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# HOMECARE Quality Management™

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# Home care patients suffer needlessly

*JCAHO turns spotlight on pain assessment*

How often have your nurses visited a regular client only to be surprised when the patient divulges that he or she has had chronic pain? The patient never bothered to mention this before, perhaps assuming the nurse could do nothing about it.

Most home care agencies would be surprised to find they have a significant problem with unmanaged pain within their patient population, says **Carol Curtiss**, RN, MSN, OCN, clinical nurse specialist consultant in Greenfield, MA, and past president of the Oncology Nursing Society in Pittsburgh.

Patients also can fail to mention their pain to physicians, which means the home care nurse might be the first to learn of it. "Patients assume clinicians know they have pain, and if we don't ask regularly at every visit, then it's very easy for their pain to be under-reported," Curtiss says. "It seems pretty incredible to me that we have known how to manage acute pain for over 20 years, and yet the management of acute cancer pain and chronic non-malignant pain is poor. People suffer needlessly.

"I believe that linking pain to the quality improvement process will be key to our ability to provide better care in the management of pain," Curtiss continues.

Recently, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, began to focus on pain management assessment in home care, making pain management an even higher priority for agencies, she says.

Quality managers should focus on proper pain assessment, communication, and their staff's own attitudes about pain, says **Colleen J. Dunwoody**, MS, RN, clinical coordinator for management at the University of Pittsburgh Medical Center and president of the board of directors of the Chronic Pain Association in Rockland, CA.

"People need to recognize their own values and their own belief system about pain," Dunwoody says. "You can imagine that if one of the care providers is someone who values stoicism, it may be difficult for them to care for a patient whose value system is markedly different, and includes open expression of pain."

Curtiss and Dunwoody give these guidelines for quality managers

setting up a pain management QI project:

**1. Create a pain management standard.**

Home care agencies need to identify whether they have a standard for pain management, and it should be in writing, Curtiss says.

If there is no standard, then agencies could refer to national standards for cancer pain as established by the American Pain Society of Glenview, IL. Also, quality managers could obtain a resource manual, called *Building an Institutional Commitment to Pain Management*, from the Wisconsin Cancer Pain Initiative in Madison. **(The manual costs $30 plus $5 shipping and handling. See source list for address and phone number, p. 35.)**

"It's difficult to maintain competency if you're not sure what you're supposed to be competent about," Curtiss says.

An agency's standard could be simple and straightforward, such as this suggestion by Curtiss: The agency requires the systematic and ongoing assessment of both pain and pain relief, including using medicines systematically and adjusting them to the individual's response. The agency combines non-drug interventions with medications as part of the plan. Staff communicates the plan to other professionals, as well as to the person who has pain.

**2. Establish an assessment tool.**

Both Curtiss and Douglas suggest quality managers ask these questions:

- Is there a systematic assessment system in place?
- What is the minimum frequency of pain assessment required for all clients?
- How often are nurses required to ask patients about pain?
- How often has the agency's care helped to relieve a patient's pain?

A variety of pain management scales can be used. Most of these have a rating system with a range from zero, meaning no pain, to 10, meaning the worst possible pain. These types of scales are subjective, but they give the clinician a good idea of whether a patient's pain is decreasing or increasing.

"Another good area to evaluate for quality improvement is the circumstances when pain is relieved," Curtiss says. For instance, what happens when a patient's pain stays above a level five for a longer than acceptable period, and how long a period is acceptable?

Curtiss recommends agencies require nurses to assess patient's pain on every visit, making it a part of the normal routine the same way they would ask the patient about eating, elimination, and mobility at each visit.

**3. Show staff how to talk with doctors about pain.**

Social biases often get in the way of providing patients with effective pain management, Curtiss says. One of these is the misconception, which some physicians and nurses have, that patients might become addicted to pain medication.

"It's an issue, because physicians are afraid to prescribe. In addition, nurses are afraid to give medications, and patients are afraid to take them because of this fear of addiction," Curtiss says. "Yet the incident of addiction in individuals appropriately prescribed medicines for pain is less than .1%."

Home care nurses can help their patients overcome pain and help physicians overcome this misconception by improving their communication skills.

