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Resolved: 1999 will be a good year for home health improvements

Experts nationwide give advice on how to make that happen

It's the beginning of a new year when all things seem fresh and possible. You've made a resolution to make the coming year a good one. What should your agency do to make sure it thrives in turbulent times and still delivers the best possible care?

Experts interviewed by *Homecare Quality Management* say your focus should be on patient care. Agencies should measure outcomes and communicate the results to payers, patients, and staff, yet stay within the confines of all the new rules and regulations that govern home care.

Beth Henn, MS, RN, director of quality management at SNI Companies in Langhorne, PA, thinks agencies need to concentrate on the basics.

"In the hubbub of constantly evolving regulations and mandates from regulatory bodies, we have to look at what are the basics of home care," says Henn, noting that agencies are spending more time concentrating on administrative requirements and less paying attention to issues like quality improvement.

However, Henn understands the need to balance fiscal and patient care goals. "The thing you have to do is balance the financial aspect with care, looking at the basic needs of the patient, and making sure the organization stays viable."

Prioritize your projects

The key, says **Cathy Neilsen**, RN, CPHQ, vice president of clinical services at In-Home Health's Minnetonka, MN headquarters, is to prioritize your projects.

"There are so many issues to deal with from trying to cut and control costs to maintaining efficiency and keeping quality high. You have to prioritize," she says.

Now, Neilsen adds, rather than blindly implementing projects, In-Home Health is spending more time determining "where we get the biggest bang for our buck. For instance, we know we want to revise our written competency tests for nurses. But the time it would take in human resources terms doesn't give us as much benefit implementing

another program, like providing nonskilled personal care providers to patients."

Once you have programs in place, you need to measure how well you meet the needs of your patients. According to **Patrice Spath**, a health care quality consultant based in Forest Grove, OR, you should resolve to incorporate patient preferences into your outcomes measurements this year.

Measure your success

"A good example is to establish a mechanism for obtaining patient and / or family goals for treatment and then measure to see if these goals are met," Spath says. "Patients and their families want to be more involved in their care and setting / measuring patient defined goals is an important part of this collaboration."

Karen Carney, editor of *The Home Advantage* newsletter in Andover, MA, thinks agencies should put together a report card of their agency.

"You have to be able to articulate what information makes your organization different and be able to share that with providers and referral sources," she says.

Once you have that information, don't just share it with physicians and payers, but share it with your staff. "Home care organizations and hospices have such a hard time articulating what they do and how they are different," says Carney. "They say they have good quality, but they can't tell you if that means there are fewer visits, or fewer hospital or emergency room visits. Pull the information together. Define what you mean by quality and share it with your staff. When they talk to patients, family, and physicians, they can explain just how you are different."

Part of successfully sharing information is determining what information different parties want to know, says Carney. For instance, social workers want to know how fast you are in the home after discharge. "They want to know they can hand a patient off to you and not be called again. They want to know you have less incidence of rehospitalization and emergent care. Other agencies might not be able to articulate this, but you can." Ask your customers, "What information do you want to know about us?"

That kind of communication with customer and referral sources also tops the resolution list of **Elizabeth E. Hogue**, an attorney in private practice in the Washington, DC, suburb of Burtonsville, MD.

"You should resolve to communicate effectively with physicians to offset whatever perceptions have caused them to reduce referrals to home care," says Hogue. She says part of the reason they may be reducing referrals is fear of falling foul of fraud and abuse regulators. But, Hogue adds, there are also fraud implications of not referring, and home care agencies should make physicians aware of this.

"Sure referring brings risk," she says. "But if you don't refer, there is a risk of liability for negligent premature discharge of patients from hospitals, or fraud in the form of underutilization of services. We have focused so much on *overuse*, but if you look at the fraud and abuse compliance guidelines from the Office of the Inspector General from July, underutilization has already been applied to managed care organizations and health maintenance organizations. If they are targeting them for underutilization, then it applies to doctors, too."

Hogue says you can find an effective way to communicate this to physicians, but it will take a one-on-one meeting between a home care executive, preferably the medical director, and the physician. "They need to explain — without it being 'refer or else' — the ramifications of failing to refer."

Communicate IPS strategies

Hogue also thinks agencies should resolve to communicate to skilled nursing and hospital discharge planners what the interim payment system (IPS) means for them.

"They need to make it clear to the planners that they can no longer just dial an agency, but really have to plan the discharges," she explains, "The advantage of this is that you not only can work on preserving important relationships by this communication, but you can insure with better discharge planning that you have fewer nonbillable visits, or fewer times where you go out to admit a patient and find you can't."

Lillia Rosenheimer, RN, MPA, associate director of nursing at Community Home Health in San Pablo, CA, says communication is one way to keep employee morale up. That's her No. 1 resolution for 1999.

"We have been forced to do more and more with fewer and fewer people," says Rosenheimer. "That makes morale a bigger issue."

Recently, an internal audit by her company brought a score in the low 90s. "We want to tell staff about the audit results during a meeting, but they always complain that we concentrate on the

things we didn't score well on," says Rosenheimer. This time, she wanted to emphasize the positive in the meeting, but save the problem areas for a later, in-depth discussion. This lets the staff savor the good news.

Veronica McCabe, RN, RNC, a quality management specialist at SNI Companies, says the increasing requirements put on home care agencies are the basis of her resolution.

Stand up and be heard

"Lobby the legislature about the impact of IPS and OASIS [Outcome and Assessment Information Set]," says McCabe. "The data collection requirements of OASIS impact how many patients we can see. We have to let the legislators know that isn't acceptable."

McCabe's colleague Henn agrees. "Turning up the gas and getting people to make noise will help. If they want home care to continue to exist, then they can't keep going the way they are," she says.

Rosenheimer also says making your voice heard about the realities of doing business is another good resolution. She advises starting with the upper management of your company.

"If someone is asking more of you than you can deliver, say so. Pipe up," she says. Her company recently asked her to gather productivity data daily. "It would have taken me hours every day to do that. I told them twice a month was more realistic, and they said fine. If something is too much, raise your voice and complain."

