the prospective payment system

B. Joint Commission vendor for ORYX
C. part of the state survey
D. part of the accreditation survey for the Joint Commission
E. A and B only
F. B and C only
G. A, B, C, and D *(The answer is G.)*

• Is it OK to enter an OASIS assessment completed by a physical therapy assistant? *(The answer is no.)*

After reviewing the test results, Lovvorn identified the problem areas, which included the third question above, and sent the staff educational self-study sheets on those areas. The sheets gave the staff the OASIS question, the OASIS definition, and some examples of how to apply that definition to the question.

Lovvorn also educated staff at weekly case conferences and by putting information on the agency's bulletin board. "But it was pretty much all self-study because inservices are so hard for us to do now," she adds. When she felt confident that the staff had been educated about the correct ways to interpret and complete OASIS questions, she gave them a post-test. The staff showed they better understood OASIS data collection by their higher scores on the post-test. "It's a great way to make sure they actually understood what they read, and then they have an opportunity to come back to me with questions," Lovvorn says.

❑ **Data integrity:** The quality improvement committee reviewed the OASIS tool, evaluating it for what was working and what wasn't, and expanded the indicators that the agency was collecting. The tool was revised twice and now is in its third edition.

The team also audits 10 charts a month and then meets monthly or every other month to discuss changes to the tool and problems that might arise. For example, in May, the QI team realized that staff mostly understood how to complete the tool accurately, but they were having problems with timeliness. So the agency implemented a 100% timeliness log entry that keeps track of exactly when the assessment is logged in.

A data entry employee checks to make sure the tool is complete, without any blank questions, and then it's logged in. Lovvorn reviews the log sheet, looking for timeliness and other problems. When she finds a problem, she shows the employee who made the mistake in an effort to correct it immediately.

That process has worked well. "We showed a pretty significant decrease immediately," she says. "Our percentage of overall problems in May was 31%, and a month later, it was 24%."

One-on-one interviews with the staff and ongoing education are the keys to the agency's success in improving data integrity, Lovvorn adds. "People are beginning to understand what's a good indicator, and it's starting to click with them."

❑ **Program compliance:** Administrators and QI staff met to develop and implement an internal tracking process. One person now receives the nurses' daily visit notes and checks them off as they arrive. If a nurse turns in a discharge note, then the clerical person looks for an OASIS discharge assessment to accompany that note.

Lovvorn and the agency's director of clinical services work at making sure all of the documentation is obtained in time for the weekly case conferences. So if a nurse turns in a Medicare 485 worksheet, Lovvorn will hold it until the OASIS assessment is completed and turned in. Then the physician is notified.

"Now we have an internal process to make sure the physician remains in the loop," she adds. ■

Source

- **Liz Lovvorn**, RN, CPHQ, Quality Improvement Nurse, Donaldson Home Health, University Medical Center, 500 Park Ave., Lebanon, TN 37087. Telephone: (615) 449-0045.

PA agency develops competency pathway

Project has been refined over past seven years

SNI Home Care of Langhorne, PA, has long been refining and expanding its competency pathway, which first became a quality improvement (QI) project in 1993.

"This fiscal year we have a competency program for all of the clinical staff, and now we're developing one for the nonclinical staff and in-house people," says **Beth Henn**, RN, MS, director of quality management for the agency, which serves 11 counties in central Pennsylvania.

The agency's work has resulted in a comprehensive competency program that incorporates the competency pathway with job functions and

provides objective outcome scores that can be used by an employee to benchmark against other employees' performances.

The competency program was presented successfully to an accreditation surveyor from the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

One of the important benefits of a competency program that provides objective scoring and benchmarking is that it results in concrete outcomes data that can be presented to managed care companies during contract negotiations. That was one of the reasons SNI developed the program, Henn says.

"Our chief executive officer said that we needed to show managed care companies that we really do have skilled nurses," she explains. "We can say we have wonderful nurses and all the patients love us, but everybody can say that."

Instead, the agency needed an objective tool to demonstrate evidence of the nurses providing quality care, she says. SNI's competency pathway eliminates subjective evaluation criteria and measures four functions: credentials, documentation, daily performance, and observable job performance.

The program provides each employee with a "report card." Supervisors receive concrete feedback on employees' performance and can use it to focus remediation efforts.

"Each area we score on is tied to an employee's ability to get a raise or to move further up the organization," Henn says. "So each year, employees have control over how well they do, and they know if they don't score at least 95% on the competency tests, then they don't get a raise that year no matter how hard they work."