Dunwoody suggests quality managers help nurses improve their ability to communicate with physicians about pain management by following these guidelines:

- Identify the problem, such as what kind of pain the person has, and be factual and specific. Avoid generalizations.
- When documenting or communicating a patient's pain, organize the information in a logical way. Have nurses always follow the same assessment order.
- Teach nurses they should never apologize when calling a physician to discuss a patient's pain problem.
- When nurses make suggestions to physicians for a change in a patient's pain management, they should use written sources, published reports, and other data to support their recommendation.

The last guideline is very important, Dunwoody says. "When you're meeting with resistance, it's helpful to say, 'I just read an article about that. May I send it to you?'"

Quality managers and nurses first should do their homework and come up with specific examples and data. Then they should communicate their suggestions in terms of this information.

"It's better to say, 'The patient needs more pain medication,' than to say, 'What you've prescribed is not working,'" Dunwoody adds.

Also, physicians like to see graphs and numbers; that's why it's important to use a pain rating system. "A nurse can say, 'We talked about this pain problem three days ago, and you recommended

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such and such, and it has dropped the patient's pain from a nine to a seven, but the patient still isn't satisfied. What more can we do?" Dunwoody wonders.

**4. Teach staff to communicate with patients about pain.**

Pain is not a visible symptom, which is why communication is especially important when nurses deal with patients who have pain. "Pain is easily overlooked unless it's prominent in the person's life," Curtiss says.

Nurses and other home care field staff need to know how to communicate with patients about their pain. Having the patient rate the level of pain is the first step. But, Dunwoody says, there are also other guidelines they may follow, such as these suggestions:

• Collect specific information about a patient's pain, including the location, the severity, and quality of pain. "By that, we mean word descriptors like 'burning,' 'throbbing,' and 'aching,'" Dunwoody says. "The words the patient uses help the nurse and physician identify the type of pain a patient feels."

• Ask the patient when the pain started and how long it lasts. If the pain varies, what seems to make it feel better or worse. For example, a patient with degenerative arthritis is more likely to have pain at the end of the day after activity, Dunwoody says. "Whereas an individual with rheumatoid arthritis is more likely to have pain at the beginning of the day when they are stiff, and it's hard to get moving."

• Next, listen to how the patient expresses his or her pain, and watch for visual clues to pain. Patients might exhibit a change in gait patterns, difficulty in coughing, and problems with activities of daily living. Home care nurses, for instance, might observe whether a post operative patient is having trouble with coughing and deep breathing because that could indicate complications from the surgery, Dunwoody says.

• Find out what causes a patient's pain to increase and what helps to relieve it. Nurses can ask the patient what they have done to make their pain feel better. "A patient might say they used yoga, relaxation techniques, exercise, or a distraction," Dunwoody says. "We want to know the full gamut of what an individual might use to relieve pain and find out if there is anything they can identify that makes it worse."

• Finally, nurses need to assess the effects of the patient's pain. For example, the pain might affect patient's emotional or psychological state, perhaps causing depression. In addition, acute pain may cause a lack of appetite or nausea and also may interfere with sleep.

Quality managers could set up some team meetings where pain is discussed by all of the health professionals involved. "It takes a team effort, and nobody can do it alone," Dunwoody says. ■

# Project improves peer review, documentation

*Agency creates thorough form*

Homecare quality managers often encounter gremlins soon after starting a peer review process. They include redundancy, inefficiency, and complexity. Often they can be eliminated by creating a thorough, clear peer review tool.

St. Joseph's Visiting Nurse Association in Mishawaka, IN, recently completed a peer review chart that has 109 questions. It covers everything from whether the 485 worksheet is complete; to whether the clinical notes are current, signed, and dated; to what the net amount is over or under reimbursement. **(See sample peer review tool, inserted in this issue.)**

The agency, led by its quality improvement team, embarked on a lengthy effort to improve documentation and its peer review process by creating the new chart. Although it's too early to say whether the new process and chart have improved clinical outcomes, the change already

resulted in a streamlined and much more efficient documentation process, says **Mark Guzicki**, RN, MBA, CPHQ, director of clinical and quality services for the hospital-owned agency, which serves northern Indiana and southwestern Michigan with 8,000 nursing visits a month.

"Historically, we've lacked a sound performance improvement process and have never taken a systematic approach to PI projects," Guzicki says.

