AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

INSIDE

AUGUST 2001

VOL. 7, NO. 8
(pages 85-96)

Want better wound care healing and outcomes? Add a dietary consult

Kansas agency's program targets chronic wounds

Including dietary consults is not a routine part of many home care wound programs, although the referrals could help improve outcomes. But Susan B. Allen Memorial Hospital Home Health Agency in El Dorado, KS, recently changed its routine chronic wound program to include a dietary consult that's not just for patients who are considered at risk.

"Based on current research and workshops I've attended on wound care, it became apparent to me that the dietitian was a very integral part of our wound care team that we were not utilizing," says **Melinda May**, BHS, RN-RRT, director of the hospital-based home health agency that serves two large counties in south-central Kansas. "We as RNs and health care professionals could be going out and doing daily wound dressings and keeping the wound clean, but unless you changed a nutritional status, the patient's care would be very long term and a costly endeavor."

Elderly patients who often have comorbidities sometimes have poor nutritional habits, which prevents the body from most effectively healing itself, May adds.

"The elderly usually have a comorbidity, whether it's peripheral vascular disease, diabetes, decreased nutritional status, malnutrition, obesity, venal insufficiency, or others that are costly to home care agencies," May explains. "My RNs are very excellent assessors, but when you look at the issue of nutrition, there are a lot of things we would not know to catch."

The home care agency has implemented a policy to have a dietary consult for all chronic wound care patients. Acute wound care patients would receive the consult only when the patient appears to be at risk, May says.

The policy is too new to measure outcomes, but the agency will gather baseline and intervention data to see if patients are healing more quickly.

Here's how the program works:

1. Initial assessment.

Within 24 hours of the agency receiving a referral, the initial assessment is done. If the clinician sees that the patient has a chronic wound, then the patient would be referred to a dietitian. The agency's policy is to have the dietitian follow-up on the referral within 48 hours, May says.

"She'll go through her nutritional assessment and come up with a plan, whether it involves meal planning, a change in diet or increasing protein intake," May says. "Then she writes her dietary plan for the patient and follows up as needed."

The agency submits a physician order for the dietary consultation and the dietitian is given flexibility in how many visits are necessary, since some patients will make the necessary changes after one visit and for others, three or four visits may be necessary, May adds.

2. Nutritional assessment and intervention.

During the nutritional assessment, the dietitian reviews dietary information and instructs the patient on changes needed to promote healing. Patients often do not understand how wounds heal and how the foods they eat could affect that healing process, May explains.

"We have them look at food as medicine for the wound itself and if they put the correct medicine in their bodies then they will heal that much faster," May says.

The patient receives written nutritional information that the dietitian will review with the patient. They include food and medicine guides developed by the American Heart Association of Dallas; the U.S. Department of Health and Human Services of Rockville, MD; Sandoz Pharmaceuticals Corp. of East Hanover, NJ; Krames Communica-tions of San Bruno, CA, and other pharmaceutical companies. **(See handout about food and drug interaction, p. 87.)**

However, the nutritional assessment and education are designed for a particular patient's needs and preferences. For instance, if a patient has certain cultural preferences in meals, then the dietitian will take them into consideration when devising a diet. The dietitian also will check with the patient to learn what vitamins and supplements are being taken, and if there are none, the dietitian may educate the patient about the importance of vitamin and mineral supplements. Nurses also review with patients information about how to prevent medical errors, including those resulting from the use of

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CE questions

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.

17. Hand-held personal digital assistants (PDAs) can enable a nurse to:
    A. complete necessary forms.
    B. schedule visits.
    C. check drug interactions.
    D. all of the above

18. Clinical staff picked to help an agency upgrade its technology need not have special computer expertise, as long as they are good problem solvers and critical thinkers.
    A. true
    B. false

19. Which of the following is the most important reason why home health agencies might consider including a nutritional consultation with chronic wound care patient care?
    A. Having a dietitian consult with a home care patient might improve reimbursement.
    B. Wounds may heal more slowly if a patient's nutritional status is poor.
    C. Nurses often do less than an adequate job explaining to patients how and what they should eat to improve their health.
    D. none of the above

20. Which of the following is an attribute of a good home health care leader?
    A. A person who would grasp and value relationships within an organization.
    B. A person who can think in terms of change and renewal and instill confidence in staff, taking them places and encouraging them to do things they might be afraid to attempt.
    C. A person who is willing to be a coach and facilitator and work beside staff rather than being the traditional type of boss.
    D. all of the above

