AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

INSIDE

DECEMBER 1998

VOL. 4, NO. 12 (pages 167-182)

American Health Consultants® is A Medical Economics Company

Prepare staff, patients for the big chill with a cold-weather contingency plan

Here's advice for dealing with winter's harsh conditions

Two or three inches of snow brings some cities to a halt. Buses don't run. Roads are closed. People can't get to work. Two years ago, when the Seattle area was hit with over a foot of snow just after Christmas, the local media told stories about home care nurses skiing in to see patients on their own initiative.

Most agencies based in areas with traditionally mild winters don't have contingency plans for cold-weather emergencies. That can place both staff and patients in danger. What can you do? Learn from the pros: agencies that deal with harsh winter conditions every year.

Each autumn, Western Illinois Home Health Care in Monmouth reviews its winter plan and re-emphasizes winter-safety precautions to staff and patients, says **Anita Rutzen**, RN, BSN, director of performance improvement/staff development.

The agency created its plan three years ago when it was first accredited by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Health Care Organizations (JCAHO). "It started out as a part of our general emergency preparedness plan," she says. "But while doing that, we realized we needed something more specific." Without a winter contingency plan, says Rutzen, there was a danger that no one in the agency would know how to make a decision on whether to declare a winter emergency.

Objective criteria make emergency decisions easier

She created a task force that included herself, two nurses, two home health aides, and a clinical supervisor. The task force developed a plan that puts the management nurse on call in charge of making a decision on whether to call a winter emergency. Rather than allowing a gut reaction to guide the decision, the task force decided to use objective criteria. "Then no one can claim the day was called on a whim," says Rutzen.

Those criteria are based on whether the National Weather Service is classifying a storm as a blizzard, or just calling for heavy snow. They also

take into consideration whether there is a winter storm advisory, watch, or warning issued. The nurse on call either phones the weather service or the nurse can check on the National Weather Service's Web site (www.nnic.noaa.gov/NIC/nwsfo.html) for the status. Only when there is a winter storm warning for most of the agency's 10-county service area is a snow day called.

The nurse in charge then calls local radio stations and asks them to make an announcement that the agency is operating under a winter weather warning. "It's a message to staff, really, to let them know they should call in," she says, adding the announcement is carefully worded to prevent patients who might be listening from panicking because their nurses might not be coming.

A phone tree is then used to ensure that all staff members are contacted about the emergency. The manager in charge ascertains which staff are mobile and determines which patients must be seen and who will see them. Rutzen says that she has even had staff use snowmobiles to get to patients.

Classify patients

Meredith Goodrick, RN, BSN, quality manager at Munson Home Care in Traverse City, MI, doesn't have a specific winter plan, but uses parts of her general emergency policy and staff safety training policies to get through the winter.

Upon intake, all patients are given a rating of either A, B, or C. The ratings indicate a patient's medical priority. All "A" patients have daily visits based on medical necessity. Patients who live alone are automatically rated "A." Patients rated "B" have a caregiver, but that person may not yet be trained. "C" patients are those for whom you can safely skip a visit, says Goodrick. A "C" patient might include someone who is a homemaker client or someone with a competent caregiver.

When an emergency situation is called, the managers on call in each of the agency's offices start a staff phone tree. Each of those managers has a list of the patients and their rating, as well as a list for each county that lists whom to call if a patient must be seen. In some instances, it is 911; in others, a private ambulance company or the sheriff's office. "Sometimes, a plow will take you in, and we have lists of which counties have snowmobiles, too," says Goodrick.

Then, patients are called, starting with the "A" patients. Those who can be rescheduled are, and those who cannot are visited by the nurse who lives closest to the client.

Rutzen's agency also gives patients a medical priority, and assigns a staff member to make it out to the patients who must be seen. She keeps a list of which nurses have four-wheel-drive vehicles and snowmobiles for that purpose.

The regular daily schedule at Western Illinois Home Health Care also helps ensure that those critical patients have been seen if a snow emergency occurs later in the day. "Our nurses try to see the most critical patients early in the morning," says Rutzen. "Once nine or 10 a.m. has passed, we have dealt with the new patient on insulin, or those who need help out of bed."

One nice thing about home health, adds Rutzen, is that clients are often very protective of staff. The day before a predicted storm, she often gets calls from patients saying they want to reschedule a visit in order to keep a nurse off the road in a potentially dangerous situation.

Both agencies address winter preparation issues for patients during intake assessments. Munson nurses encourage patients to keep a week's supply of food, medication, water, and heating fuel on hand. For those who may not be able to afford large quantities of fuel, Goodrick says nurses help clients by putting them in touch with fuel assistance programs. If a patient doesn't qualify for a state-funded program, there are church groups and other private resources that can help.

Goodrick says one problem common in her region is old houses dependent on wood heating. For those patients, intake safety assessments also include a look at whether there are adequate smoke alarms in the house.

Staff motto: Be prepared

Rutzen says educating your staff on winter issues is at least as important as educating your patients. Every autumn, Western Illinois Home Health Care holds an inservice to remind staff of what they need to carry for their winter protection. The items they say are a must include:

- a small shovel;
- kitty litter, sand, or other abrasive items;
- newspaper, roofing shingles, or a small bit of carpet for traction;
- extra clothing;
- an ice scraper;
- snow chains that fit your car and which you know how to put on;
- jumper cables.