Here are some key features of the program:

- **Credentials:** The human resource team tracks employees' professional licensure, health requirements, and CPR certification. Professional staff who are missing any of those credentials are suspended from providing patient care.
- **Documentation skills:** Documentation skills are measured through a peer review process. Employees who are not documenting charts or other paperwork correctly and consistently are subject to a focus review. If the chart audit indicates the employee does not understand proper documentation, then the supervisor will provide individual remediation.
- **Daily performance review:** Each employee's immediate supervisor completes the daily performance requirement section of the competency exam. For example, supervisors check to make sure employees return paperwork in a timely fashion and that they attend case conferencing and any required inservices.
- **Observable job performance:** The agency's goal is to have employees perform in the field as precisely and correctly as if they were being observed during a Joint Commission or state survey, Henn says. "They have one chance to do it, and they know we're coming, and we'll go through the whole visit with objective measures in safety and infectious control and responsibility."

For example, a supervisor may analyze a therapist's or nurse's hand-washing procedure. The supervisor observes how long the employee washes his or her hands and all of the steps the nurse takes in doing so. Each step of the process is scored.

The competency program also entails standardized testing in four areas. Those tests contain

the same core competency materials that are used to evaluate staff during actual, on-site field assessments. "This allows us to make sure they are practicing what they preach," Henn says.

Staff must score 95% in each area. If they do not, they are placed in a remedial program. "So we hit the points each person does not understand," she says.

Staff can study at their own pace

Henn and two other quality improvement employees designed the competency program based on their research of the core competencies required for licensing and certification.

"We went back and looked at all the surveys from the Joint Commission to see if there were any deficiencies or recommendations to address," she says. "We read home care literature and looked at tips of areas the state and Joint Commission review."

Using that material, they began to write questions for the competency tests and developed material for a self-learning module. The competency tests are designed to take one hour to complete. Each includes 25 questions.

The self-learning modules were important to the program's success because the field staff no longer have time to sit through lengthy inservices. This way, they can study at their own pace at times that do not interfere with client visits. "If we bring our field nurses into the office for inservices, we're losing . . . business in the field," Henn explains.

Once the competency exams and self-learning modules were completed, the QI staff presented the material to a committee for review. The committee made some changes after several meetings, then the QI staff brought the revised tests to a small group on a trial basis. They made further changes, based on the pilot project.

The next step involved analysis of the results. Any areas that consistently gave staff difficulty became small performance improvement projects. The quality improvement team also fielded suggestions from the staff. When the refining process was done, the competency program was integrated more fully into the agency's computer software.

Having a thorough and objective competency program enables an agency to be fully prepared for any surprise survey visits. "The staff will know all policies and procedures and do their tasks right 100% of the time," Henn says. "That's the ultimate goal."

The staff at SNI may not be at 100% yet, but they have definitely improved and the program is working, she adds.

"I know it's working because when I go out in the field and watch the staff do a procedure and they miss a step, they look at me and say, 'I know what I did wrong,'" Henn says. "In the past, they might not have known they missed a step, but now they do." ■

Source

- **Beth Henn**, RN, MS, Director of Quality Management, SNI Home Care Inc., 880 Town Center Drive, Langhorne, PA 19047. Telephone: (215) 641-8000.

Reap big rewards with recruitment project

Agency finds money isn't only worthwhile goal

One of the downsides of a thriving economy is that it's hard to recruit and keep professional and trained staff. Add to that problem the cyclical nature of health care, which occasionally has a nursing shortage nationwide, and individual home care agencies are left with quite a dilemma. How can they recruit and keep the best staff?

CareGivers of Southwestern PA in Greensburg, PA, has faced that problem in hiring and retaining both nurses and home care aides. "We, like

COMING IN FUTURE MONTHS

- ■ Will PPS open the door wider to telemedicine?
- ■ Help patients reminisce to improve quality of life
- ■ What does the public really think of home care?
- ■ Learn about a care delivery model that focuses on patient outcomes, not visits
- ■ Develop an optimal volunteer system without increasing costs

everyone else, are extremely short of help," says **Mary Jane Helfrich**, RN, chief operating officer of the agency, which serves an area 30 miles east of Pittsburgh. "The problem started five years ago, and it has gone downhill consistently, so last year we decided to do something about it."

