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INSIDE

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AUGUST 1999

VOL. 5, NO. 8
(pages 93-104)

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Improperly documented work could waste everyone's time

'Good' documentation increases after QI program

Many hospitals and home care agencies have shown in recent years that home health services are essential to improving care and reducing the emergency room and hospital costs of congestive heart failure (CHF) patients.

But developing a thorough CHF home care program is only half the task. It is equally important to make sure your nurses document the care they provide meticulously and accurately.

Home Health and Hospice of the Whidden Memorial Hospital in Everett, MA, set up a special performance improvement project to address CHF documentation. As a result, the agency's percentage of good CHF documentation rose from about 87% in May 1997 to nearly 94% in January 1999, says **Marjorie Cook**, RN, MBA, CNAA, director of performance improvement for Hallmark Health Home Care in Malden, MA. Whidden Home Health and Hospice is a part of Hallmark Health.

> ***"We lived by the premise that if it wasn't documented, you didn't do it."***

Cook describes how Whidden set up its CHF documentation project, outlining these steps:

1. Identify the problem.

The agency first identified the problem with CHF documentation in May 1997, after the performance improvement team took a close look at CHF patients and their outcomes. CHF was the agency's most frequent diagnosis, with about 5% of patients being admitted solely for CHF and 20% of patients having CHF as one of their diagnoses, Cook says.

Although the agency's hospital readmission rate for CHF was low, managers thought they could improve it through making sure nurses followed the standard of care and provided better documentation, Cook says. "We focused on improving documentation, and lowering the readmission rate was a positive side benefit."

As a result, the agency has a readmission rate below 5%, which is

one-fourth the readmission rate of a peer agency with whom Whidden benchmarks some data.

The performance improvement team developed a cause-and-effect diagram to use as a visual aid when discussing what problems needed to be tackled in order to improve the documentation. The diagram listed problems under the categories of materials, people, equipment, and methods. For example, a people problem is lack of communication, and a materials problem is the lack of a CHF teaching tool. **(See cause-and-effect diagram, inserted in this issue)**

"We divided the problems into different categories so we could get a better picture of what we were faced with and why we had incomplete documentation," Cook explains.

Also, team members wrote down the driving forces and restraining forces affecting a goal of improved documentation. They looked at the positive elements of the project and also the road blocks they might encounter along the way.

For example, the team determined these were the driving forces:

- **Increase patient education around the disease process to enable the patient to be independent in health care management.**
- **Prevent hospital readmissions for CHF.**
- **Decrease the number of visits required for CHF patients, while maintaining high-quality care.**
- **Ensure patient assessments are uniform, complete, and reflected in clinical documentation.**
- **Ensure communication occurs between clinician and physician regarding any status changes.**

And these were the restraining forces:

- **Lack of uniform teaching tool.**
- **High number of elderly patients with multiple health care issues.**
- **Elderly patients with cognitive issues preventing retention of taught information.**
- **Variation in staff's ability to document in PtCT computer system.**
- **Lack of caregiver to instruct and entrust in patient care.**

"The team had predicted the more important road blocks, but there are always some things you never think about until you actually do the project," Cook says.

2. Develop strategies to improve documentation.

The performance improvement team brainstormed and came up with a several strategies for fixing the problem, including:

- **Developed a CHF teaching booklet that nurses would use when teaching patients and their families about the disease.**
- **Created a CHF flowchart, which is an overview of the operational process of what occurs when a referral comes in for a patient with CHF.** The chart details how the referral is handled within the agency, step by step. At one point, the chart asks whether the CHF standard of care was adhered to. If the answer is no, then the chart directs managers to review the nurse's documentation and intervene as necessary. **(See CHF flowchart, inserted in this issue.)**
- **Designed a CHF standard of care chart that outlines the main actions needed in order to improve documentation.** Each action also includes arrows suggesting dates and a timeline for improvements to be made and concluded. **(See CHF standard of care chart, inserted in this issue.)**
- **Educated employees at staff meetings, at inservices, and on an individual basis about how to improve their documentation and care for CHF patients.**

"We lived by the premise that if it wasn't documented, you didn't do it," Cook says.

Booth of answers

The agency reinforced the use of the CHF pathway and set up a booth on CHF teaching at a staff competency day. Nurses visiting the booth had to explain how they use the CHF teaching booklet and recite the CHF standard of care and how it is delivered. The booth manager provided additional CHF education to anyone who had problems answering those questions at the competency booth.

3. Measure staff's documentation improvements.

The performance improvement team monitored nurses' progress in improving CHF documentation by checking off a group of indicators on a CHF monitor form. **(See CHF monitor chart, inserted in this issue.)**

The agency monitors charts involving patients admitted with a diagnosis of CHF. Some of the areas that managers review are whether nurses assess with each visit a patient's blood pressure, pulse, respiratory rate, edema, lung sounds, cough, and weight. Managers also check paperwork to make sure the nurse notified patients' physicians within four hours of having an abnormal finding, and see if the nurse has documented patient teaching in a variety of areas. ■

Save time, money! Ease nurses' paperwork burden!

Sounds too good to be true? Going paperless works!

Technology has gotten a bad rap this year. With everyone focused on year 2000 computer problems **(see story p. 104)**, many agencies might view making some systems improvements as a bad bet for now. But at Partners Home Care in Chicago, nurses have seen a drop in paperwork, managers have found chart reviews easier, and paper consumption is likely to drop — all as a result of a paperless chart program, says **Donna Escallier**, RN, director of continuous quality improvement and education at the 70-clinician agency.