Medication Guide for Patients

Discharge Instructions Addendum
A Medication Guide for Patients
FOOD AND DRUG INTERACTION GUIDE

• **Coumadin.** Avoid drastic changes in consumption of foods high in vitamin K, such as asparagus, broccoli, brussels sprouts, cabbage, cauliflower, chick peas, collard greens, green leafy vegetables, kale, lettuce, spinach, turnip greens, oats, herbal teas, soybean oil, and liver.
• **Diuretics, potassium-losing** (i.e, Hydrochlorothiazide, Lasix, Bumex). Your physician may instruct you to eat foods high in potassium, such as milk, artichokes, asparagus, avocado, lima beans, brussels sprouts, carrots, dried beans, lentils, potatoes, spinach, winter squash, sweet potatoes, tomatoes, tomato juice, apricots, banana, cantaloupe, dates, figs, grapefruit juice, honeydew melon, oranges, orange juice, peaches, prunes, prune juice, pumpkin, and raisins.
• **Diuretics, potassium-retaining** (i.e., Aldactone, Maxzide, Dyazide) and **ACE Inhibitors** (i.e., Capoten, Prinivil). Use caution when using salt substitute and light salts. These products may contain large amounts of potassium.
• **Iron supplements.** Avoid taking with milk, eggs, coffee, or tea. These items should not be taken at the same time or within one hour after a meal. Liquid iron should be added to water or juice and given through a straw to prevent tooth stains.
• **Lithium** (i.e., Lithane, Eskalith, Lithobid). Maintain a regular diet that includes salt intake and eight to 10 glasses of water daily.
• **Monoamine Oxidase Inhibitors** (i.e., Marplan, Matulane, Nardil, Parnate). Avoid tyramine-containing foods, such as avocado, bean curd, fava (board) beans, green bean pods, olives, pickles, sauerkraut, overripe vegetables, bananas, canned figs, overripe fruit, raisins, raspberries, aged cheeses, caffeine, coffee, tea, chocolate, yeast abstracts (marmite), brewer's yeast, MSG, meat tenderizers, ginseng, miso soup, yogurt, soy sauce, sour cream, caviar, aged game, bologna, pickled/dried herring, liver, salami, shrimp paste, smoked meats, summer sausage, beer/ale, Chianti, port wines, red wines, sherry, vermouth, and white wines.
• **Tetracycline.** Avoid milk and milk products. If necessary, these products may be taken one hour prior or two hours following medication administration.
• **Medications to be taken with food.** Advil, aspirin, Ceftin, Cytotec, Feldene, Macrodantin, Mevacor, Mexitil, Motrin, Naprosyn, potassium, Parlodel, Sinemet, steroids, Tagamet, Ticlid, Tonocard, Toradol, Vantin, and Voltaren.
• Medications to be taken 30 minutes before meals: Glucotrol, insulin, Lopid, Prilosec, and Reglan.
• Medications to be taken on an empty stomach (at least one hour prior to a meal): Bumex, Carafate, Hismanol, Penicillin and derivatives, Isoniasid, Zithromax, Tetracycline, Lorabid, and Dyazide.
• Avoid alcohol with the following medications: Aspirin, Coumadin, Dilantin, Flagyl, Inderal, Isoniazid, tranquilizers, Isordil, Lanoxin, Lithium, Lomotil, Marplan, Matulane, Mysoline, Nardil, nitrogylcerin, Nizoral, Parnate, Procan, Quindine, Tagamet, Tambocor, Tegretol, Tonocard, Tylenol, antidiabetic medications, antihistamines, antidepressants, pain medications, sleeping medications, and sedatives.
• Avoid antacids (Maalox, Mylanta, Tums, etc.) with the following medications: Achromycin, Cipro, Coumadin, Declomycin, Floxin, Lanoxin, Maxaquin, Minocin, Nizoral, Noroxin, Quinidex, Quiniglute, Rifamate, Sumycin, Terramycin, and Tetracycline.

As the patient, you play an important role in your medication therapy. Never hesitate to ask questions concerning your medications. You will experience the maximum benefits of your medication therapy if you take the medications as directed by your physician and pharmacist. You should ask you physician and/or pharmacist the following questions when a new medication has been prescribed:

1. What is the name and the strength of the medication?
2. Which medical condition is the medication for?
3. How should I take the medication?
4. What are the common side effects of the medication?
5. Does the medication interact with other nonprescription drug products that I have at home?
6. Is it safe to drink alcoholic beverages with the medication?
7. What should I do if I miss a dose?
8. How should the medication be stored?
9. Is a generic brand of medication available?
10. Can my prescription be refilled? How many times?