Hogue says the whole issue of IPS and PPS also has an impact on one of her suggested resolutions.

"You have to resolve to manage your patient mix without incurring legal liability. You have to be willing to control who you admit and who you provide services to without incurring liability for abandonment. I find agencies all over the country that either don't believe it can be done, or are unwilling to make the internal changes they have to make it work successfully, such as screening admissions, making sure patients meet Medicare criteria, or ensuring that they are generally clinically appropriate for home care."

Once you do that, you have to continue to monitor your patient load and make sure you remain under cost caps and aggregate per beneficiary limits.

Another resolution that fits under the general legal heading, says Hogue, is to implement or continue to implement a fraud and abuse compliance plan.

"We hear providers say, 'I can't afford to do this,' all the time," Hogue says. "I understand that perspective when they are talking to consultants who tell them they need a six-month internal audit that will cost $50,000. But they can skip the internal audit, develop a plan, implement it, and then do an audit. If you can't afford to have a fraud and abuse compliance plan, then you can't afford to be in business. There are very few issues I put at the top of my list, but these are up there. These are things that must happen." ■

SOURCES

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Develop action plan for using OASIS data

Here's how to make OASIS part of your QI efforts

Using data from the Outcome and Assessment Information Set (OASIS) may move your quality improvement efforts up a notch. But the million dollar question is: Do you have an action plan for using the data?

A written and detailed action plan will give you an outline of each quality improvement step you'll need to take for a particular indicator. It's also a good way to make sure your QI process stays on track and doesn't end when the first

desired outcomes are achieved **(see related story, p. 6).**

The Center for Health Services and Policy Research (CHSPR) at the University of Colorado in Denver, developed OASIS and the Outcome-Based Quality Improvement (OBQI) process with funding from the Baltimore-based Health Care Financing Administration (HCFA) and the Robert Wood Johnson Foundation in Princeton, NJ. CHSPR suggests an action plan incorporating these six elements:

- target outcomes;
- target care behavior;
- statement of "best practices;"
- interventions to implement or reinforce "best practices;"
- responsible persons, time frame;
- monitoring and follow-up activities.

The action plan serves as an agency's guideline, says **Karin Conway**, MBA, RN, senior researcher at CHSPR. Conway, and other CHSPR colleagues, including director **Peter W. Shaughnessy**, PhD, and associate **Kathryn Crisler**, MS, RN, spoke about using OASIS data to measure outcomes and improve quality at the Washington, DC-based National Association for Home Care (NAHC) conference held recently in Atlanta.

Sharon Johnson, MSN, RNC, CNA, director of clinical practice and outcomes management at Jefferson Home Care Network in Ardmore, PA, also spoke about action plans at the NAHC conference.

Conway says the action plan needs to be put in writing so everyone can understand exactly what it says. "In a way, it is kind of a guidepost so that everybody can use the same information," Conway told home care directors and quality managers at NAHC.

Conway and Johnson suggest agencies use these guidelines to develop a plan of action:

1. Target outcomes.

Jefferson Home Care Network is one of three home care agencies of the Jefferson Home Health / Main Line Hospitals network. The home care agency was one of the original 50 agencies involved in the OASIS demonstration project and has been collecting OASIS data for three years.

"We have gone through two cycles of process of care investigations," Johnson says, adding the outcomes are in the areas of hospitalization, stabilization of dyspnea in cardiac patients, and improvement in urinary incontinence.

The first step in targeting outcomes was to form a multidisciplinary team, Johnson says. The team represented a continuum of care, including discharge planners from the hospital.

"We did some brainstorming and asked some pointed questions, such as, 'What kinds of patients do you see readmitted to the hospital from home care, and why,' and 'What are some services we need to provide in home care to keep people out of the hospital?'" Johnson explains.

Conway suggests quality managers focus on the patient, patient care, and the target outcome.

"This may seem obvious, but we found last year in the national demonstration project that those agencies that did not improve in their target outcome for the previous 12 months weren't exactly clear that it was patients they were focusing on," she says.

2. Target care behavior.

Agencies should avoid turning a focus on staff behavior into a witch hunt of who did what, because this won't get everyone on the same team, Conway says."What you want to be able to do is look at a neutral subject, such as patients, and say the patients are not being taught, or the patients are not being assessed by such and such. Give that kind of detail."

Home care agencies have some control over what and how their employees are teaching patients, so this makes a good target area, she adds.

Johnson created a fish bone-shaped cause and effect diagram, with the head serving as the outcome and the fins as the issues. For example, when the agency looked at hospitalization, she collected about 45 ideas from the team brainstorming session. She narrowed those down to four categories of people issues, information issues, procedure issues, and environment issues.

"From there, we could actually list common causes and begin to identify some of the actions to correct," Johnson adds.

3. Write statement of best practices.

Jefferson Home Care Network's best practices were developed from the cause and effect diagram, Johnson says. The diagram also was useful in preventing the multi-disciplinary team from jumping to the wrong conclusions about various outcomes.

For example, when the team looked at the dyspnea outcome, most of the nurses were positive that the outcome was less than desirable because the therapists did not know how to assess dyspnea at discharge. Johnson did not put this on the best practices statement because the cause and effect diagram proved this was not the case.

"We were able to prove to them that this was not the problem," she says. "You have to really be

careful not to jump on those quick solutions and problem-solve before you really know what the problem is."

The best practices should include precise clinical activities, Conway says. She suggests quality managers take the following steps:

- identify the patient population;
- identify actual clinical processes, including assessment, evaluation, and teaching;
- make sure you have the clinical discipline that is supposed to be involved in that clinical intervention or process;
- determine how often it's going to happen, when it is going to happen, and what to do about it;
- know who is going to do the best practices and what patient population is going to be focused on;
- make sure you have only three or four best practices.

"Any more than that really gets in the way," Conway says. "People start seeing a massive list of things that have to be improved, and they start feeling that this is not attainable."