Make Your Own Coffee Can Survival Kit

• A 2- or 3-pound coffee can. Punch three holes in the top edge, spaced equally.
• A 60-inch piece of twine, cut into three roughly equal pieces. This is used to suspend the can.
• Two large safety pins for suspending the can.
• A candle, two inches in diameter. Place on the lid under the suspended can to melt snow.
• One sharp pocket knife or a pair of sharp scissors.
• Three pieces of bright cloth, 2" x 36", to tie to antenna and door handles.
• Several packets of instant soup, hot chocolate, tea, and bouillon cubes to mix with the melted snow.
• A small package of peanuts.
• A small package of fruit-flavored candy — avoid chocolate.
• A pair of cotton athletic socks.
• A pair of cotton glove liners.
• Two books of matches.
• A sun shield blanket or two large plastic leaf bags. The bags reflect body heat and reduce heat loss from wind.
• A pen light and batteries. Keep the batteries separate.
• Any personal medications.
• If you have a 3-pound can, you will have additional room for adhesive bandages, aspirin, and a small radio.
• If there is still room left, you can increase the quantity of any of the above items.

When completed, place a stocking cap over the kit and carry in the passenger compartment of your car.

Remember: Hypothermia can happen to anyone!

Source: Illinois State Police, Springfield.

The agency also suggests that employees carry a "coffee can survival kit," an idea borrowed from the Illinois State Police. The kit includes items that can help someone trapped in their car in the snow or cold to survive until help arrives. **(See survival kit list, above.)**

Munson Home Care employees are told to carry similar items in their cars during the winter and add a few extra items such as a flashlight and batteries. They also are randomly checked to see that they do, indeed, carry those goods. "We don't really have a problem, though, because most people take winter seriously," says Goodrick. "The problems occur when someone moves up here from say, Detroit, where they have maybe 40 inches of snow a year and figure they can handle what we get. But 40 inches isn't 200," she says, adding that 200 inches of snow per year isn't as much a concern as ice and cold.

Rutzen agrees that extreme temperatures are more worrisome. When the wind chill factor hits 40 degrees, she constantly tracks the staff. She calls patients to see that the nurse or aide has arrived and that both employee and client are well.

After a winter weather emergency has forced the plan to be put into effect, Goodrick leads a debriefing to see if any changes need to be made. "The first time we used it was because of a blizzard, and the problem we had was that some nurses felt they had to visit all their 'A' patients, even if there wasn't a scheduled visit that day. That was mostly an education issue. We tweaked the phone tree, too."

After the first winter her plan was used, Rutzen also surveyed the staff to see whether they thought it worked well. They did, she says. The plan is now reviewed every autumn.

For those unfamiliar with snow, Rutzen says you should educate your staff on its potential hazards. "I think home care nurses are just notorious for going around without jackets. They go from house to car to house. But they need to know, even if they don't bundle up, they should have the gear available to them to do so."

Goodrick's advice is to be sure nurses know that if they feel unsafe on the road, they shouldn't wait for a manager to call them and tell them it's time to call it a day, but to take the initiative themselves. "We are sitting in an office, not out on the road. If they don't feel conditions are safe, they need to take themselves off the road and call us. A nurse in the ditch is no help to anyone."

Indeed, despite Rutzen's plan, at least one nurse does get stuck in a ditch every winter — yet another reason, she says, why everyone needs to be prepared. ■

SOURCES

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Preparation is key to JCAHO survey

Your agency can't get ready at the last minute

Martha George, owner of Spring Hill, TN-based consulting firm Healthcare Accreditation Consultants, remembers innumerable times she has received calls from home health agencies saying, "The surveyor is coming next week. Can you help us get ready?"

It is in some ways exasperating, says George, and in some ways indicative of how busy agencies are just trying to survive. "They just don't spend the time getting ready for a survey that they ought to," she says.

There are major drawbacks to not preparing for a survey by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in Oakbrook Terrace, IL, says George.

Those range from Type 1 recommendations and focus surveys that eat up time and energy to conditional accreditation or even losing it altogether.

Going above and beyond

"Not preparing for a survey simply means you won't do well," says George. "There are people out there who say they obey the law, do well on their state surveys, and then assume that means they'll do fine on a Joint Commission survey. But the commission goes above and beyond."

She recalls one home health agency that purchased a manual to prepare for its first survey. "But the manual was based on 1993/1994 standards, and this was 1996. They put it on the shelf, figured they were doing a good job, trying hard, and the commission would understand. Instead, they got nailed on infection control, care planning, safety, equipment management, and performance improvement."

The agency was given a focus survey date six months down the road, but didn't call George until the day before JCAHO was scheduled to arrive. "I couldn't do anything for them," she recalls. "The only thing I could do was get them ready for the second focus survey, four months later."

The preparation worked, and the Type 1s were removed.

George likes nine to 12 months to prepare an agency for a first accreditation survey, and 18 months for triennials. The length of time often seems daunting to agencies, she admits. "It can be accomplished quicker, but that requires more intensity." In addition, if you have to show 12 months' process for your triennial, you really need more than a year to implement and evaluate programs. "The ideal would be to maintain

Financial and Management Questions to Ask During Survey Preparation

1. How do you determine the needs of your patients?
*2. What resources do you supply your employees to provide and support care and services?
* 3. How do you determine the learning needs of your staff?
* 4. Describe your ongoing educational and staff development programs.
* 5. Describe your employee orientation program.
* 6. How are you involved in the Performance Improvement Program?
* 7. How did you decide what to monitor through Performance Improvement?
*8. How did you decide what resources are necessary to support Performance Improvement?
9. Have you added or subtracted any new services in the last 12 months? How did you determine this need?
*10. Do you maintain an annual operating budget?
*11. Explain the budgeting process.
12. Who is involved in the budgeting process?
*13. What data is used to determine budgeting needs?
14. Have you established goals for your organization? What are these goals?
*15. What do you do if a key staff member terminates or is otherwise unavailable for work for an extended period of time?
*16. Who is in charge if you are absent?
*17. Do you have policies and procedures that address financial planning?
18. What is the involvement of the governing body as it applies to organizational planning?
*19. Where do you see your organization in two years?