Tips to Help Prevent Medical Errors

A Patient Fact Sheet
Medication Precautions

• **Make sure that all of your doctors know about everything you are taking.** This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs. At least once a year, bring all of your medicines and supplements with you to your doctor. Brown-bagging your medicines can help you and your doctor talk about them and find out if there are any problems. It also can help your doctor keep your records up to date, which can help you get better-quality care.
• **Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.** This can help you avoid getting a medicine that can harm you. List all medicines you are currently taking, including any herbal supplements and vitamins/minerals. Herbal supplements may interact with prescription medications.
• **When your doctor writes you a prescription, make sure you can read it.** If you can't read your doctor's handwriting, your pharmacist might not be able to, either.
• **Ask for information about your medicines in terms you can understand — both when your medicines are prescribed and when you receive them.**
— What is the medicine for?
— How am I supposed to take it, and for how long?
— What side effects are likely?
— What do I do if they occur?
— Is this medicine safe to take with other medicines or dietary supplements I am taking?
— What food, drink, or activities should I avoid while taking this medicine?
• **When you pick up your medicine from the pharmacy, ask: "Is this the medicine that my doctor prescribed?"** A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88% of medicine errors involved the wrong drug or the wrong dose.
• **If you have any questions about the directions on your medicine labels, ask.** Medicine labels can be hard to understand. For example, ask if "four doses daily" means taking a dose every six hours around the clock or just during regular waking hours.
• **Ask your pharmacist for the best device to measure your liquid medicine.** Also, ask questions if you're not sure how to use it. Research shows that many people do not understand the right way to measure liquid medicines. For example, many use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people to measure the right dose. Being told how to use the devices helps even more.
• **Ask for written information about the side effects your medicine could cause.** If you know what might happen, you will be better prepared if it does, or if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicines could help patients recognize problem side effects and then give that information to their doctor or pharmacist.
• **Here are some other steps you can take:**
— Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.
— Make sure that someone, such as your personal doctor, is in charge of your care. This is especially important if you have many health problems or are in a hospital.
— Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything he or she needs to.
— Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.
— Know that more is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
— If you have a test, don't assume that no news is good news. Ask about results.
— Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources. For example, treatment recommendations based on the latest scientific evidence are available from the National Guideline Clearinghouse at www.guideline.gov. Ask your doctor if your treatment is based on the latest evidence.

Source for both charts: Susan B. Allen Memorial Hospital, El Dorado, KS.

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over-the-counter food supplements. **(See tips on preventing medical errors, p. 88.)**

The dietitian then tells the nurse what dietary information has been reviewed and what needs to be reinforced.

3. Monitoring patient status.

Nurses and the dietitian discuss patients' wound care and nutritional status at weekly case conferences. Sometimes these sessions result in the dietitian hearing about a particular case in which the dietitian needs to be involved, although a referral had not yet been made.

When the dietitian makes only one visit to a patient, the nurses will continue to monitor the patient's progress, including nutritional status. Nurses ask patients questions to assess whether they are following the dietitian's guidelines. When patients don't comply, it's noted in their chart.

May says this information will be collected and analyzed to see if wound outcomes are better for patients who receive the nutritional assessment and adhere to the dietitian's recommendations when compared with patients who receive the information but do not adhere to the dietary plan.

4. Providing multiple visits.

If a nurse reports at a case conference that a patient is not adhering to the nutritional plan, then the dietitian may pay the patient another visit and reinforce the importance of nutritional status to both the patient and family caregivers.

"A lot of times they see the same nurse day after day, and it's good to have a new face visiting them who will reiterate what we're trying to accomplish," May says. "So if we feel like we need an extra push to make the patient more adherent, we'll send the dietitian back out."

However, nurses and the dietitian cannot force a patient to improve his or her diet. "We stress that you don't have to do this, but it will help you to become more independent and allow you to do the things you want to do in your life," May says.

Sometimes, it simply will not work. For example, the agency had a younger non-Medicare client who had renal disease and was an alcoholic. The patient was shuttled back and forth between dialysis, home care, and acute-care services. No matter how the dietitian and nurses explained to the patient that continued alcohol use would only keep the patient ill, the patient would not stop drinking and there was nothing they could do about the problem, May recalls.