4. Implement interventions or reinforce best practices.

Jefferson Home Care Network uses a focused record review process to assess how the agency is doing on its hospitalization outcome goals. "We looked at patients' rehospitalization within 14 or 30 days of the start of care," Johnson says.

Initially, the agency looked at 120 charts. Now each quarter, the agency reviews 25-30 charts, looking at these specific areas:

- Were the patients in the right specialty program?
- Were the disciplines in there, if needed?
- Were the clinical nurse specialists used if they were needed on a case?
- How many nurses were in to see that patient?
- How many visits did the patient have?
- Was the visit pattern changed appropriately for the patient's needs?

"We pulled out ideas from brainstorming, the cause and effect diagram, and collected data on that," Johnson says.

One area the team targeted involved nurses reporting congestive heart failure (CHF) patients were not going into the cardiopulmonary team, but instead were going to the medical-surgical team. This led to team writing as a criteria: Was the patient referred to the appropriate specialty team?

"Basically, our intake department wasn't following referral guidelines for specialty teams," Johnson says.

One guideline is that any patient with two episodes of CHF within six months will be placed on the cardiopulmonary team.

The other problem relating to repeated hospitalizations was that the agency was underutilizing occupational therapists. "We did education for the staff on the role of the occupational therapist," Johnson says.

One of the agency's biggest interventions during the first year was to implement interdisciplinary rounds that would focus on criteria every team would discuss on a weekly basis. Each team will talk about any patient who has been re-hospitalized, asking these questions:

- Why were they rehospitalized?
- Was there something we could have done differently?
- Could we have prevented that hospitalization?
- Was it truly a new diagnosis?
- Was it truly something that was out of our control?
- Or, could we as clinicians have prevented that hospitalization?

"We also talk about every new admission that has complex needs," Johnson says. "Any patient who has a home situation that puts them at risk, any patient who has two or more disciplines in the home is discussed at start of care to be sure that we are targeting them and moving them in the right way through their episode of care."

Other interventions included additional staff and patient education. The agency created a patient education sheet that tells patients when to call their home care nurse and agency.

"We make it clear to patients that there are times when the nurse can help them, rather than to have them immediately go to the emergency room," Johnson adds.

Conway suggests quality managers make sure their staffs know what any changes are. From the beginning of the process of care investigation, the agency should tell staff where the agency currently stands, where the agency is progressing, and ask the staff what they think about it.

"Make sure that the people who are actually doing the work are invested from the beginning; the only way you can actually get people invested is to get them involved," Conway explains.

5. Select responsible persons and a time frame.

Identify who is responsible for reviewing the plan of action and plan which dates that person will review it. Also, state on the action plan when

the next outcome report will be available, Conway says.

"So many times people want to know, 'Okay, we are progressing; we have this monitoring in place; the interventions are going very well, but how do we know the effect on the actual patients?'" she adds. "The best way to do that is the outcome report; you want to make sure that you have the date of when to expect that."

6. Monitor and provide follow-up to all changes.

Monitoring is very important to make sure that the plan of action implementation occurs as planned, Conway says. "You can have a perfect plan; unless you put it into action, it is worthless," she adds.

In fact, she says, monitoring was identified by many of the national demonstration agencies as one of the chief reasons they were able to improve outcomes.

Jefferson Home Care Network places a strong emphasis on continual monitoring through its chart reviews.

"We developed our own monitoring tool that was used during this initial investigation," Johnson says.

The agency also monitors its progress through quarterly record reviews and spot checks. Also, the agency monitors activities through interdisciplinary rounds.

Here are some examples of Jefferson Home Care Network's monitoring activities:

• During the agency's 1998 work on pain outcomes, pain management guidelines were developed into a patient education tool that would go into every patient's chart.

"We found when we did our investigation that many of our patients have pain, even if that is not their primary problem and the primary reason they are on home care," Johnson says.

If the pain guidelines do not apply to a particular patient, the clinician can use the guidelines for another case. But if they're needed, they are readily available.

• The agency ensures coordination of care and the interventions related to those best practices by having the staff attend weekly interdisciplinary rounds.

"We also developed a documentation sheet for those rounds," Johnson says. "A copy is left in the team's minutes, so we can also take a look at those just to be sure that the content of the discussion at those rounds is focused in the area that we want it to be focused."

• The agency revises items on the action plan according to what is discovered through the monitoring process. One problem in 1997 was that the agency was behind in the implementation of a dyspnea patient education packet.

"It was very easy to address that by simply reprioritizing our staff development specialist's project list," Johnson says. "I moved this to the top of the list, and it happened a lot quicker." ■

SOURCES

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Thinking of scanning your OASIS data?

Evolving technology is promising, but untested

Many agencies have started seeing advertisements and brochures about new scanning technology that promises to make collecting Outcome and Assessment Information Set (OASIS) data faster, easier, and cheaper. But according to one watchdog agency, few agencies implemented it or are far enough along in the process to be able to report positive results. Still, it might be worth investigating, says **Joe Cortese**, director of management information services at Montefiore Home Health in Bronx, NY.

Montefiore started looking at the different scanning technologies as a way to make data gathering and input more accurate. Cortese has looked at optical mark sense scanning, which reads cards with filled-in bubbles or squares and scanning that reads characters such as numbers and letters.

Currently, he is leaning towards the optical mark sense scanning, as its accuracy runs at about 99.5%. Scanning technology that can also read numbers has about 95% accuracy, Cortese adds. If you add letters, accuracy drops to about 85%.

"The big question is whether you can reduce what you need to scan to mark sense, or perhaps limit characters to digits," he says. "Then you have to know what happens when an error occurs. Most scanning schemes either stop and wait when there is an error, or read everything, and have a rejection cue where all the errors are stored. Someone has to sit and go through all of those unreadable items."

The differences in the scanning technologies, leaves Cortese wondering whether it will be faster, more accurate, and cheaper. He especially wonders about the latter.