QI managers found about 40% of the information collected in some charts were redundant and too complex. "We spent so much time on the insignificant part of charting and documentation that we had no time or resources to focus on what's important, and the important information got buried in the myriad of paperwork people were trying to chart," Guzicki says. In addition, the old documentation system and charts were too difficult to track for trends and sentinel events.

Guzicki and other QI managers decided to revamp the agency's documentation through a formal peer review process. Here's what they did:

**1. Refer to the experts.**

They plowed through a manual by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, looking for high priority indicators that should be a part of the agency's medical record, Guzicki says.

"We wanted to build our tool around the Joint Commission requirements and to include those things we might want to look for that the OIG [Office of Inspector General in Washington, DC] might want to look for," he adds.

Quality managers had several important goals:

- Keep it simple.
- Make the peer review tool user friendly.
- Make sure the tool differentiates between clinical aspects of chart review and clerical aspects of chart review.

For example, a clerical aspect might be the question of whether there is a signed advanced directive in the chart. "It doesn't require a clinician's skills to look for that," Guzicki explains.

The clinical aspect includes asking whether a discharge plan is appropriate, or whether there is evidence that clinical care is reasonable and necessary.

Guzicki and another quality improvement manager created a draft of the peer review tool. "We let people tear that apart and put it back together," he says. "We have since modified the form and it continues to evolve, but it's working fairly well."

**2. Form a performance improvement team.**

The agency included Guzicki and all disciplines on the team. Team members included therapeutic staff, nurses, nurse leaders, home health aides, clinical manager, medical record specialist, and a representative from the human resources team.

The team's role was to look at trends and problems that appeared as the peer review process collected data. Guzicki built an Excel data base for the peer review charts, so tracking trends is now much easier.

"If we analyze the clerical component and find we have an inordinate amount of failures to get the bill of rights signed, then we'll focus on that," he says.

**3. Begin improved peer review process.**

Each month, a quality improvement clinical employee and a clerical employee review a total of 5% of the agency's total charts. This amounts to about 40 charts a week. They match the visit frequency with that of billing to make sure the agency had new verbal orders when providing treatment.

For example, they'll answer these questions:

- Was the physician order returned and in the chart on time?
- If the agency delivered pharmaceutical supplies, was there a copy of the delivery on file?
- Was the LPN supervision completed at least one time per month?
- Is there evidence the nurse or therapist provided appropriate teaching? Is the patient response to teaching evident?

Each peer review chart takes about 30 minutes to complete, Guzicki estimates.

The peer reviewers are looking for exceptions, which may be omissions or errors. For instance, an exception might be that a nurse's note for July 11, 1998, is not on file. "Sometimes the clinician has it in her travel file, but it has not been properly filed, so the peer review serves as a good prompter," Guzicki says.

Another exception might be that the medication sheet was not updated at the time of the last new medication. When ever these problems are found, the nurse involved and the nurse's clinical manager are given a report, and they have seven days to correct the problem.

**4. Use the peer review data for PI projects.**

The peer review process has shown the redundancy in many of the agency's forms. "Whenever a regulation or business requirement changed,

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the agency would simply add something to existing forms," Guzicki says.

"By incrementally adding onto our package, we've created a monster that's designed to fail," he adds. "For example, we have forms that ask five to six times for the medication record."

The agency plans to tackle the project of revamping and simplifying documentation.

"Our next step is to make contact with a number of benchmarking organizations about documentation to form a needs analysis for the facility," Guzicki says. "We've gone as far as to investigate a point-of-care documentation system."

The peer review chart database also makes it a simple matter for Guzicki or other quality managers to run a report that lists the findings down into groups, according to the types of problems. This gives a clear-cut look at trends, and helps the agency's performance improvement team set goals and priorities for future projects. ■

# Agency restructures as part of QI project

*Agency meets IPS goals, sails through survey*

Sometimes the best results come from a quality improvement process that begins with home care managers taking a long look in the mirror.

Parmenter VNA and Community Services in Wayland, MA, managers took that long look at their own reflections and decided they could best improve their agency's customer satisfaction, quality, and utilization by changing their own jobs.

"We wanted to make the managerial part a little less top heavy," says **Marilyn Bonkovsky**, RN, clinical manager for home care, hospice, and CQI for the agency which has 24,000 visits a year.