In other instances, the dietitian may need to repeat the education because the patient has poor cognitive status and was unlikely to understand or remember the information after only one visit.

And, in at least one case, the dietitian had to meet again with a patient and family because interpersonal dynamics between the patient and a daughter were causing conflicts. The daughter was severely strict with her mother over what she could and could not eat. The mother thwarted her daughter's efforts by asking a neighbor to sneak cookies to her. Finally, the dietitian had to meet with the daughter and explain that the patient has the right to eat the wrong foods and that the staff and family can only encourage her to adhere to her meal plan.

Selling nutrition is part of the dietitian's duties, May notes. "Our dietitian loves to do this work and she loves home care with a passion, so this is something she really has a heart for." ■

Train home care staff for leadership roles in agency

Training improves morale

Although it's increasingly difficult for home care agencies these days to recruit qualified professional staff, it's also hard to find or develop good leaders and managers.

The Detroit-based Henry Ford Health System Home Health Care has applied performance improvement principles to developing home care leaders. The organization initiated a leadership program that incorporated these major components of quality leadership: leaders who can use the tools of strategic planning, process improvement, data analysis, and employee attentiveness to produce business results and customer satisfaction, says **Greg Solecki**, vice president for home health care with this large, urban health care system.

The agency has incorporated that model into its business by using this criteria during performance evaluations and during the strategic planning process.

"We began to look at the distinction between traditional managers and what we hope are new-thinking leaders," Solecki says. "We want to instill in all types of staff the passion for leadership, so even a file clerk, a home health aide, and a home health nurse would be encouraged to think like leaders."

Here's how the home care agency has developed its leadership training program:

1. Identify ideal leadership characteristics.

The home care agency's management identified these leadership abilities:

- one who would accept leadership changes that are needed for success;
- one who would grasp and value relationships within an organization;
- one who will help staff put an emphasis on mission, vision, and values;
- those who can think in terms of change and renewal and instill confidence in staff, taking them places and encouraging them to do things they might be afraid to attempt;
- those who are willing to be coaches and facilitators and work beside employees rather than being the traditional type of bosses;
- those who can focus on quality, service, and customers, and not just the bottom line;
- those who can gain commitment from others rather than demanding compliance.

The last characteristic of a leader is especially important, Solecki says. "As we continue to experience labor shortages in critical key positions within the home health industry, the old style of being a boss and demanding compliance is not going to work with the new-style employee," he explains, "so leaders are those who can gain a commitment from folks."

While discussing the important characteristics of a leader, the agency's managers debated the nature vs. nurture question, which is whether a leader is born with a certain personality that leads him or her to seek leadership skills or whether a leader is cultivated by mentors / teachers.

Finally, they decided that even if leaders are born, not made, the leadership program could help them be better leaders. And if leaders can be cultivated, then the agency could find out what that formula would be and develop it, Solecki says.

2. Develop program to provide technical skills.

As a result, the agency developed the Leadership Home Health Care program, which teaches staff the technical skills needed to deal with conflict and other issues.

The program teaches participants standard human resources skills such as how to hire staff and help employees improve and how to understand rules and regulations. They also learn how to do home care billing and other technical issues.

"We tried to instill the concept that the process you own is tangential and has an effect on a multitude of other processes throughout the home health agency," Solecki says. "So we tried to connect the dots for people, and we put them through training every month to give them a bigger picture."

Leadership program participants attended classes on a variety of subjects, taught by various people, including physicians. **(See leadership program activities, p. 91.)**

The program consisted of classroom educational meetings one day a month for six months and various hands-on learning experiences.

Each month, different guest leaders speak to participants. One month, physicians from the Henry Ford Health System talked about home health and physician communication. Their lecture was direct and met the leadership program's objectives partly because the program leaders told the physicians in advance what they thought were the barriers to good communication and how those barriers could be turned into opportunities, Solecki says.

3. Offer hands-on learning opportunities to potential leaders.

"We required leadership home health care participants to have a number of learning experiences that we felt would solidify the classroom-learning experience," Solecki says.

These hands-on activities might include attending a medical advisory board meeting and attending a monthly income-statement meeting.

"We had them process bills in the billing department and we had the office staff make home visits with the clinical staff," Solecki explains. "Ultimately, we tried to make sure the participants were getting a better glimpse and a better grasp of the bigger picture, not just within our agency, but also within the health care system and community."