"The programs I have looked at have base software costs of $4,000 to $8,000," he says. "There is a scanner, which costs $800 to $1,600. You also have to decide if you want a backup scanner. You need a fairly robust PC that will cost another $2,500. The price can easily go up to $10,000 to $12,000. And that's just to have it sit there. There is also the forms, which in the case of OASIS I have seen . . . that run from 60 cents to $1.15 each. Then there is the human component of who will sit by the machine."

Some scanning companies will lease the technology. Scanning Concepts of Minneapolis can lease programs for as little as $500 per month, says education manager **Laure Campbell**, RN. That package includes the software, a bar code label printer, forms, and a scanner. The forms are standard, although you can have them customized. Depending on the length, they cost from 62 cents to $1.40 each, she says.

Cortese's biggest problem is that he can't find anyone who has used the scanning programs already to talk about them.

"Most vendors don't have active users, although they may have pilot projects," he says. "Still, there is no one really out there who you can ask what their experience has been."

Montefiore still hasn't made a decision on which, if any, scanning program to use. "We are still focusing more on collecting data in the field," Cortese says. "We can always use manual entry as a beginning while we wait for more information on scanning."

However, he believes that this is the wave of the future. "I believe in data-driven decision making. Without data, you are guessing in the dark. I think anything that makes data more accurate and available faster is a good idea."

Cortese would love to hear from others who have experienced this. In the meantime, he has the following advice for agencies thinking about scanning technology. "List your requirements. If you know you have a pool of clerical people available, that will have an impact. If you have no staff available, you'll want a more automated system." ■

SOURCES

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Companies That Sell Scanning Programs

Auto Data Systems, Minnetonka, MN. Telephone: (612) 938-4710.
Home Care Information Systems, Inc. Bloomfield, NJ. Telephone: (973) 338-3153.
ScanHealth, Duluth, MN. Telephone: (218) 723-4084.
Scanning Concepts, Minneapolis. Telephone: (800) 362-3282.

Handling difficult patients requires careful policy

Issue impacts employee safety, discrimination

Recently, In-Home Health's Mesa, AZ, office took on a patient who initially caused no problems. As time progressed, nurses reported more and more problems, not with the patient, but with his wife.

"Nurses and nurses' aides were telling me that she was being mean," recalls **Teri Clark**, RN, BSN, visit division manager.

After several such complaints, Clark went to the patient's home to assess the situation.

"I've gone out before to try to settle down cranky patients, but this was the wife. We didn't talk specifically about anything, but about her concerns. I think it did her good to see that the boss was coming out. She wanted to know that her husband was something more than a number."

Just having Clark go out was enough to solve

the problem, and there hasn't been a complaint about that client since. This is one of the easier instances of difficult patients and family members that home care agencies face. Handling these situations requires a clear policy on how to deal with problems while staying within the confines of the law.

Take an instance where a patient requests the agency only send white nurses to the home. Crestview Hills, KY, attorney **John Gilliland** notes that just as you can't refuse a patient based on race, you can't honor a request for a caregiver to be a certain race or gender.

"The only exception to that is a gender preference when the care provided involves the patient's sexual privacy, bathing of genital area, for instance. Otherwise, you can't honor preferences."

Gilliland says a racial preference by the patient is grounds for discharge. "If you were to honor that request, you risk a suit of racial discrimination for the employee, even if the employee has other work. Separate but equal is not the law of the land. You can also lose your Medicare certification for doing this."

Cathy Neilsen, RN, CPHQ, vice president of clinical services at In-Home Health in Minnetonka, MN, says their policy is to tell such patients that In-Home Health will send a qualified caregiver. In such instances, she has to also be concerned with employee safety — particularly if a nurse goes in who is *not* of the patient's stated racial preference.

"Before I would send a caregiver to that situation, I would do a personal assessment. You have to err on the side of employee safety."

Safety issues are also a concern when there are abusive patients. Neilsen recalls one instance where a male client was physically abusive to two female aides. "Then we sent a male aide and he was just as abusive. Then it's a discharge issue."

Clark says she has had two occurrences of patients who have sexually harassed staff. In one case, a quadriplegic patient made statements that upset an aide who was bathing the patient and had to put a condom catheter on him.

"She finished her care and reported the incident to us," says Clark. "We talked to the social worker who visited the patient with the case manager and made it clear that any more of that kind of behavior would lead to discharge. It worked. There were no more problems."

Gilliland deals with issues surrounding difficult patients several times a year. "The problem is to avoid patient abandonment," he says. "That becomes an issue of 'reasonable notice.' But there is no clear definition of what that is."

When you have to terminate

Gilliland asks his clients two questions to determine whether there is a case for abandonment:

• **How long will it take to find another agency?** The time may be dependent on your market (less time in an urban area than rural), the kind of care the patient needs, or the "difficulty" that leads you to want out of the relationship.

"There is no specific amount of notice," he says. "It depends on the case. You need to give reasonable notice, and that changes." In a rural area, a ventilator-dependent patient is going to need more notice — maybe a couple of weeks," Gilliland says. "If the care is not life threatening for a weekly visit patient, then maybe you can terminate today because they have time to find another provider."

• **What happens if they don't get another provider?** A little discomfort isn't a problem, but hospitalization or death is cause for concern.

Gilliland asks his clients to document this and pick a date to terminate care. Then, in writing, confirm to the patient and / or the family the termination date, the reason, the agency's willingness to assist with continuity of care and to brief a new agency, and the names and numbers of agencies the patient or family can call.

"Then stick to your deadline," says Gilliland. Often, patients won't believe you are leaving until the nurse doesn't show up. "That's really hard on nurses, because they are caring by nature. Patients will often try to manipulate nurses to keep them there. You have to stick to your guns."Send a copy of the letter to the physician, he adds.

All terminations should be done in line with your discharge policies.

"Remember those policies should be broad enough to take into account uncooperative and harassing patients. Make sure the policy covers whatever issue you are talking about," says Gilliland. If that policy has in it a minimum notice for termination, then unless it is a case where safety is an issue, then you need to stick to that policy.

While Gilliland notes that you can't share patient information without that patient's consent, often the incidents which led to termination are reflected in chart notes.