The agency began to look at restructuring its management in mid-1997. Some people felt the agency's management structure could be improved for better efficiency and use of managers' time and talents, Bonkovsky says. "We were looking at implementing some changes when the word of the interim payment system (IPS) came down. We added some things and saw that what we had was helpful, but we needed to take some further steps."

## Change can be good

Jobs changed for everyone at the agency's top. And the agency has been very successful in achieving its goals as a result, Bonkovsky says.

Here's just a few indicators of that success:

• The agency's utilization rate for Medicare clients in 1997 was an average of 47.8 visits. The agency reduced that to an average of 33 visits in 1998, a 33% reduction.

• The agency's referral numbers increased 7% over the same period.

Best of all, quality of care did not suffer as a result of the reduced utilization, Bonkovsky says. The agency was surveyed in the fall of 1998 by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and Parmenter VNA received accreditation with commendation.

Also, a patient satisfaction survey taken in the third quarter of 1998 shows a 92% satisfaction level, which was an increase over the roughly 86% patient satisfaction reported for the fourth quarter of 1997.

In addition, the agency's fund-raising and grant revenues increased 120% over the same year.

Bonkovsky explains how the small agency embarked on and succeeded with its restructuring project. Here are the steps taken:

**1. Managers assessed their own talents, skills.**

The agency's eight managers met in a half-day workshop to start the quality improvement process. They started with the agency's current organizational chart and analyzed it, using the Nashville, TN-based Health Corporation of America's FOCUS-PDCA process improvement model. **(See February 1999 issue of *Homecare Quality Management* for a description of how the model works.)**

Managers created an inventory of their organizational skills and leadership goals. "We listed what we thought we currently had and what we needed in the future in order to improve our organization," Bonkovsky says.

The inventories covered a wide range of skills, from diplomacy and coaching organizational

skills to leadership roles of score keeper and absentee ruler. **(See organizational skills inventory and leadership role inventory self-evaluations, inserted in this issue.)**

For each attribute, managers rated themselves according to a scale of their personal skills being at the top, middle, or bottom. This way, they could each see their own strengths and weaknesses. The management committee tallied these individual responses and produced a bigger picture of the agency's strengths and shortcomings.

At the next meeting, the managers received handouts listing the tallied items, which listed with "Xs" how many managers had listed a particular attribute on the inventory sheets.

**2. Managers identified problem areas.**

The tallied inventories and highlighted some areas that the agency needed to make a priority. They also opened up the discussion about what systems work for the agency and what doesn't work.

"It was very time consuming," Bonkovsky says. "We talked about internal support services across all programs."

In all, they came up with 20 areas that posed problems to either leadership or organizational structure.

Their next step was to create an ideal organizational chart. Each manager created one and turned them over to the executive director and assistant director who put the eight individual charts together to create one new chart.

Next, managers discussed the agency's clinical and supportive / preventative programs, and areas of future development. They also talked about ways to make their own jobs more manageable and about how to add responsibilities to various management positions. Plus, managers addressed how to develop growth opportunities for the staff and how to develop supervisory leadership skills in the areas that were identified as lacking.

"We needed to clarify authority and responsibility to improve decision making so there would be an authority and accountability that went with that," Bonkovsky says.

Managers worked on some of these issues and came up with ideas between meetings. "An awful lot of work was done between each session," Bonkovsky recalls. "We made good use of the time by preparing ahead each time."

**3. Managers discussed solutions.**

They brain stormed to find solutions. For example, the managers decided management jobs could become more manageable if managers would make decisions without first talking to several other managers.

"If we could clarify areas of responsibility and authority and accountability we could be more efficient in decision making," she says.

They decided to set up regular meeting times for people in management to discuss specific projects and areas of concern. This replaced the former practice of simply having managers run to their supervisor every time they have a question, Bonkovsky says.

"This makes better use of everybody's time, and it's not as though you couldn't talk to someone if you needed to, but you organize your time better," she adds.

## *Look for opportunities*

Bonkovsky says the change in the agency's decision-making process means that managers now take greater responsibility for making decisions. For instance, as clinical manager, she might discuss a particular hiring decision or a change in policy or procedure with other employees. Now, Bonkovsky makes the final decision without necessarily seeking a consensus. "I would make the final decision if there's a difference in opinion," she says.