Note: Asterisked questions have been asked during a recent survey of a Healthcare Accreditation Consultants client.

Source: Healthcare Accreditation Consultants, Spring Hill, TN.

Commonly missed survey criteria

Everything but the kitchen sink

Just what areas do agencies fail to prepare for adequately prior to a Joint Commission survey? Just about all of them, says **Martha George**, owner of Healthcare Accreditation Consultants, a consulting firm in Spring Hill, TN. **(See related story on preparing for an accreditation survey, p. 170.)**

Here's her top 10 list:

1. Infection control. Staff remember hand washing, but agencies often forget infection surveillance and tracking.

2. Safety. Agencies forget to consider fire safety plans and evacuation routes. Staff security also is often overlooked.

3. Human resources. Mistakes here are legion, says George. You might have a personnel record, but do you know you have to have health files that contain results of TB skin tests and hepatitis B Waivers? Do you know the health file has to be separated from the personnel record?

And don't forget about staff education and competency, says George. "Think of every type of procedure your staff does and write it on a list or create a form," she says. "Check each one off as they do an inservice or skill lab. This is much easier than trying to get it done in a week."

Then trend and analyze the results, she says. "Agencies don't do this because they sometimes don't know how. The terminology 'to aggregate the results' makes it sound more complex than it is. It can be intimidating, but all you have to do is have written tests after an inservice. Grade the tests, see how they score, and note what questions are missed. This is identifying a learning need through aggregating and trending data. Simple."

4. Contracting. "There are certain things outlined by the Joint Commission that you should have in your contract, but legalese is hard to read. Agencies forget to compare their contracts with the commission list and they are cited for it."

5. Ethics. While she has never seen a Type 1 issued for ethics mistakes, George says there are a couple areas that people often miss. "One thing that is easy to correct is marking on your brochures which services you provide and which ones are contracted to others. People always miss that, but all you have to do is put an asterisk after that service and a small footnote that this is handled through contract."

6. Leadership. Agencies overlook financial questions. **(For a list of some of those questions, see box on p. 170.)**

7. Physician licensing. You have to come up with a method to verify each physician's license, she says. George suggests using the State Board of Medical Examiners or the Joint Commission-accredited hospital you are near or associated with.

8. Orders. Many companies get caught for not being specific or missing something on their orders. One client had a caregiver for an Alzheimer's patient use a bed sheet to restrain the patient while using a lift. The company received a Type 1 with one month report because there was no order for restraint.

9. Medication Profiles. Be sure, says George, that your medication profiles include everything. Don't forget over-the-counter, herbal, and home remedies. Make sure your medication profile matches the 485 exactly.

10. Consistency. Your notes should match your order (485s or supplementals) and should also match your medication profiles.

George says she is seeing a lot of problems with physician orders these days. "These seem simple, but they can be very tricky," she says. "Pay special attention to them, because with new standards, they can be more bothersome than they have been in the past, and if you get a recommendation on these, you may trigger recommendations in other areas. Do lots and lots of chart and document reviews." ■

readiness to avoid hectic preparation. However, I have never seen this."

The rationale for continuous preparation is sound, notes George. "We see people coming to their next survey, and we are doing the same things time and time again, making the same recommendations," she notes. "It's just a waste of time and money. But people lose their focus. When the commission comes, all their efforts are there. Then when the survey is done, the focus is

on building revenue and business, and just keeping the agency open. Especially now."

George's firm has started a maintenance program for agencies. She and her staff go into agencies quarterly to evaluate policies, procedures, and programs. But she says an agency can have their own continuous preparation strategy simply by forming a master committee to oversee survey preparation.

Sometimes, an agency's management committee takes on this role. Other committees, such as safety, performance improvement, and infection control should meet monthly to go over the areas of the JCAHO standards manual that apply to each. Some areas, such as ethics, need only be evaluated once a year. If you have a small agency, George says you can bundle these committees into one committee.

George believes strongly in creating checklists of tasks that need to be accomplished, as well as accompanying time lines and deadlines that someone at the agency is responsible for meeting. Those deadlines should be realistic and have some "grace time" built in.

Committees can develop lists of questions to ask themselves in advance of a survey that will help them to determine whether they are ready. **(For a sample list of questions, see box, p. 170.)**

Regular check-ups of each section of the manual are a must for preparation, she says, advising that agencies pick one section per month to go over. Don't skip anything, George adds. Agencies that have survey problems can make mistakes in any area, she notes. **(For a list of commonly overlooked areas, see related story, p. 171.)**

The bottom line is that failing to prepare for a survey means running the risk of dragging out the accreditation process. "That increases frustration among staff, makes it hard to focus on other projects, and you can even lose accreditation." ■

SOURCE

Martha George, owner, Healthcare Accreditation Consultants, Spring Hill, TN. Telephone: (931) 486-0566.