"If you get a call to admit a patient and the other agency won't say why they discharged him

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or her, then that should be a big red flag to you."

In-Home Health's policy on discharge also includes a referral to adult protective services in cases where termination is immediate due to issues of employee safety, to ensure continuity of care.

Communication is key

A good policy for dealing with difficult patients, says Clark, will include the following elements:

• **A chain of discussion.** The employee tells his or her supervisor, who pulls together a care conference which includes the family or caregiver if appropriate. The physician is also notified about the problem, not just because termination could impede care, but because the physician might be able to help in dealing with the difficult patient.

• **A method of conveying behavior dissatisfaction to the patient.** This should include verbal and written methods. In-Home Health uses a case manager or social worker for the verbal presentation.

Clark adds that a good policy must make it clear to staff that they can report an incident and action will be taken.

"We have no way of finding out about problems other than from our staff," she says. "They have to know there is an open door policy."

Agencies wanting to develop a good policy may want to use their ethics committee to formulate one, since so many of the issues surrounding difficult patients bleed into issues of abandonment and patient discharge, Clark adds.

If you have a corporate office, she suggests that you bounce ideas off of appropriate executives at the corporate level, and make use of its legal department to ensure your policy is within the bounds of the law. If you don't have a corporate entity, you should talk to peers and colleagues in your area.

Finally, don't imagine you can think of all the potential issues that may arise, warns Clark. She recalls one instance where a patient was espousing religious beliefs that the employee found disturbing and offensive. Eventually, she was able to broker an agreement that maintained care by having the patient promise not to bring up the topic again. ■

Fine-tune your patient satisfaction survey

Agency strives to make 'A' grade an 'A+'

As most home care agency quality managers know, patients rarely give poor ratings on patient satisfaction surveys. Therefore, it's common for agencies to receive scores of 95% or better in patient satisfaction.

If everything the agency does is so great, how will the staff know what to improve?

One answer is for the quality manager to target any areas that receive less than a "good" or "excellent" rating on the patient satisfaction form. Agencies that work to bring a 95% up to a 98% or a 98% up to 100% will continue to improve because they are making efforts to do so.

Ambassador Home Health in Downey, CA, makes excellence in patient care a top priority, says **Gifty-Annette DuBois**, RN, COHN, BS, administrator and chief executive officer for the freestanding agency that serves Orange County in California with about 1,800 visits a month.

"We look at every aspect of what is going on with the patient," she says.

This close attention to detail has paid off in high customer satisfaction ratings. "Our patient satisfaction is always high, a 97% or 98%," says **Nerissa Hall**, RN, RMN, SCM, MA, director of patient services.

Hall says the agency doesn't coast on its ratings because there is still that 2% of patients who were not happy for whatever reason. The agency monitors all complaints to see if anything could have been done to satisfy those customers.

The surveys are sent to all clients after discharge or after their first recertification. The surveys of discharged patients are on blue paper and the surveys of patients who have been recertified are on pink paper.

Here are some of Hall's tips to improving your patient satisfaction scores:

1. Make sure your form is easy to understand.

Ambassador Home Health's patient satisfaction form is one sheet of paper, tri-folded. It notes at the top: "Thank-you for allowing us to provide

care for you and your family members. In order to better serve our patients, we need your assistance. Please take a second to fill out this questionnaire and return to our office, postage paid."

The front page also includes the agency's mission statement. The survey has 10 questions that can be answered by circling a number from one to four.

"Three is good and four is excellent; anything under three we say we're not meeting our goals," Hall says.

However, the agency initially had a problem with the number system. Earlier surveys had the number one equal to excellent, and the number four equal to poor. Some surveys came back with all fours circled.

"We'd call the patients and say, 'We noticed you weren't happy with your care; could you please tell us what we did wrong,'" Hall recalls. "They'd say, 'No honey, it was great. I just read the survey wrong.'"

Since it appeared that the agency's elderly clients expected a rating system to have the number one equal to poor and the higher numbers equal to higher ratings, the agency changed the survey's rating system. Hall says they haven't had any confusion over the numbers since.

2. Select questions that will give you important feedback.

Ambassador Home Health supervisors wanted to look at both patients' overall satisfaction with the agency and their satisfaction with staff.

The first question, which is, "How do you rate the overall performance of our staff?" is broken down by classification: nurse, home health aide, physical therapy, occupational therapy, master's level social worker (MSW), and speech therapy.

"If the family was satisfied with the MSW but dissatisfied with the nurse, they each have their own line of rating," Hall says. "And if we have 10 complaints one month about aides, we can focus on the home health aides."

The agency's other questions are:

- **How would you rate your involvement in decision-making regarding planning your home health services?**

The agency typically has high ratings on this question, Hall says. "When we open a case we say to the patient, 'It's very important that you be a part of the planning of care; you need to give us input, and if you're not happy, you need to discuss it,'" she says.

- **How were your opinions considered in planning your discharge from home care?**

Some patients misunderstand the purpose of home care and how the home care nurse will not be able to visit them indefinitely. The agency's nurses explain to the patient upon admission that home care is temporary, and once patients reach the plan of care goals, the agency will discharge them, Hall explains.

- **The staff treated me, my family, my home, and my belongings with respect.**

Hall says this question was written as a positive statement so it would be easier to understand.

- **Staff explained my condition, rights, and responsibilities, and other procedures related to the care I received.**

Nurses give a copy of the patient's rights to each patient. They also explain advanced directives and the procedures they will be doing. Then the nurses document that they explained all of these matters.

- **The staff generally arrived as scheduled.**
- **How would you rate your ability to reach your nurse or therapist, or have your calls promptly returned?**
- **How would you rate the courtesy and helpfulness of the office staff?**

The agency's policy is to never allow a telephone to ring more than three times. "If it's not answered on the third ring, then I will answer it or any one of us in the office will," Hall says. "We say, 'Thank you for calling Ambassador Home Health. This is Nerissa. How may I help you?'"