"Everything doesn't have to be a group decision or group consensus, and that cleans things up a bit," she adds. "Along with that is the responsibility. If you make the wrong decision, you have to live with it."

For another solution, managers decided to increase their leadership skills by looking for opportunities to lead and learn, such as joining statewide committees and attending meetings where they might interact with other home care managers.

**4. Managers began new jobs and roles.**

The biggest restructuring change was to assign managers new responsibilities and roles.

Here are some of the role changes the agency made:

• The executive director and assistant director traditionally shared responsibilities and work. This led to duplication of efforts. Now, the assistant director handles all the day-to-day managerial tasks, and the executive director focuses on one of their identified areas of concern: fundraising efforts.

"One thing we needed was a big capital campaign. The executive director began to work with the board to get this off the ground,"

## SOURCES

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Bonkovsky says.

That turned out to be an extremely fruitful change. A year after the change, the executive director helped to increase the agency's nonoperating revenues by 120%.

• The agency created a position of clinical care coordinator to manage the agency's case utilization. The coordinator is an experienced registered nurse whose job is to monitor and evaluate the utilization and appropriateness of clinical services.

"When we saw IPS coming down, it became extremely clear to us that we had to address finances," Bonkovsky says.

### *The new reductionism*

Some managers heard about the role of a clinical care coordinator at a home care program on IPS, and the concept seemed to fit the agency's needs.

Instead of hiring someone new to take over this position, the managers decided to have one of the current clinical managers switch roles. The agency had a clinical manager for hospice and one for home care. The change meant only one clinical manager would handle both hospice and home care, and the other clinical manager would become a clinical care coordinator.

The clinical care coordinator's responsibilities include:

• collaborating with the intake coordinator;

• admitting nursing clients and developing a plan of care in collaboration with the primary nurse;

• facilitating on-going evaluation of agency clients for appropriateness of services;

• coordinating with the clinical manager and scheduler to assure the delivery of adequate and appropriate services to the client;

• developing or selecting clinical outcome measurement tools;

• implementing clinical outcomes;

• assisting with orientation, evaluation, observation, and instruction of clinical staff;

• assisting in planning and implementing clinical inservice programs;

• participating in quality improvement activities.

The change resulted in the agency's 33% utilization reduction.

Bonkovsky says the agency also altered the way it approaches new home care cases by hitting hard at the beginning with many services, then reducing visits after the first few weeks. "Now, when patients need the most help, we give them the most services and then ease off."

At admission, the clinical care coordinator explains to patients how the agency will approach their care and how the patient should be able to manage alone after a certain number of weeks. "This way, we feel we have a very good approach to patients so they know what to expect from us," Bonkovsky adds.

**5. The agency streamlined services.**

"I think the tendency for a while in home care was to be an agency that could be all things to all people, to have one of every service," Bonkovsky says. "We were trying to develop a psychiatric nursing program, wound care program, maternal and child health, and on and on."

During the restructuring meetings, managers decided to stop diversifying because some these programs were too expensive. For example, they cut the psychiatric nursing program altogether and didn't replace the wound care nurse when she quit. If the agency needs a wound care expert, there are contract resources available. Instead, the agency now focuses on only a few specialty areas, including the maternal and child health program, rehabilitation, and oncology nursing.

Likewise, managers decided to reduce the agency's geographic area, acknowledging that it's not cost effective to drive long distances for a few clients that could be handled by some agency closer to their homes.

Bonkovsky says the restructuring process was time-consuming and difficult, but has been well worth the effort. Besides resulting in some positive financial and quality outcomes, the effort enabled the agency to direct its attention on some important long-term plans.

For instance, the agency now is a partner with a developer to start an adult day health program, a residential hospice house, and an assisted living program.

"We've decided to put our energies in those directions, and cut bait on things that were not working and looked like they'd take a lot of time and would not be cost effective," Bonkovsky says. ■

# PI program targets visit frequency

*Audits spur effort to ensure appropriateness*

If necessity is the mother of invention, then the interim payment system (IPS) has surely spurred many agencies to change policies and procedures. Nowhere is that more evident than at Western Illinois Home Health Care in Monmouth, which implemented IPS in October 1997.