Areas to Focus on During Survey Preparation

1. Patient Care: care planning, referral, transfer, discharge, medication monitoring, orders, documentation.

2. Infection Control: universal precautions, biohazardous waste and disposal, reportable diseases, TB skin tests, hepatitis B. Waivers, surveillance of patient and employee infections.

3. Safety: incident reporting, safety hazards, home safety, fire safety, emergency preparedness.

4. Human Resources: personnel records, references, hiring practices, evaluations, job descriptions, competency.

5. Ethics: billing practices, professional ethics in patient care, patient care issues, abuse and neglect.

6. Education: patient education issues, guidelines, hand-outs.

7. Leadership: financial planning, organizational goals, mission statement, organizational charts.

8. Information Management: medical records, retention, documentation.

9. Performance Improvement: monitoring activities, process improvement, identified problem areas, statistical analysis.

10. Equipment Management: calibration, tracking, maintenance, cleaning.

11. Law and Regulation: the Centers for Disease Control and Prevention (Atlanta), Occupational Safety and Health Administration, Health Care Financing Administration, Department of Transportation, and Food & Drug Administration (all in Washington, DC).

Source: Healthcare Accreditation Consultants, Spring Hill, TN.

Data integrity ensures reliability of outcomes

Here are tips to correcting collection mistakes

When a Kentucky home care agency received its first report based on data collected with the Outcome and Assessment Information Set (OASIS), it looked as though the agency needed to improve its dyspnea care.

"We followed steps to identify the proper standard of care and to determine how far away we were from that standard," says **Marly Auerbach**, RN, BSN, MPH, director of quality management for Lifeline Home Health Care in Somerset, KY. The freestanding agency serves the rural southeastern and southwestern portions of Kentucky.

The agency is part of the OASIS project, officially called the National Medicare Quality

Assurance and Improvement Demonstration, conducted by the Center for Health Services and Policy Research (CHSPR) in Denver.

The agency decided to hold a mini-refresher course for staff and develop a standard of care for each visit during a short period of time, Auerbach says. But it didn't work because the problem wasn't only in patient care. It was also in the data collection. It turned out the nurses didn't understand what dyspnea was and were identifying too many patients as having dyspnea.

"There was a lot of inaccuracy in reporting which patients needed this level of intervention, so we had an overinflated count," Auerbach says. "And consequently, those people weren't getting better because they didn't need to."

For example, patients who had temporary shortness of breath were being diagnosed with dyspnea. These brief episodes might have occurred after exertion. "But it's not the same thing as a cardiac patient who seeks to get dressed in the morning and is huffing and puffing," Auerbach says.

The agency held meetings, asked staff for input, and again emphasized education. Auerbach says they simplified the agency's teaching tool for dyspnea, making it one page of very practical instructions. **(See dyspnea teaching tool, p. 176.)** The changes appear to be working, although the agency will not know until the May OASIS report whether dyspnea outcomes have improved, she says.

SunPlus Home Health in San Diego, which also is part of the OASIS demonstration project, has had a similar data collection problem. Quality managers found that nurses sometimes wrote down the wrong diagnosis for patients who were readmitted to the hospital, says **Estelle Wolf**, RN, former director of professional services for the freestanding agency that has about 6,500 visits a month.

For example, if a patient had a primary diagnosis for wound care, but had returned to the hospital for treatment of congestive heart failure, the nurse might write that the patient was admitted to the hospital for wound care. This would skew the wound care outcomes numbers on the OASIS report, Wolf says. **(See story on how SunPlus solved data collection problems, p. 174.)**

Home care agencies often have problems with collecting accurate OASIS data, says **Peter W. Shaughnessy**, PhD, professor and director of CHSPR.

"One of the biggest issues is data accuracy, and that's going to be an issue nationally," Shaughnessy says. "If data are not of sufficient integrity, then all this reporting and so on will not help agencies out one bit."

Shaughnessy was the principal investigator with the center's work in developing OASIS and the Outcome-Based Quality Improvement (OBQI) process. The Baltimore-based Health Care Financing Administration (HCFA) and the Robert Wood Johnson Foundation in Princeton, NJ, funded OASIS and OBQI.

Audit data internally

As Lifeline Home Health Care and SunPlus Home Health quality managers discovered, sometimes you will not realize you have a data collection problem until after you receive an outcomes report. "It's very important to establish a program of internally auditing data and encouraging staff to make sure the information is accurate and that they don't leave items off and so on," Shaughnessy says.

One way to ensure quality data is to follow a set process in handling OASIS outcome reports. Shaughnessy and CHSPR researchers **Kathryn Crisler**, MS, RN, and **Karin Conway**, MBA, RN, spoke about how to handle OASIS data and outcome reports at the recent Washington, DC-based National Association of Home Care (NAHC) conference held in Atlanta.

The research center has had experience in handling OASIS collection and analysis for the past few years. Shaughnessy and Crisler told quality managers who attended the NAHC conference there are some basic steps they should take to improve the entire data collection and reporting process. Here are their suggestions:

1. Commit to making the most of OASIS collection.

Quality managers should make sure their employees understand what OBQI is, what outcomes are, and how they can be used, Shaughnessy says."One of my concerns with the national program is that agencies will say, 'I'll do just what I have to do and no more' to meet the letter of the Medicare mandate," he says. Agencies that take this attitude will have difficulty making quality improvement projects out of their reports, he adds.