The idea was to show potential leaders how it feels to be at some other job or to have different medical responsibilities. For instance, a leadership program participant might learn from a lecture by a physician or from attending medical advisory board meetings that physicians have a variety of daily challenges that make it difficult for them to always communicate effectively with home care staff.

Through these empathy-building sessions, potential leaders learned that barriers to success were not unique to them or to home health care, but were universal throughout the health care industry.

4. Test participants.

The agency gave participants a pre-test to

assess their baseline knowledge and leadership ability and a post-test within six months to measure their improvement.

"What we saw was that participants valued the leadership home health care experience and did grow in understanding of the bigger picture," Solecki says. "They better understood tasks and interrelated processes."

During National Home Care Month, the leadership program graduates were recognized at the annual employee recognition reception. So far, 17 people have volunteered and successfully completed the Leadership Home Health Care program.

"It dovetailed in with all of our other employee recognition efforts and was very positive and well-received," Solecki notes. "We made sure we got plenty of splash within our systems' newsletter and other in-house publications, and we made sure in the home health newsletter that they were honored as well."

5. Identify outcomes.

The post-test showed that leadership training participants had improved in their understanding of what it takes to be a good leader.

"They all understood the difference between being a new leader vs. a traditional boss," Solecki says.

Some of the program graduates were promoted to management positions. Those who did not apply for a promotion had at least gained some enrichment in their current positions and were content to stay where they were. "From our perspective, that's OK, too," Solecki says.

"We wanted to deploy leadership to every level and to every type of employee, and some left for better positions outside the organization, which was OK," he adds.

Due to the program, home care managers began to see some improvements in the relationships between various processes, such as clinical operations and financial operations. Members of the leadership training program began to volunteer to participate on process improvement teams that were cross-functional in nature.

"We had them working on processes like the timeliness of our billing process, for which we relied upon timeliness of clinical documentation being returned and timeliness of it being entered into a computer database, and the timeliness of getting the bill out the door," Solecki explains. "And we saw an improvement in that."

Even in processes where there was no noticeable improvement, managers saw that there was less acrimony between departments and less of an us-against-them mentality.

6. Adjust program when necessary.

After some successful years of the formal leadership program, home health care managers decided it was time for some changes.

With the implementation of the prospective payment system, it became clear that staff no longer had time for the full leadership training program. Also, the agency now has to focus more on recruiting and retaining staff since there is an industrywide labor shortage.

"The challenge of the environmental pressures combined with our desire to more effectively deploy leadership development has caused us to rethink having leadership classes," Solecki says.

Currently, a team is looking at re-engineering the leadership development program and so a leadership course was postponed this year.

"That's been met with mixed emotions," Solecki says. "We're all a little melancholy, but also enthused about taking what we have learned and making it more broad-scaled and effective."

Future leadership training courses might involve brown-bag lunches, newsletter education, periodic fliers, voice-mail messaging, and other types of group, committee, and project team meetings that infuse leadership training in their goals.

"We're looking at a number of vehicles because everybody is strapped for time; and because our mission is to put patient care first, we can't add time to anybody's day," Solecki explains. "So we have to be more creative and we're trying to build in our desire and approach to train leaders in already-existing avenues, and that's going to be a challenge for us." ■

Henry Ford outlines its path to good leadership

Home health system focuses on results

The Henry Ford Health System Home Health Care in Detroit has a leadership program that is designed to teach volunteer staff how to become organizational leaders.

The program has included participation in the following activities:

- Attending a leadership training orientation.
- Participating on a committee to revise the home health care Physician Communication Guidelines.

Sources

- **Melinda May**, BHS, RN-RRT, Director of Home Health Agency, Susan B. Allen Memorial Hospital, 119 Jones, El Dorado, KS 67042. Telephone: (316) 322-4540.
- **Greg Solecki**, Vice President for Home Health Care, Henry Ford Health System, One Ford Place, 4-C, Detroit, MI 48202. Telephone: (313) 874-3135.

• Job shadowing for several hours with a case manager.

• Job shadowing with a home health supervisor.

• Attending a maternal/child team meeting, an advisory group to home health care meeting, a medical advisory group meeting, and an executive management staff meeting.

• Attending a high-tech leadership meeting, a managers' meeting, an information services task force, and a chief information officers advisory committee meeting.

• Accompanying a nurse or therapist or home health aide on a home visit.

• Taking courses on home health care, branch operations, and getting business results.

• Attending lectures/courses on managed care and physician relations, human resources, therapy services and clinical services.