According to **Anita Rutzen**, RN, director of performance improvement/staff development, IPS prompted the agency to look at "everything to see where we were efficient and whether the number of visits was effective and appropriate." The subsequent audit of half the open cases at the agency showed some problems with appropriateness of visit frequency and services provided.

Rutzen and her management team instituted a program which, while not yet totally solving the problem, has certainly brought the agency a good way towards its goal of having 95% of the charts show appropriate use of services and disciplines.

Rutzen says that in January 1998, as the agency began working under IPS, the management team pulled patient charts for a close look. Team members, including Rutzen, the director of clinical services, the central intake nurse, two team managers, and the home care coordinator, were each assigned a portion of the 150 open cases and told to look at half of the selection they were given, she says. How they chose which charts to audit was left up to each team member.

Along with general compliance issues, such as whether the plan of care was signed, the team looked for several items that would justify care. The audit sheet included places to document:

- the personal care needs of the patient;
- whether the patient was bed bound, chair bound, or incontinent;
- the reason for extended duration of care over the projection was documented;
- whether there were hospitalizations, abnormal vital signs, or other reasons that might indicate a rationale for increasing visits;
- what skilled nursing was ordered and what was documented.

If the team saw the same thing documented time and again, Rutzen says that would be a signal of overutilization. "For instance, if we are there to instruct them on medication or diet, we know that teaching and training take time. But you hope new things are being taught at each visit.

The team also looked at what disciplines were used in conjunction with the diagnosis of a patient and in terms of what was being written about them. "If the nurse documented that a patient had problems obtaining medications, and there was no social worker referral," says Rutzen, "that could demonstrate evidence of underutilization of disciplines."

## *Something to aim for*

The chart review was very time consuming, taking 15 to 20 hours per person on the team. It took about a month to complete the chart review, Rutzen says. In addition, the charts fell short of the agency's goal of 95% appropriateness in visit frequency and discipline.

Rutzen would not disclose the actual numbers, but noted there was a statistically significant number of charts that showed both under- and overutilization of visit frequency. She also noted while there was little problem in overusing the disciplines, there was an issue in underutilizing other needed services.

The next step was to develop an action plan to correct the problem. First, the management team shared all the data with the managers. "We felt that it wasn't just the staff in the field that had the problem, because they are conferencing on cases with their first level managers," she notes. "We felt the first area for improvement was with those managers."

Along with the data, Rutzen and her team provided managers with literature to help them better understand the appropriate frequency for various diagnoses. **(For a list of the literature Rutzen used, see box, p. 41.)**

At a March 1998 inservice, the data and literature was shared with the 12 nurses at Western Illinois Home Health Care, and the management team created new processes to ensure improvement. First, managers were required to start using a conference sheet that recorded discussions they

### SOURCES

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## Further reading

These two books are available from Aspen Publishers, 200 Orchard Ridge Drive, Gaithersburg, MD 20878. Telephone: (800) 638-8437. (301) 417-7650. Web site: www.aspenpub.com:

- *The Home Care and Documentation Guide* by Emily Huebner and Patricia Harrison. Aspen Publishers, 1991.
- *The Orientation Guide to Home Care Nursing* by Caroline Humphrey and Paula Milone-Nuzzo, Aspen Publishers, 1995. Publisher's list price: $39. ■

had with nurses about patient care. Second, each nurse was assigned to a member of the management team. Those managers now review with their assigned staff members the visit frequency and discipline mix upon intake and recertification of each patient.

When the program was first put in place, there was some grumbling among the nurses, Rutzen admits. After all, she was adding work for them, as well as for management. "But no one wants to deliberately provide inappropriate care. And, with the threat of legal action for fraud and abuse and inappropriate care, we really had pretty good buy-in."

Because the agency is computerized, she was also able to keep the additional work to a minimum. Usually, the additional discussions between management and nurses can be handled over the telephone, and in most cases, staff members don't spend more than an additional half hour per week on paperwork or meetings.

### *A sense of accomplishment*

While Rutzen says the data is still being compiled, she already has a good sense that the PI program is working. "People talk more about diversifying their discipline mix on cases," she says. "In reviewing cases with the nurses, you can tell they are thinking more about the appropriateness of utilization. When a patient is hospitalized, they talk about increasing visits. When they talk about recertifying clients, they talk about if it is justifiable, or if they really need to be talking about custodial care. That is new."