Shaughnessy says he empathizes with the burdens carried in recent years by the home care

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Staff solve OASIS data collection problem

SunPlus Home Health in San Diego was concerned about urinary tract infections (UTIs) and wound care after the staff read the agency's first Outcome and Assessment Information Set (OASIS) report two years ago.

The report compared the agency to other agencies involved in the National Medicare Quality Assurance and Improvement Demonstration project conducted by the Center for Health Services and Policy Research (CHSPR) in Denver.

Based on the report's findings, the agency decided to improve its UTI and wound care outcomes by forming a plan of action and increasing staff education, says **Estelle Wolf**, RN, former director of professional services for the agency.

The QI process has resulted in improvement in statistics for UTI and wound care patients, and these were reflected in the agency's second OASIS report a year later, Wolf said. **(See SunPlus' plan of action, p. 177.)**

Here's how the agency assessed the problem and made improvements:

1. Form staff committee to assess report.

"I believe in staff participation because I think it leads to more buy-in and acceptance," Wolf says. "When a new process is introduced I feel it is much easier to have the involvement of the supervisors, management, and field staff who are going to be using the new process."

When the agency received its first OASIS report, Wolf formed two staff teams, one for each office. The teams included a supervisor from each office; a representative from each discipline: a nurse, a therapist, an aide, and a social worker.

Wolf gave the team members OASIS data and asked them to do a comparison of how the agency fared against the national average. "They came back with 10 categories, and what we needed to do was sit down and evaluate what we were doing well, what was average and what might be areas of concern," Wolf explains.

Each office chose one area of concern, with one selecting UTIs and the other selecting wound care.

2. Check to see if information is valid.

The committees first checked the validity of the information. The staff submitted the original OASIS data, so committee members checked the original charts.

"We went back and did a two-fold exam," Wolf says. "We looked at the chart information and the information sheet that was submitted to the center that collected the data to see whether the information given to the center was in fact valid information."

Why was the patient admitted?

They discovered that nurses sometimes failed to identify a patient's diagnosis correctly at the time a patient was admitted to the hospital. The nurses might simply write down the patient's primary diagnosis, even if that diagnosis had nothing to do with the reason for the patient's return to the hospital.

Patients who were admitted to the hospital for an acute episode of congestive heart failure may have been identified only as wound care patients. This would result in skewed statistics, perhaps showing worse outcomes for wound care patients than what actually occurred.

"A few of the charts that came out deficient actually were not because the information sheet used by the staff was done incorrectly," Wolf says. "We would have fallen within the national norms if the initial information given to the data center was correct," he adds.

3. Decide how to solve the problem.

Next, team members analyzed the care provided to the wound care and UTI patients, and they analyzed all documentation to see how they could prevent nurses from documenting the incorrect diagnosis.

The committees also analyzed patient incidence reports, commonalities, causal factors, and whether the standard practice was followed.

"After we retrieved all this data, the next part was to take all this information and decide how to educate the staff," Wolf says.

One solution, team members decided, was to educate the staff on how to use the statistical data sheet.

"I had committee members decide what needed to be taught, and helped them gather the tools, write lesson plans, and make a presentation to the staff," she adds. ■

industry. And some agencies look at OASIS with the same amount of disdain they view other government impediments thrown at them, he adds. "It's hard for them to separate the utility of this from the burden that everything else represents," Shaughnessy says.

Agencies must recognize the importance of a standardized data collection system and outcomes reports if they expect to receive any benefit from this investment. "Some agencies will know the value of this and be able to deal with it better than others," Shaughnessy adds.

2. Learn how to collect clean data.

Make sure the entire OASIS data set is complete for each patient, and make sure the data set is embedded within your assessment instrument, Shaughnessy advises. For example, look at the OASIS item on grooming. If an agency already has a grooming item on its assessment form, then take that out and combine it with the OASIS item on grooming, he says.

"Once you have duplicity, you have declining interest on the part of the providers," Shaughnessy says. "And they already think OASIS is overwhelming." A well-designed assessment form with OASIS data should take no more time at the start of care than the current form takes, he adds.

Re-evaluate every item, every time

Another important tip is to not allow nurses and therapists to easily see what previous OASIS items were for a patient. This encourages complacency and might result in staff missing important changes in a patient's condition.

One of the demonstration project agencies, for example, used a vendor who set up the option for agencies to carry forward all of the OASIS items from the first data point at the start of care to the first follow-up point, Shaughnessy says.

"They could simply replicate the data, and the idea behind that is if the patient's status hasn't changed, why do we have to manually enter this all again?" he says. "But this creates a strong incentive to the clinician to not change anything, and that shows up in outcomes reports, where all the patients appear stable and remain the same."

CHSPR researchers tell agencies not to allow clinicians to carry data from one time point to another. Instead, they should re-evaluate patients at every step of the way.

Another way to ensure data accuracy is to conduct spot checks to evaluate the data's accuracy. Another clinician could visit another employee's patient and collect the same OASIS data that the primary provider had collected. If the spot-check person finds any discrepancies, then he or she can discuss these with the clinician.

3. Understand risk adjustment.

When home care agencies first begin to receive outcomes reports based on OASIS data, they may find that these reports have not been adjusted for risk. These are called unadjusted outcomes reports, Shaughnessy says.

What that means is agency X may have a predisposition toward an improvement in ambulation, so you would expect agency X's outcomes to be better in ambulation than a national reference sample of agencies. The unadjusted outcomes reports would reflect that agency X has done a better job in ambulation.