- **How likely would you use this agency again or to recommend this agency to friends or relatives?**

COMING IN FUTURE MONTHS

- Improve your peer review process
- Reduce diabetes utilization
- Tackle frequent flier problem
- Can new services bring life to your agency?
- Wound outcome program reduces recovery time

SOURCES

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• **Overall, were you pleased with our services?**

Underneath each question, there is space for comment or suggestion for improvement.

3. Look for trends of problem areas.

Hall reviews all surveys and looks for problem areas. When she sees a rating that's lower than "good," she'll call that patient directly, saying, "My name is Nerissa at Ambassador Home Health. We provided home health services for you. Thank you for filling out your questionnaire. I noticed a few areas where we didn't meet your needs, so could we talk about it?"

Two survey questions had been returning with lower ratings, and the agency targeted these areas for improvement. The question whether the staff arrived as scheduled had received poor ratings. Hall investigated this problem by speaking with staff and patients who had made the complaint. She learned that nurses or therapists were telling patients they would arrive at a specific time. If they were a little late, the patients would be upset."They could have had bad traffic, or the last patient could have detained them," Hall explains.

The delays often were unavoidable, so the agency's quality assurance group, consisting of aides, case managers, supervisors, and Hall, fixed the problem by changing how the staff would tell patients their expected arrival times. Instead of giving patients an exact time, the staff would tell them they'd arrive within an one hour time frame. For example, if the nurse intended to see the patient at 2 p.m., the nurse would say, "I'll be at your home between 2 p.m. and 3 p.m." This way the patient would not become anxious if the nurse still has not arrived at 2:30 p.m.

The strategy appears to have worked. Patient satisfaction ratings for this question have improved since the agency switched to giving time frames.

Another problem area involved the question about patients' ability to reach their nurse or therapist. Nurses always told patients that they could call the agency during its office hours of 9 a.m. to 5:30 p.m., or they could reach a home care professional through an answering service that is available nights and weekends.

The problem appeared to be that patients expected to speak with their nurses immediately when they called the office, even when someone else at the office was able to answer their questions, Hall says. "That was another area where we needed to give them some education."

Now nurses tell patients to call the office if they need the nurse or have a problem, and the office will call the nurse's beeper number, if necessary, because the nurse most likely will be in the field. ■

Improve pressure ulcer outcomes with protocols

Pressure ulcers are costly and preventable, as is unintentional weight loss in elderly patients. Some experts believe a key component to preventing these problems is to focus on patients' nutrition and diet.

The Chicago-based American Dietetic Association (ADA) has medical nutrition therapy protocols, developed by dietitians and published by the ADA and Mobile, AL-based Morrison Health Care. These protocols are for the prevention of unintentional weight loss and treating pressure ulcers.

"Every year, about 60,000 people die from complications related to pressure ulcers," says **Jody Vogelzang**, MS, RD, LD, FADA, president of JLV and Associates in Southlake, TX. Vogelzang chairs the dietetic practice group of the American Dietetic Association.

"Unintentional weight loss is an indicator of a lot of co-morbidities," Vogelzang says. "Malnourished older Americans can attract more infections and diseases, and surgery is riskier for them."

Patients with either a pressure ulcer or unintentional weight loss can result in high medical costs and poor outcomes in disease treatment or surgery recovery.

Home care agencies may use the protocols with their care pressure ulcer care pathways to help improve treatment. Here's how they work:

1. Pressure Ulcer (Stages I-IV):

Before the initial session, the nurse would obtain baseline measurements of the patient's

biochemical / blood work within 30 days. The nurse also would obtain the patient's baseline weight and clinical signs and symptoms of Stage I, II, III, or IV pressure ulcers.

The first step is to include nutrition standards in the nursing assessment, Vogelzang says. "If there is a nutrition risk, it should be flagged and something has to be done about it."

Nurses would assess these items, as well:

• **Functional outcomes:**

- activities of daily living;

- Braden Scale for predicting pressure sore risk score;

- incontinence / urinary / fecal status;

- chewing and swallowing problems;

• **Quality of Life Evaluation**

• **Behavioral Outcomes:**

- whether oral intake is adequate in protein, calories, fluids, vitamin C, and zinc;

- what is patient's knowledge of flood and drug interaction;

- review appropriate care and treatment as prescribed.

All of those items except for the biochemical measure would be evaluated three more times. The biochemical measure would be evaluated during the last intervention.

The expected outcomes would include the following:

• to improve, achieve, or maintain appropriate biochemical values when properly hydrated;

• to raise or maintain body weight as appropriate;

• to hydrate the wound and improve the wound status through healing without further breakdown;

• to have the patient be able to feed self and / or eat with assistance, and to raise the mobility and activity level;

• to raise the Braden Scale score;

• to reduce incontinence through bowel and bladder training;

• to have the patient consume the appropriate amount of food and fluid;

• to improve the patient's quality of life;

• to have the patient consume adequate nutrients to heal the wound;

• to have the patient consume food and drugs at appropriate times and in appropriate amounts;

• to teach patient that wound care with adequate nutrition heals wounds.

Vogelzang says home care dietitians or nurses need to consider environmental factors that could negatively affect any of these measures. For example, the patient's care plan may say the patient needs to increase protein, which generally is found in meat. But if the patient has ill-fitting dentures, the patient might have trouble chewing it.

"The meat will sit on the plate," Vogelzang says. "What looks good on paper may not translate into increased protein for that patient."

Solutions may be to have the patient puree meat or to obtain protein through a nutritional drink.

The ideal goals would be as follows:

• to have biochemical measures of less than 3.5 g / dL for Albumin; 11 g / dL of HgB, and 33% Hct.

• to have patient avoid weight loss of greater than or equal to 5% in 30 days or greater than or equal to 10% in six months;

• to have the patient consume nutrition as prescribed;

• to have a Braden Score of 17 or higher;

• to increase mobility and activity based on the patient's health condition;

• to control incontinence to prevent further skin breakdown;

• to achieve or maintain adequate nutrition and hydration;

• to improve a quality of life that's appropriate to the patient;

• to maintain an oral intake of 1.25-1.50 grams total protein per kilogram of body weight with 70% high biological value;

• to have a minimum of 30-35 mL / kg body weight;

• to have no evidence of food and drug interaction.