• Attending committee meetings, such as the operations committee, home marketing committee, quality leader committee, quality improvement meeting, corporate nursing executive committee, and home health revenue and expense meetings.

• Participate in a new open packet process in which the participant will follow the new open from the time it is submitted into the office; checked by the supervisor; submitted to data entry for logging, coding, entering, and printing; proofing by leadership, and sent to the physician for signing.

• Assist with Friday morning work planning, working with team leaders at 7:30 a.m. in assigning cases.

• Participate in a chart review with the quality improvement department in response to a query and assist with the chart review and assist with preparation of the response for medical review.

• Participate in the trial bill process at the branch office and assist with the review of the trial bills, problem solving, and billing preparation.

• Observe a complete interview process and role play for an interview. ■

VNAs make the leap to new technology

Laptops, PDAs now used on nursing visits

Two visiting nurse associations (VNAs) undertook massive technology upgrades over the past year, despite the already daunting challenge of simultaneously weathering the new Medicare prospective payment system (PPS).

At the VNA of Hudson Valley, in Mount Kisco, NY, staff switched to a new computer system in July 2000, in part to prepare for the move to PPS. Since then, the agency has begun issuing laptop computers to its nursing staff.

In Santa Ana, CA, VNA Home Health Systems undertook an even greater leap. This year, clinical staff began switching from paper documentation to using personal digital assistants (PDAs) — small, hand-held devices on which nurses complete forms, schedule visits, and even research drug interactions.

Administrators in both organizations say any agency contemplating such an upgrade should be prepared for a lot of hard work.

"It invades every single inch of your organization to do something like this," says **Jeneane Brian**, BSN, MBA, president and CEO of VNA Home Health Systems, who wrote the software for the PDA-based system her nurses use. "It's going to take a lot of time and attention and people are going to have to be willing to do more than the normal stuff to get it done."

New system saves time

As the VNA of Hudson Valley prepared to cope with PPS, it had to deal with a time-consuming dual computer setup, says **Susan Tucker**, RN, BSN, director of quality improvement.

OASIS data were being entered into one computer system, and the rest of the agency's information, including billing and visits, being entered into a separate system.

In addition, the VNA wanted a system that would coordinate with other organizations in its health care network. And Tucker says the agency wanted eventually to incorporate laptop computers into nursing visits.

The rollout of the new system last summer,

with an initial focus on the agency's financial operations, turned out to be a blessing during the PPS transition. "We've been very lucky; we didn't have problems dropping RAPS [requests for anticipated payment] that some other vendors have had," Tucker says.

A key factor in the technology upgrade has been the new clinical information systems department, led by **Joyce Galuppo**, RN, MS, a former clinical manager with 25 years of home care experience. She and another clinical information services staffer work with two nonclinical employees who specialize in the system's hardware and software.

The group serves as a liaison among all the departments, and between the departments and the new computer vendor. Galuppo and her associate helped train different departments in how to use the system, and keep staff on top of upgrades as the company sends them.

Assessing nurses' computer skills

To train the nurses, the agency began by assessing their computer skills, Tucker says. Groups with more experience moved through the training process more quickly and in larger groups. Nurses who were computer novices were given more training time and smaller groups to work in.

Forms are filled out on the laptops using a stylus, so there's little typing involved.

"We rolled them out at first doing admissions," Tucker says. "Then they started doing recerts on them, then resumptions." She says the agency hasn't yet started doing discharges on the computers because of all the complex issues involved. The agency plans to be doing discharges on computer by early next year.

She says nurses tend to follow the same work patterns they did when filling out forms on paper. Those who did the paperwork while in the home do so on computers now. Those who simply took notes and filled out their paperwork later now use their notes to complete forms on computer.

As the nurses have become more proficient with the laptops, the agency has been able to process cases more quickly. Tucker says that at first, it was taking 17 days to produce a Centers for Medicare and Medicare Services (formerly the Health Care Financing Administration) 485 form. Now it takes four to five days.

As the quality improvement (QI) department tracks the process, it looks for areas that are slowing things down and addresses them. QI staff review all the computerized records to be sure OASIS questions are being answered properly and that ICD-9 codes are correct.

Galuppo says that as nurses raise usability issues, her department helps devise work-arounds, which are short-cuts that can solve the problems.

Some of the limitations of the new system, such as an inadequate care-planning component, are being addressed by the vendor in upgrades. Others, such as reporting limitations, are addressed by a separate ORYX vendor whose reports meet the agency's needs, Tucker says.