Risk adjustment levels the playing field. It eliminates differences between a particular agency's outcomes and the national reference sample when these differences are based on a particular agency having patients who are at greater or lesser risk of poor or superior outcomes.

Which patient attributes influence outcomes?

If an agency simply wants to compare one year's outcomes to a previous year's outcomes, then risk adjustment might not be necessary. It's more useful when one agency is compared with other agencies.

The first step in risk adjustment is to determine the relationship between a given outcome measure and those patient attributes that influence the outcome. For example, suppose agency X had a hospitalization rate of 23%, which was slightly above the national sample hospitalization rate of 22.5%. However, this agency also had a smaller percentage of women patients than the national sample, and the national sample listed a hospitalization rate for women at half that for men. When agency X's hospitalization rate is adjusted to reflect its case-mix difference, its risk-adjusted hospitalization rate actually is considerably better than the national sample.

4. Investigate care delivery.

CHSPR suggests agencies take these steps in the process of care investigation:

- select target outcome;
- enumerate important care behaviors correlated with the target outcome;

(Continued on page 179)

Teaching Tool for Dyspnea

Nurse Action
I = Instruction
O = Observation
R = Review/Reinforce
P = Prompting
D = Demonstrated Procedures
H = Handout Given

DYSPNEA - subjective sensation described as unpleasant breathlessness, shortness of breath, tightness in chest, inability to breath deeply enough, or inability to get air out.

Patient/Caregiver Action
O = Observed
V = Verbalized Procedure
D = Demonstrated Procedure
P = Required Prompts

Patient's Name: _____ MC#_____

	Nurse Action								Patient Response							
Date																
1. Correct PO medicine management (observe patient in process).																
2. Correct use of O2 therapy.																
3. Use of nebulizer.																
4. Use of inhalers.																
5. Airway clearance; cough, deep breath, increase fluid, position.																
6. Disease Process.																
7. S/S to report to MD or nurse: increase or change in sputum, fever, fatigue, confusion, weight gain, edema, nocturnal dyspnea, increase in dyspnea, angina pain, palpitation.																
8. Breathing techniques of pursed lip and abdominal breathing.																
9. Energy conservation; 8 hours sleep/24, frequent rest, small frequent meals, rest prior to meals.																
10. Lifestyle changes; avoid respiratory irritants, avoid infection.																
11. Instruct on healthy habits, immunization, (vaccinations), rest, exercise, regular MD follow-up.																
12. Measure to cope with anxiety.																
13. Report weight gain of 2 pounds in one day or 5 pounds/week.																

_____ _____
Signature Signature

_____ _____
Signature Signature

Source: Lifeline Home Health Care, Somerset, KY.

Plan of Action for Continuous Quality Improvement

QUALITY IMPROVEMENT TEAM MEMBERS

1.	RN Chairperson	4.	RN	8.	RN
2.	RN	5.	RN	9.	RPT
3.	RN	6.	RN		
		7.	CHHA	10.	RPT

Outcome Report Date: 2/5/98
Plan of Action Date: 3/24/98

1. Target Outcome Addressed by Plan of Action: "Improvement in Patient Wound Status."

2. Action Plan for: a. Remediation b. Reinforcement

3. Identified Problem or Strength:

1. Patients are requiring emergent care for wound infection and/or deteriorating wounds as documented in the PPS Reporting Tool.
2. Charts audited reveal that the PPS forms and Admission/Discharge forms are not being completed accurately.
3. Charts audited reveal that some care providers did not follow MD orders.

4. Care Behaviors or Processes Selected as Best Practices:

a. **Assessment:** All patients must be correctly identified (on admission), as to the type of Integumentary Status, Open Wound or Pressure Ulcer (staging and treatment needs). The assessment information must be documented on the Patient Progress note and on the PPS Form.

On discharge - the Integumentary Status (open wound and/or pressure ulcer) must be accurately denoted. The staging of the pressure ulcer and the status of the surgical wound must be clearly and accurately selected. The Emergent Care/Inpatient Admission section of the PPS form must be filled out accurately to reflect if ANY emergency care was indicated. The Emergent Care Reason Section on the PPS form must denote the REASON (symptom/disease/comlaint) the patient sought emergent care.

b. **Documentation:** All care must be documented on the Discipline progress note and on the Wound Care flow sheet according to policy. Wound Care/Pressure Sore nursing care must be provided according to the physicians and practice guidelines. Communication and collaboration, between team members and Health Care Providers, must be evident in the progress note as it occurs. The patient's response to care/interventions must be reflected in the progress note.

c. **Care Planning:** Patients/Caregivers must be involved in the plan of care and instructions regarding disease process, infection control, and signs and symptoms reporting must be evident in the progress notes. Discharged goals must be determined at the start of care.

5. **Intervention Actions:**

Action	Time Frame Start:	Finish:	Responsible Persons	Monitoring Approaches (and Frequency)
a. All staff to be inserviced as to the proper use of the Prospective Payment demonstration form and given a brief overview of the OASIS Project. Office Manager will be recruited to assist with the inservice.	3/19/98	5/19/98		100% of all appropriate staff will be expected to attend the inservice or instructed by members of the committee by 4/19/98,
b. A practice guideline will be selected/developed by members of the committee in conjunction with the wound/ostomy care nurses and submitted to the administrator for subsequent inservice.	4/20/98	5/20/98		The practice guideline will be reviewed with the appropriate staff. The CQI team will audit Care of Wound/Pressure Ulcers, using the new audit tool by 5/30/98. Each member will audit one chart.
c. Results of the indicator to be reviewed with the staff.	5/20/98	6/30/98	All members of the OASIS committee.	