The goal of 95% appropriateness is lofty, and Rutzen isn't sure if this first go-round will get the agency all the way there. "If not, we'll take a second look at our action plan and see if there is something missing."

"I think that in the home care climate that we are in, you have to defend whatever you are doing," says Rutzen. "If you don't know your data, then how can you defend your actions? This is one piece of it."

There was an added bonus to the program, too, Rutzen adds. Going over the charts made the team confident that they would sail through their state survey. "Those chart audits prepared us," she says. "We knew we were ready for it." ■

# Send expensive consultants packing

*Here's how to run your own mock survey*

With reimbursement declining and regulatory requirements increasing, finding the money to spend on an outside consultant to do a mock survey may seem prohibitive. But there are ways you can take advantage of internal resources to make sure you are prepared for surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) when they come.

**Barbara January**, RN, clinical services specialist at In Home Health in Minnetonka, MN, runs a mock survey program internally for the agency, which has 29 branches in 14 states. Initially part of the agency's internal compliance program, January's Branch Assessment program evolved as Joint Commission accreditation started becoming more important. "We have an ongoing evaluation and monitoring system for each branch's compliance with and adherence to applicable federal, state, and local laws and regulations, as well as JCAHO standards, company policies, and standards of practice," she says.

The plan has not only ensured that branches are prepared for their surveys and know what to expect, but it also highlighted problem areas in those branches and enabled managers to take corrective action before the surveyor's find them.

January says each mock survey consists of several elements, all of which parallel what will happen in a real JCAHO survey. The surveys take two to three days each, depending on the size of the branch and the services it offers. For

instance, a branch that has hospice will take longer. "If you want to adequately evaluate a branch, you have to do home visits. You can't do that in less time," she adds. **(For more on what her mock surveys include, see related story, p. 43.)**

After each mock survey, the branch is given a written assessment report of the findings. Branch managers are then required to create a plan of correction and action plan for any areas deemed non-compliant. This plan is reviewed and approved by the corporate office, says January, and remains "open" until the plan is completed.

### Better compliance, better information

The impact of the mock surveys has been significant, January says. Among the key benefits have been improved infection control practices, equipment management procedures and documentation. "This just makes staff more aware of things beyond hand washing," she says. "They ask themselves if they are packing wounds correctly, and if they are using sterile equipment when they should."

In the documentation area, one area that branches failed was keeping glucometer logs current. "We implemented a very formal program that includes a quarterly report on that topic alone," says January. "There isn't a problem any more."

Another benefit to the program is that managers and supervisors who are new to the job have an easy-to-follow audit tool at their disposal that helps them to quickly identify problem areas at a branch even before they are totally familiar with company policies and procedures. "They can also review the most recent Branch Assessment Report to identify any areas of noncompliance."

While In Home Health is a large organization with resources at its disposal for a formal program, January says smaller organizations can still put their own mock survey programs in place with minimal effort and existing resources.

"With tightening budgets, it is increasingly difficult for home health agencies to hire outside help to do this kind of assessment," she says. "But you can do this by using your present tools. For instance, if you are a Medicare certified agency, you already do quarterly record reviews. Just make sure that your record review tools include the criteria surveyors will be looking for when they review your charts."

When you go with staff on home visits, adds January, look for what surveyors look for, such as breaks in infection control practice or confidentiality. Interview patients about what they have been told about patient rights, hotline numbers, and advance directives.

Periodically, you can use staff meetings to practice survey interview questions. Check to see if your staff understands policies and procedures by quizzing them, says January.

### Take advantage of other resources

If you are a hospital-owned agency, or if you have close ties with a hospital, you can also use their resources as a boost to your own. Meadville (PA) Medical Center has a VNA operating its home health agency. **Marie Pears**, CPHQ, quality and survey coordinator for the hospital, says the hospital joined forces with VNA for a mock survey.

A year prior to its first survey, the hospital and home health agency formed committees to review policies and procedures to make sure they were ready. They did find some problem areas during what Pears calls a "dress rehearsal for the real thing," and were able to correct them before the actual JCAHO survey.

When the real surveyors came in, the answers to the questions they asked came more easily to staff, Pears adds. The results were remarkable at the hospital and home health agency. "Our grid score was 100, and I think that is attributable to the mock survey," Pears says.