The agency made staff recruitment and retention a performance improvement project, following all of the usual steps. Here's how it worked:

1. **Identify the problem.** It wasn't difficult to see that the agency needed to improve its employee recruitment and retention process. Managers identified that as the main problem and then called an employee meeting to learn more about the smaller issues relating to it. Employees might have offered a few clues, but Helfrich and other managers had a better idea. They decided to track all staff present at the meeting as a group throughout coming months and years. "We decided to keep these people as a core group and track them over the years," Helfrich says. "We'd assess the pros and cons of their jobs."

During the meeting, the employees expressed satisfaction with the agency's flexible hours, the office staff's professionalism, the free CPR course, the free TB test, and the free mandatory education courses. "Some agencies make you get all of this on your own, so at the meeting they identified those as the things they liked about the agency," she says.

2. **Find out what staff dislike about their jobs.** Predictably, some staff desired a bigger paycheck, but that could not be changed, particularly because the agency relies solely on private-pay clients and does not receive Medicare, Helfrich says. "When I explained to them that we're not a Medicare agency and we have to bill for our services, they were able to understand a little bit why we have to keep costs low," she explains. "The patient is paying out of pocket for these services, and we do pay a good salary, anyway."

The staff also said they wanted more agency socialization — events the entire staff could attend, along with their families. That was another difficult area for the agency to improve because the agency employs only about 50 staff. A big event, such as a Christmas party, would be difficult to hold at a time when all staff could attend because some employees work late shifts.

Employees asked for health insurance, which the agency could not provide because, although it's a subsidiary of Westmoreland Health System

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. ■

Homecare Quality Management™ (ISSN 1087-0407) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Homecare Quality Management™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $319. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies. $191 per year; 10 or more additional copies, $128 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $53 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Executive Editor: **Jim Stommen**, (404) 262-5402, (jim.stommen@ahcpub.com).
Associate Managing Editor: **Lee Reinauer**, (404) 262-5460, (lee.reinauer@ahcpub.com).
Senior Production Editor: **Terri McIntosh**.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Editorial Questions

For questions or comments, call **Lee Reinauer** at (404) 262-5460.

in Greensburg, PA, it doesn't receive hospital benefits.

3. **Create solutions to areas of staff discontent.** Managers brainstormed with the staff to find solutions to the areas they identified as problems. One solution involved the issue of increased staff socialization. Although the agency couldn't hold its own Christmas party, managers could make sure employees were invited to a Christmas party held at the health system's hospital. All employees and their families could attend the event.

Although it wouldn't be feasible financially to give each employee a salary increase, managers decided they could offer bonuses based on the number of hours worked in a quarter. Any employee who worked 500 hours in a quarter would receive a $60 bonus, which would be paid twice a year, and the hours would be carried over from one quarter to the next for an accumulative effect.

Managers created another benefit for staff: free tickets to a local amusement park. Employees could visit the park whenever it was most convenient. One ticket, valued at $20, was given to each employee. Then, employees could buy additional tickets at $10 each so they could bring their families along.

4. **Improve staff recruitment efforts.** The agency advertises for employees in the local newspaper, placing classified ads every two weeks. "We also work with the local community college and vocational tech school, which offer classes for certified nursing assistants," Helfrich says, "and we work with the job improvement service here in the county. It's an unemployment service from the state."

The county's low unemployment rate has made those efforts challenging, particularly when the agency tries to hire certified nursing assistants (CNAs). "It used to be that people tended to go into health care, but now they go into retail markets and other industries," Helfrich explains. "To find CNAs, we try to target high school graduates who may not have the resources to go to college but still are caring individuals who are interested in helping people."

The agency also has participated in college job fairs and has even offered paid CNA training, which cost $465 per person for an 80-hour home care aide course. Although it was not overly successful — of four people who started the course, only two completed it, and only one of those still works for the agency — it was a creative solution to the recruitment challenge.

"It's becoming much more difficult to recruit employees or even to get them to answer your ads," she says.

5. **Track current employees to see if improvements help retention rates.** The agency will continue to follow the staff who attended the meeting last year for at least five years. Those include RNs, LPNs, and home care aides. A year has passed since the meeting and since changes were implemented, and the retention rate has been 75%, which is fairly good, Helfrich says.

"We're very happy with 75% retention because they are good employees and work very hard for us," she explains. "Many work overtime, and they have a commitment to their patients and are very responsible people." ■

Source

- **Mary Jane Helfrich**, RN, Chief Operating Officer, CareGivers of Southwestern PA, 501 W. Otterman St., Suite D, Greensburg, PA 15601. Telephone: (724) 850-6950.