6. **Evaluation**:

a. Review of Plan:	6/30/98	Responsible Persons OASIS committee members
b. Monitoring Activities. All new employees will be oriented to the Practice Guideline and the correct use of the PPS form.	During the orientation period.	Clinical Supervisor
c. Internal audits will be performed by designated CQI members with reports to the OASIS committee until outcome standards are met.	Quarterly	Designated CQI Committee Members.

Source: SunPlus Home Health, San Diego.

(Continued from page 175)

- determine target care behaviors;
- state problems or strengths;
- specify best practices to adopt or reinforce;
- spread best practices across your agency.

The quality manager should ask and answer these questions:

- **What are the best practices I want to put in place?** Crisler suggests agencies specify exactly what a clinician should do, exactly when it should be done, and exactly how it should be done.
- **When I see a patient who is at a level less than fully independent in ambulation, what do I want to investigate in terms of pain?**
- **How do I determine whether I need to implement a specific type of pain management program?**
- **What are the indicators for that at start of care or at other points, and what is that pain management approach?**
- **How do I make sure my clinicians do it?**
- **If I decide activity intolerance was really the underlying problem, what does that mean?**
- **What kind of graded exercise program do I want to make sure happens?**

Use quality improvement techniques to identify best practices and to encourage clinicians to follow these best practices, Crisler says.

"You have a specific outcome on which you start to focus," she adds. "And then you look at the care that was actually delivered to get to that outcome to decide what's your problem or what is your area of strength." ■

SOURCES

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Service lines can help in categorizing patients

When you put together reports for managed care organizations (MCOs) or quality improvement projects, you probably use ICD-9 codes or categorize patients based on primary diagnosis. But these groupings may not accurately reflect the type of care you provide for patients.

After all, when your nurses visit patients they are given cases based on the type of service they will provide, not necessarily based on the diagnosis, says **Alexis Wilson**, RN, MPH, PhD, founder and chief research officer of Outcome Concept Systems Inc. of Seattle. Her company provides a software program based on the Outcome and Assessment Information Set (OASIS) and provides benchmarking services for the home care industry.

For example, nurses might see two patients for infusion care and provide similar services, although one patient has AIDS and the other has cancer. These two patients would be put into different diagnostic groups when it's time to measure outcomes.

Instead, Wilson suggests, these patients might more easily fit into the same grouping of infusion care. "My idea was to take a look at grouping patients according to actual services they receive," she says. "You could be an AIDS patient, but the primary services you receive from the agency are infusion services."

Wilson developed a list of 14 service lines based on this concept. Service lines are a potentially useful tool for research and are a better tool to help agencies understand the costs and outcomes of their services, Wilson adds. **(See list of service lines, p. 181.)**

"This is a creative way of categorizing patients, and it reflects the way we talk about patient care on a day-to-day basis," says **Pamela Ferrari**, RN, director of quality assurance of Visiting Nurse Association of Hudson Valley in Mt. Kisko, NY. The agency serves a county north of New York City with 90,000 visits last year. "Nurses don't say, 'I have a patient with urinary retention'; they say, 'I have a catheter change,'" Ferrari explains.

Ferrari has used the service lines for quality improvement goals and for marketing purposes. Service lines have helped the agency make decisions about what types of services to market now that the home health landscape is topsy-turvy under Medicare's interim payment system (IPS).

"For example, we wanted to know whether the psychiatric program is something we should be marketing at this point," Ferrari explains. Her question was: "Are psychiatric services using certified psychiatric nurses a financially solvent part of the business to be in at this time?"

Ferrari pulled up all of the case data related to the service line for psychiatric care. It corresponds to ICD-9 codes of 290 and 319. The statistics showed that psychiatric care is profitable and its clinical outcomes were positive.

Ferrari says she found that patients who saw a psychiatric nurse required fewer overall visits than patients who had other home care services. Plus the psychiatric patients had equally good outcomes, and their care costs less when compared with other patients, she adds.

Unlike diabetic and wound care cases where the agency's services exceeded its Medicare beneficiary cap and the agency lost money under a prospective payment system, psychiatric services fell below the cap, Ferrari says.

Another benefit of using service lines is that they are fairly easy to translate from ICD-9 codes collected from an agency's database and from OASIS tools. Care plans also may be used.

Ferrari and Wilson explain how quality managers can use service lines with these pointers:

• Develop better outcomes reports.

"Service lines can be useful for developing practice patterns or best practices for caring for patients," Wilson says. For example, quality managers can use service lines to compare outcomes among patients using similar services to see which type of treatment resulted in fewer visits, hospitalizations, and emergency room visits.

Visiting Nurse Association of Hudson Valley has a standards manual with care plans that list requirements. For example, the standard requirements for treating a terminally ill patient require nurses to discuss hospice and make a social worker referral, Ferrari says. "These are our standards, and when every nurse goes out to see a patient and write a care plan, my quality assurance department checks that care plan against the service lines," Ferrari says.

Quality managers review and compare the outcomes for patients in that service line. They check to see how many patients were admitted to the hospital and how many developed competency in handling their disease. With diabetic patients, for instance, the quality manager checks to see how many patients who had a skilled deficit in insulin injection when admitted had shown improvement in their ability to self-inject insulin. "And it might show us how many visits it took to get them independent," Ferrari says.