In the end, she says, initial concerns that the new system wasn't clinically friendly turned out to be mistaken.

"They thought it wasn't going to help nursing in any way, that it was going to be a nightmare to work with, and I think, after six or eight months, that people saw this wasn't quite so," she says.

When Brian came to VNA Home Health Systems last September, the agency was not automated on the clinical side, except for the inputting of data from paper records for Medicare reimbursement.

She says that arrangement makes it hard to fully monitor the effectiveness of care, since retrieving data from paper records is so laborious.

"What you see happening in most cases is that there are assumptions made from very small sample sizes," she says. "This agency is generally known throughout the community to be providing excellent care. I just don't know that we had the data analysis function to prove that."

As she considered computerizing the clinical operations, she looked at a system that would have included laptops in the field. But she was unimpressed with the company's response to the PPS conversion.

At Christmas, she discussed the matter with her grown children, some of whom are in health care and all of whom are computer-savvy.

They were the first to suggest to her that the Palm Pilot she used every day to stay organized might be the right choice for nurses in the field.

"My daughter, who is a nurse, said she uses hers at work, and my son went and found some development software that we could use to make a little program on," she says.

Brian already had given the devices to her executive team as Christmas gifts. Soon after, she offered to buy PDAs for the management staff. She told them: Try one for 30 days, and then decide whether to stay with the automated planner or go back to a paper organizer. All but one remained with the PDA.

As she explored the idea of a system based on Palms or similar devices, she used a software development program to create forms that could be filled out using the PDA's small screen.

A nurse can attach the device to a special keyboard, or use her own home PC. The data then are sent in an encrypted form to the main office to insure confidentiality.

One benefit from the new system will be to clear out a stockpile of old and useless forms that the VNA now stores. Brian says her agency has 9,000 such forms, each costing about 25 cents, that were discontinued because of outdated information or other problems.

Because she can edit the computerized forms herself, making changes is relatively simple. Brian recently appointed a nurse informaticist who will be taking over that job.

There still is one major form that nurses haven't gotten yet on the hand-held devices. Because of the complexity of the OASIS assessment — "it would take 100 screens to get through it" — Brian decided to work with an outside vendor for that form. Two companies she's reviewed already have developed OASIS forms for PDAs and a third wants to work with the agency to develop one.

She says that for agencies that don't want to try to develop forms in-house, PDA-based software for home health should be available in the next few years.

Brian also has made contacts outside the agency to make the best quality assurance use of all the new data.

She says she hopes to get graduate informatics students from San Diego State University to help create the necessary queries and analytical tools needed to make sense of all the computerized information.

Brian admits that her problem now is the opposite of when she started — instead of too little data to work with, she now has almost more than she knows what to do with.

"We're almost into a tsunami of data and we have to figure out how to make the most of it," Brian says.

Tucker and Brian suggest several strategies for smoothing the transition to new technology:

• **Plan to hold on to your old systems.** It's impossible for an agency to simply switch off one computer system and turn on another. Tucker says that for the first year, an agency needs to maintain the old system on at least a few computers to provide access to records and statistics.

And don't be too quick to throw away all the old paper forms once nurses have been switched to laptops or hand-helds. Brian says there will always be those at VNA Home Health Systems who work on paper, primarily nurses who work infrequently and don't spend enough time at the agency to become proficient on the computerized forms.

• **Look for added features to help clinical staff.** While an agency may switch to portable computer technology for financial or operational reasons, the devices can actually help nurses in the field deliver better care.

Brian says the biggest surprise with the introduction of hand-helds in her agency has been how nurses use them to help support clinical decisions.

VNA Home Health System's PDAs include pharmaceutical software that allows nurses to research drug interactions and contraindications.

"A nurse can look up all the drugs a patient is on, right there in the home," Brian says. "I think that is one of the most powerful things that I have ever been able to put in a nurse's hand."

Don't rush the introductions

Other programs can help with infection control and calculating IV drips.

• **Introduce staff to the technology gradually.** Brian says she introduces nurses to their new PDAs over a six-week period to help them get used to them. She starts with a 90-minute overview of the device.

"We show them how to physically turn them on, then we walk through some introductory information on how they navigate around. I let them have them for a couple of weeks, just to play with it."

A few weeks later, nurses learn how to fill out their first form, then another form, and eventually,

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must begin filing forms by computer.