2. Prevention of unintentional weight loss:

Nurses would obtain baseline measures of the biochemical parameters of Albumin, HgB, Hct, BUN, and Creatinine. They also would assess the patient's weight, height, and body mass index; hydration status, and blood pressure.

"Albumin shows the protein status, and it's so important for the patient to have an adequate protein source," Vogelzang says. "Generally, it's the protein source that is used for energy when weight loss is occurring."

Also, the nurse or dietitian would check to see if the patient has dry mucus membranes, which could indicate clinical dehydration.

Next, the nurse would look at functional outcomes, including:

• activities of daily living;

• exercise tolerance;

• whether patient demonstrates self-feeding skills.

SOURCES

American Dietetic Association, P.O. Box 97215, Chicago, IL 60678. Telephone: (800) 877-1600.
Jody Vogelzang, MS, RD, LD, FADA, president, JLV and Associates, 903 Dowling Court, Southlake, TX 76092. Telephone: (817) 424-2627.

Again, the quality of life would be evaluated, and these behavioral outcomes are assessed:

- food and meal planning;
- vitamins and mineral supplements with acceptable doses, if required;
- does the patient tolerate the consistency of foods served;
- does the patient have knowledge of food and drug interactions.

Expected outcomes are:

- laboratory tests repeated based on the client's condition;
- weight increases or is maintained as appropriate;
- prevent dehydration and edema;
- blood pressure is within normal limits of client's history;
- activities of daily living are maintained or improved;
- the patient's mobility and activity level is raised;
- patient maximizes food intake through cueing, self-help devices, or feeding assistance;
- patient's quality of life is improved;
- patient consumes nutrient-dense foods, snacks, and supplements with greater than 30 to 35 kcal / kg;
- if necessary, alternative nutrition support is provided to prevent further weight loss and reduce complications;
- patient is free from signs and symptoms of vitamin and mineral deficiencies;
- patient consumes 90% to 100% of meals, snacks, and supplements without distress;
- a dietary adjustment is made for food and drug interaction.

The ideal goals are:

- biochemical values of: Albumin at 3.5 g / dL; HgB at 11 g / dL; Hct at 33%; BUN at 8-20 mg / dL, and Creatinine at .7-1.5 mg / dL;
- patient maintains weight to greater than 85% of usual body weight;
- patient's blood pressure is less than 120 / 80 mm Hg;
- patient is able to participate in exercise appropriate for tolerance;
- the quality of life is improved as appropriate to the patient;
- patient has an increase of intake of nutrient dense foods and maintains or increases weight gradually;
- prevent complications associated with low body weight, medication noncompliance, and vitamin or mineral deficiencies.

For each of the protocols, there are four interventions that are spaced two to four weeks apart, Vogelzang says.

The protocols also include flow charts and a second page with spaces for the clinician to check specific assessment items for each intervention date. The Braden Scale for predicting pressure sore risk is also included in the protocol packet.

[Editor's note: The protocols were published by the American Dietetic Association in a manual, Medical Nutrition Therapy Across the Continuum of Care. *The manual comes with a computer disk, so health care providers can alter the protocols to better fit their own organizations. The manual and disk cost $90 for nonmembers or $75 for members. Shipping costs 10% of total. For more information about the pressure ulcer and unintentional weight loss nutrition protocols, you may contact the American Dietetic Association at (800) 877-1600, ext. 5000.]* ■

GUEST COLUMN

OIG broadens background checks for home health

By **John C. Gilliland**, II
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Crestview Hills, KY

News: The Office of Inspector General's (OIG) Compliance Program Guidance for Home Health Agencies states that home health agencies should conduct reasonable and prudent background investigations of applicants for employment and prohibit the employment of individuals who have been recently convicted of a criminal offense or who are listed as debarred, excluded, or other-

wise ineligible for participation in federal health programs. Consistent with that recommendation, as part of the federal budget package passed last October, Congress included a process for home health agencies to request FBI criminal background checks of applicants for employment.

Background: For the past several years, the number of states which require criminal history checks for home care employees has steadily increased. In some states, detailed requirements are established by statute and address such matters as what crimes prohibit home care employment and for whom and when criminal history checks must be conducted. In other states, the requirement is general, stating only that agencies must conduct such checks. When a state does address the issue, it typically requires criminal history checks for clinical staff employees but not office staff.

The increasing concern of state governments to have the criminal background checks of home care employees also has been reflected in the proposed new Medicare conditions of participation for home health agencies. In the proposed COPs, HCFA proposed criminal background checks of home health aides stating:

"Home care patients are a vulnerable and confined population. It is necessary to ensure the provision of safe, quality care to patients in their homes. We are proposing one specific measure in this proposed rule — a criminal background check of home health aids as a condition of employment. . . . Proposing criminal background checks as a condition of employment for home health aides is one vehicle to guard beneficiaries from abusive practices in the sanctity of their homes. . . ."

Although state and Medicare requirements focus on criminal background checks of clinical employees, the desirability of criminal and other background checks for all employees was recently emphasized by the OIG of the United States Department of Health and Human Services. In the OIG's Compliance Program Guidance For Home Health Agencies the Inspector General stated:

"For all new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, home health agencies should conduct a reasonable and prudent background investigation, including a reference check, as part of every employment application.

"The application should specifically require the applicant to disclose any criminal conviction . . . or exclusion action. Pursuant to the compliance program, home health agency policy should prohibit the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs. . . ."

Aside from fraudulent activity, the OIG recommended:

"Since providers of home health services have frequent, relatively unsupervised access to potentially vulnerable people and their property, a home health agency should also strictly scrutinize whether it should employ individuals who have been convicted of crimes of neglect, violence, or financial misconduct."