Then these outcomes might be compared with care plans to see whether cases with the better outcomes followed the agency's standard requirements for that type of case. If the number of visits seemed high or if the outcomes were disappointing, then the agency might have a diabetes specialist provide an inservice on special techniques for instructing patients on insulin injection.

Visiting Nurse Association of Hudson Valley did exactly that with diabetic cases, and then quality managers checked again after the inservice to see if outcomes improved. "We were looking at the percentage of patients who go from having minimal to moderate skill to competence in diabetic care," Ferrari says."We saw a 25% improvement."

• Learn which programs to develop and eliminate.

Visiting Nurse Association of Hudson Valley had a nurse leave who had specialized in wound care and ostomy care. "Our question was, 'Should we hire a new person, and is it an area of business we want to be encouraging and talking up?'" Ferrari says. "We're not going to turn people away, but should we seek them out in this environment?" For example, if the agency wanted to market to wound care patients, it could market its services to a local wound care clinic.

Ferrari pulled up data on all patients under the service line for wound / ostomy care. Wound care corresponds to ICD-9 codes 870 and 8977, but since any patient can develop a wound, ICD-9 codes might not reflect the true number of wound patients. Ferrari suggests quality managers use the OASIS tool to track all of the wound care patients. On the OASIS tool, questions M440 and M550 pertain to wound and ostomy care.

Ferrari found that her agency's wound care

Clip this guide to service lines

Service lines are units of analysis that allow for comparisons based on the types of services patients receive, instead of their diagnoses.

The Outcome and Assessment Information Set (OASIS) tool is a logical progression to service lines, says **Alexis Wilson**, RN, MPH, PhD, founder and chief research officer of Outcome Concept Systems Inc. in Seattle. Wilson's company created 14 service lines for which it is developing a benchmark database for home care agencies.

The service lines are described as follows:

1. Terminal care: life expectancy of less than six months.

2. Infusion care: intravenous, total peritoneal, or enteral nutrition.

3. AIDS care: HIV illness.

4. Wound/ostomy care: open wound, skin ulcer, or bowel ostomy.

5. Incontinence care: incontinent of urine or urinary catheter.

6. CVA care: physical or self-care deficits from stroke.

7. Diabetic care: care/teaching to control diabetes.

8. Cardiac care: care/teaching to control congestive heart failure, arteriosclerosis cardiovascular disease, or other cardiac conditions.

9. Psychiatric care: care/ongoing assessment for mental/emotional problems.

10. Rehabilitation care: care/therapy pertaining to musculoskeletal system.

11. Respiratory care: care/teaching to manage respiratory disease.

12. Oncology care: services for neoplasm.

13. Maternal/child health: children under 18 or care during pre/postpartum.

14. All other categories. ■

patients require a lot of nursing visits. "And you don't want to take on patients who take up a lot of visits under IPS," Ferrari says. "So it appears we don't want to market a wound care program."

But this didn't provide the whole answer, so Ferrari made another comparison, using the wound care service line. She compared the number of visits for patients treated by the wound care specialist vs. the number of visits for patients treated by other nurses.

She found that nurses who are wound care specialists reduce the number of visits per wound case. It made sense to at least train one nurse to become a wound care specialist.

• Demonstrate over- or underutilization.

Ferrari also took a look at patients who are overutilizers, such as patients who have received services for more than a year. The 14th service line, which is open-ended, could be used for checking patients with long lengths of stay.

"I do a consistent reporting of those patients," Ferrari adds. "I look at why we haven't succeeded with this patient yet." Perhaps the nurse is at fault, or perhaps it's just that there is a solution to the problem that no one has taken the time to find. "Say you have a patient still on service for catheter care, and maybe the patient could get to the doctor once a month to have that catheter changed," Ferrari suggests.

Another example might be a patient who has received long-term service because he needs a regular injection of Calcimar, a drug that increases bone density. Perhaps that patient now could benefit from a new nasal spray drug that has the

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.-6:00 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: custserv@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $278. Approximately 18 nursing contact hours annually, $328; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies. $139 per year; 10 or more additional copies, $83 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $41 each. (GST registration number R128870672.)

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same benefits and that the patient could administer himself, Ferrari says.

Anecdotal evidence suggests the strategy is working, Ferrari says. "We've had people learn to administer their own medications and treatments who never had before."

• **Market the more profitable services.**

Service lines give a clear picture of the average cost of a particular service, its average number of visits, and its outcomes, Wilson says. They can be used to market a home care agency's services to managed care organizations, who often are looking for that type of data.

However, Ferrari says MCOs so far have not show a lot of interest in the information. "My gut feeling is they'll accept a contract if you take the lowest price they have," she says.

"What will change is they're going to start looking for agencies that have the kind of information we have as we move into an environment of risk adjustment and cost sharing," Ferrari adds.

However, the agency has used the service lines to determine other marketing strategies, including shifting focus to its psychiatric program.

Ferrari adds that service lines work and could be one more way for quality managers to compare outcomes and utilization rates. "You need to use all of your information to make informed business decisions." ■

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CE objectives

After reading this issue of *Homecare Quality Management*, CE participants will be able to:

1. Assemble their own winter survival kit.
2. Plan for their next JCAHO survey.
3. Propose steps to follow in the process of investigating care delivery after receiving an OASIS report.
4. Recognize the concept of service lines as developed by Outcome Concept Systems in Seattle and their use in collecting patient data. ■