At the very least, says January, any agency can take the JCAHO standards manual and go over it


**COMING IN FUTURE MONTHS**

- Prepare for accreditation with some new tips
- Are you prepared for a payer audit?
- Details on a new program for cutting costs
- Can a PI program cut supply costs?
- Public input may change JCAHO standards

**SOURCES**

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to see whether it will pass muster during a survey. The best way, she says, is to devote a month to each of the 11 chapters of the manual, taking December off for the holidays.

"Once the survey is over, keep the process going," advises January. "If you conduct regularly scheduled branch assessments, you can catch areas of noncompliance before they become troublesome." ■

# What should your mock survey include?

*Eight items you shouldn't forget*

When **Barbara January**, RN, clinical services specialist for the Minnetonka, MN-based In Home Health, developed an in-house mock survey program for the agency's 29 offices, she wanted to be sure she covered all bases. Over time, a typical practice survey developed to include these eight items:

**1. Agenda review.** January starts by holding an opening conference to introduce the corporate representative who will conduct the survey to the branch staff and to review the survey agenda.

**2. Home visits.** A sampling of visits from the day the survey starts is chosen. January says she likes to make sure certain kinds of visits are included. "Infusion and wound cases are my top choices. That ensures I see some complex cases that deal with infection control issues."

**3. Staff interviews.** January likes to interview staff members in groups, bringing in a few aides or nurses at one time. "I don't want just one person to get all the benefit," she says. These group sessions usually last about 30 minutes each. She supplements that information with one-on-one interviews with nurses while she's in the car going on home visits, or with people she sees in the hallways during the three-day survey. Along with answering typical survey questions — such as what would an aide do if they suspect a patient was being abused — these meetings also give staff a chance to bring up other issues. "However, staff members know that this isn't time to bring up personnel issues. They know they can talk about policies, processes, and procedures."

**4. Document reviews.** This includes a review of policy and procedure manuals, training and continuing education materials, administrative and professional advisory board meeting minutes, pharmacy dispensing records, client education materials, and equipment maintenance records.

**5. Random chart reviews.** January says she selects clinical records of both current and discharged clients from all divisions.

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**6. Review of contracted services.** January looks at the services to make sure they are in compliance with JCAHO and agency policies and other regulatory requirements.

**7. Employee personnel/medical file review.** A random sampling of these records are chosen for review.

**8. Exit conference.** This last step includes reviewing the findings of the mock surveys with staff and management and making recommendations for improvement.

"The process closely mirrors the Joint Commission survey," says January. "We have found that this gives branches the best experience for what a real survey will be like." ■


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NEWS BRIEF

# Y2K problems could lead to Type I's

*Agencies need to be prepared before survey*

Facing a survey this year? If so, you had better be sure your agency is ready for any issues related to the year 2000 computer problem (Y2K). According to the Joint Commission on Accreditation of Health Care Organization's (JCAHO) Web site, www.jcaho.org, Y2K is one area of focus for surveyors this year.

Organizations not ready for Y2K could receive Type I recommendations. To avoid that, JCAHO says you should identify and assess the implications of Y2K on your operations, including computer systems, medical equipment and utility systems. In addition, agencies should determine whether organizations that provide you with supplies and services are addressing the Y2K issue.

According to the Web site information, surveyors will ask whether your organization is trying to:

- identify its Y2K vulnerabilities;
- upgrade software programs and equipment to make them Y2K compliant;
- identify corrective manual alternatives when necessary;
- consider possible community disaster scenarios related to Y2K in your emergency preparedness planning;
- develop contingency plans to handle Y2K disruptions that are not identified ahead of time or are outside the organization's control.

For more information on Y2K issues and how to solve them, see November 1998 *Homecare Quality Management*.

The Web site also pointed out other areas of focus for surveyors this year. They include:

- staffing levels and competencies;
- control of high-risk medications;
- oversight of contracted services;
- timeliness of care;
- licensing of facilities and caregivers who provide services across state lines. ■

## CE objectives

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

1. Propose a pain management assessment plan that incorporates better communication with patients and other health care professionals.
2. Describe the duties of a clinical care coordinator who will oversee case utilization.
3. Create a more effective peer review tool.
4. Plan a mock survey. ■