"We're not giving them an option but we're giving them time," she says. "Altogether, it takes about six weeks to roll out that first form. And then after that, I don't have any problem because all I get then is pressure about where's the rest of [the forms]." ■

Choose the right staff to lead technology march

Those who've made the leap to new technology say a key to success is identifying staff who can serve as a liaison between the home health operations and the new computer system.

At the Visting Nurse Association (VNA) of Hudson Valley, in Mount Kisco, NY, one of those people is **Joyce Galuppo**, RN, MS, the agency's new director of clinical information systems. Asked what attributes her job requires, she answers expansively.

"You need someone who knows home care, who knows all the pieces, soup to nuts. Someone who has the clinical experience, who's had supervisory experience, and knows the big picture. But also has the ability to solve problems and do critical thinking. And has a sense of humor and is willing to work long hours."

Sometimes, that person, like Galuppo, is identified by administrators and assigned to the task or is the administrator**. Jeneane Brian**, BSN, MBA, president and CEO of VNA Home Health Systems in Santa Ana, CA, not only has overseen her agency's switch to a personal digital assistant (PDA)-based system, she actually wrote the software to create the forms her nurses use.

But neither woman, surprisingly, is your prototypical computer geek. Before taking on these projects, both say they were computer-literate, but had no specific programming or technology training.

"I owned a computer, and I could get on the Internet," Galuppo says. "I'm a pretty good typist, and I knew [Microsoft] Word very well. Did I know a whole lot of anything about computers? No. Did I learn this new system? Yes."

What's more important than computer-savvy is the clinical mind that a home health manager brings to the task of automating an agency, Brian says. Take the forms she creates. Because her nurses use hand-held devices with small screens, questions must be phrased so that they fit into a small space.

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.

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Subscription rates: U.S.A., one year (12 issues), $339. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies. $203 per year; 10 or more additional copies, $136 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 $57 each. (GST registration number R128870672.)

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"I believe that does take a clinical content knowledge person," she says. "I think a nurse needs to do that because only a nurse is going to know what that question implies and what the question is going for.

"The programming part to me is the typing part, and that's almost the fun part," Brian says. "The harder aspect of it is making sure you're asking the right questions and you're giving the right prompts for answers without biasing the information."

When VNA of Hudson Valley began the process of switching to a new computer system, it assigned two clinical staffers to help coordinate the change. One was Galuppo, then a clinical manager, with more than 20 years of experience. The other came from the agency's quality improvement department.

Both were sent to training sessions conducted by the vendor, where they learned about all aspects of the new system, including the software's financial applications. The breadth of understanding was essential as the team worked to bring each department up on the new system, first the back office and financial staff, then the clinical staff.

Because the new system ties the financial and clinical sides together so closely — it won't allow the agency to process a request for anticipated payment unless all of the assessment forms are filled out properly — Galuppo acts as a go-between, helping iron out problems as they come up.

"When the finance people run into a glitch — the visit isn't in, or the assessment hasn't been locked, or there's a question about the HHRG [home health-related group] — I'm the person who touches base with the clinical people," she says.

Choosing a project leader

Brian says that whoever is assigned to lead a technology project needs to be experienced enough to understand all of an agency's operations. "That's usually not somebody at the entry level of your organization," she says.

At the same time, the person tapped can't be so vital to day-to-day operations that the agency will fall apart without him or her. Galuppo says that when she first moved to the clinical information services role, she was relieved of all of her other duties for six months. Then, the job became permanent.

Brian says an agency should expect to lose the use of that staffer for at least a year.

"Whoever it is that's in charge of it needs to wake up in the morning thinking about it, and go to bed at night thinking about it, every single day," she says. "I don't know how else it can get done."

In her own case, Brian started VNA Home Health System's upgrade shortly after taking the helm in September. She says she was lucky the agency was so well run when she arrived that she could take on the automation project herself.

"I've been able to have the luxury to focus on this very intently for several months now without it meaning the agency faltered in any serious way," she says.

For Galuppo, focusing on the technology project hasn't distanced her from the home care nursing she loves. Before dispatching nurses with laptops out on visits, Galuppo tested the system herself in the field.

Whenever the agency installs an upgrade, she's the one who field-tests it.

"I think of myself as a nurse first, and I truly love nursing," Galuppo says. "We have all this equipment, you walk in with this laptop, but when someone's feet are really dirty and disgusting, you still have to pull the basin out and wash their feet. You still have to do hands-on.

"That's what I love about this. I don't see myself ever giving that piece up." ■