The federal government's concern for background checks of home care employees also was addressed by Congress in the recent federal budget package for fiscal year 1999.

Title I, Section 124, of the conference report permits home health agencies to submit a request for FBI criminal history information for applicants for employment in a position involved in direct patient care. Regulations concerning how to make such requests must still be established, but requests will need to be submitted within seven days after fingerprinting the applicant and a fee, not to exceed $50 per request, may be charged.

Finally, aside from specific statutory or regulatory requirements, there also is the issue of negligent hiring. Failure to conduct a reasonable and prudent background check of a home care employee could provide the basis for a lawsuit against your agency. If a patient is harmed by an employee for whom a background check was not conducted, and the check could have avoided that harm, your agency could be held to have been negligent in its hiring procedures.

What This Means to You: Clearly, the trend is to require or, at least, strongly encourage home health agencies to conduct background checks for employment applicants. When a state law requires background checks, it tends to be for criminal background checks of clinical employees to guard against hiring persons who would present a risk to patients. But, as recommended by the OIG, an effective corporate compliance program goes beyond criminal history checks for clinical staff and includes checks of other employees for financial misconduct and exclusion from participation in federal health programs.

As you develop your agency's policies concerning background checks, there are a number of things you should consider:

What does your state law require? Does your

state require any type of background checks for home care employees? If so, what are the specific requirements? If your agency provides services in more than one state, you need to know the law of each state. Your policies must be consistent with applicable state law.

1. Subjects of background checks.

You need to identify what job titles or employment classifications will be subject to background checks. Are you going to conduct background checks only for clinical employees, or will you follow the advice of the OIG and have background checks for any employee exercising discretionary functions in your agency? Perhaps you will conclude that it is best to conduct background checks for all employees of your agency because. It is conceivable that any employee could become involved in fraudulent activity.

What about independent contractors? Will you require background checks for them, too? The OIG recommends it.

2. Applicants for employment and current employees.

You may require background checks for applicants, but what about current employees? If it is important to have background checks for new employees, it would seem just as important to check the backgrounds of your present employees.

3. Nondiscrimination issues.

Because members of some minority groups are arrested more often than whites in proportion to their numbers in the population, courts have held that a conviction for a felony or misdemeanor may not, by itself, lawfully constitute an absolute bar to employment. The concern is that making a conviction an absolute bar to employment will have a disproportionate affect on the employment opportunities of members of those minority groups.

The courts have held, however, that an employer may give consideration to the relationship between a particular conviction and an applicant's fitness for a particular job. The decisions indicate that misdemeanor and felony convictions can be cause for rejection only if their number, nature, and recentness would cause the applicant to be unsuitable for the position. In other words, a mere conviction cannot bar employment; you have to determine the relevance of the conviction to the job. Note, however, that some state laws may absolutely bar home care employment of individuals convicted of certain specific crimes; you need to check your state's law.

Part of your employment policies concerning criminal conviction information probably will include inquiring about prior criminal convictions on written applications for employment. Reflecting the legal requirements from a nondiscrimination perspective, it is important to accompany such inquiries with a statement that a conviction record will not necessarily be a bar to employment and that factors such as age and time of the offense, seriousness and nature of the violation and rehabilitation will be taken into account. Subject to what your state's law may require, possible wording in that regard could be:

"Have you ever been convicted or pleaded guilty to a felony or misdemeanor? If so, please explain. (Note: A conviction record will not necessarily be a bar to employment. Factors such as age and time of the offense, the seriousness and nature of the violation and rehabilitation will be taken into account.) "

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You also should inquire about exclusion from participation in health care programs. Wording in that regard could be:

"Have you ever been debarred, excluded, suspended, or otherwise made ineligible for participation in any federal or state health care program, such as Medicare or Medicaid? If so, please explain."

4. The background check itself.

You will need to decide what background checks your agency will conduct. Possibilities in that regard are noted in the sidebar to this article.

5. Payment for the background check.

You need to check your state law to see if there is any prohibition on requiring an applicant for employment to pay any fees required for a background check. In the absence of such a prohibition, you probably can place the expense on the applicant.

6. Types of criminal convictions which are relevant to various jobs in your agency.

Unless restricted by state law, what criminal convictions will be relevant to you in deciding to hire someone is at your discretion. From a nondiscrimination perspective, you should only consider convictions which are relevant to the job involved. For example, for clinical employees you would be concerned with crimes involving abuse, physical violence, or theft, to name a few. For persons working in the office and dealing with claims submission and billing, you would be especially concerned with convictions for crimes involving financial responsibility, e.g., embezzlement, fraud, tax evasion.

If the background checks are handled by the hospital's human resource department, be sure it is knowledgeable concerning the nature of home care employment. Some convictions which might be acceptable in a hospital due to direct supervision of the employee may not be prudent in home care where employees function much more autonomously and third party reimbursement is greatly dependent upon the employee's documentation.

7. Conditional hiring.

Because of the delay in obtaining the results of a criminal background check, some agencies may want to hire someone immediately subject to a satisfactory background check. If the background check is unsatisfactory, the employee may be terminated. Agencies taking this approach must be concerned with the potential liability for negligent hiring if they conditionally employ a person who harms a patient before the criminal history is received and that history shows convictions for abuse. If it was important to conduct the criminal background check in the first place, it would seem to be equally important to know the results prior to placing the employee in a position which could result in harm to the patient or fraud in the operation of the agency.

Dealing with the delay before the results of a criminal or other background check is received appears to be one of the biggest problems for agencies.

8. Enforcement of policy.

Finally, whatever policy you adopt, be sure that you follow it. The policy will be evidence of the standards you have adopted for the operation of your own agency. Do not commit yourself to an approach you will not follow. ■

CE objectives

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

1. Repeat the six elements of an action plan, as recommended by the Center for Health Services and Policy Research in Denver.
2. List variables in scanning technology now available to make it easier for home care agencies to use the OASIS tool for QI initiatives.
3. Identify acceptable circumstances for terminating patient care.
4. Prepare a protocol for preventing unintentional weight loss in patients. ■