The program started eight months ago, and has been a breeze to implement at the agency, which serves the Chicago metropolitan area and whose employees make some 80,000 visits per year. Escallier says the decision to move to electronic charting was pushed by her 50 nurses, who had been using laptop computers for two years. They objected to having to come in every other day to do paperwork. "And it was also a financial decision," she says. "We figured we could reduce paper and filing costs."

Last fall, Escallier and the vice president of clinical operations developed a program. Escallier was in charge of writing new policies **(see sample policy on electronic medical records, p. 96)**, and the vice president researched the legal implications. "She checked with [the Health Care Financing Administration], the state of Illinois, and our legal counsel to see what the requirements were."

Escallier penned policies that focused on data security and password policies. As soon as legal counsel approved the policies, they set a date for conversion of Nov. 1, 1999. "At the start date, we told everyone we would stop printing anything but 485s, verbal orders, physician orders, and paperwork that required patient signatures," says Escallier. "Before then, we had printed every piece of paper for the chart."

Staff were instructed on the new policies and told to change passwords. Prior to the conversion, the system administrator had a list of everyone's password. Now, only the nurse knows the passwords, thus preventing data from being altered.

Happily, Partners didn't have to add any hardware or software to make the project fly. "We use the Delta system, and when they made their upgrade to prevent note changes, that's when we knew we would have data security that would enable us to go to electronic medical records. We didn't have to spend anything." Indeed, the only cost was the staff time spent in the confidentiality and security seminar.

"And even that wasn't new information for everyone," she says. "We stressed the password security and went over signs that it might have been breached." Key among those signs: an unsuccessful log-in notation in the system at a time or on a day when the nurse or clinician wasn't working. The staff is encouraged to check the log-in attempt file regularly.

A positive experience

While the eight months of operation have probably saved on paper and filing costs, that data haven't been compiled yet, says Escallier. However, there is ample evidence that nurse satisfaction is much higher. "They are much more efficient and feel they aren't wasting time to come in and sign pieces of paper. We get information from them in a more timely manner, and they spend more time with patients." That means that existing patients get better quality time, Escallier adds, and that nurses have more time available to see new patients.

In addition, management finds it easier to do chart audits, which can be done electronically, and nurses, clinicians, and management all have immediate, up-to-date information on patients at their fingertips. Where they previously had two days to get notes in a patient file, says Escallier, now staff have to do it within 24 hours.

That immediate access has an indirect impact on patients, Escallier says. "I expect a note to be in right away, not in 48 hours," she says. "I think that means we can provide a better quality of care. But we haven't quantified that yet."

Further evidence that what Partners did came with a fraud and abuse survey and a visit from the Office of the Inspector General (OIG). In both instances, the system worked, was approved of and, in the case of the OIG, was remarked upon as being a great idea. A state survey is due later in the year, and Escallier thinks that will also go smoothly. "We will assign the surveyor a view function on a terminal, or print-off files — whatever they prefer."

The only real problem, Escallier says, has been that outside vendors who have contracts to do

(Continued on page 97)

Electronic Records Policy

Title: **CONVERSION TO ELECTRONIC RECORDS**
Information Systems, Effective Date: November 1998

POLICY

To assist in meeting our mission to provide high-quality home health products and services in a cost-effective manner, Partners Home Care will convert to an Electronic Medical Record System in November 1998. The following procedures will outline the conversion process as well as refer to the necessary policies, procedures, and agreements that are modified or added to meet the needs of an electronic medical record system. The procedure will also outline the ongoing process changes to meet the recommended government standards for electronic medical record keeping.

PROCEDURE

1. The agency will name a Health Information Security Officer (a.k.a. System Administrator), as well as a backup. When possible, the Health Information Security Officer will be the Director of Information Systems, and the backup will be another Information Systems associate familiar with the Clinical Link/Total Home Care systems. In the absence of the Health Information Security Officer, Security Officer access will be given to the back-up person.
2. The Health Information Security Officer's role is to ensure the integrity, reliability, accuracy, and security of information and data in the Clinical Link/Total Home Care system. This is accomplished by:
   a. Limiting system administration duties to the Health Information Security Officer.
   b. Limiting knowledge of the root password to Health Information Security Officer and backup.
   c. Changing root password periodically, after access by Delta for maintenance operations or after any critical event:
      (1) Suspected breach of security
      (2) Employee with root password knowledge terminates employment
   d. Establishing access security controls by job descriptions and assure they are implemented to reasonably protect information.
   e. Authorize and implement changes in access only by written request. The request includes information regarding who is generating the request, the access to be increased or denied, the reason, the effective date and the termination date of modified access if there is one, approval or denial notation by the security officer. These will be kept on file for reference.
   f. Implement appropriate security measures over software and hardware to reasonably ensure the protection and integrity of information.
   g. Periodically reviewing and/or revising the Information Systems policies and procedures to ensure adequate data protection.
   h. Identify, establish protocols, and obtain licensure for any software deemed necessary for agency functioning that will not compromise data integrity by establishment of change requests and testing procedures for all changes in hardware, software network.
3. A new COMPUTER AND INFORMATION USAGE AGREEMENT will be explained to all current associates having any access to the Clinical Link/Total Home Care system, their understanding verified, and signature obtained.
   a. 100% compliance will be accomplished prior to the implementation of electronic medical records.
   b. This agreement will become part of the orientation of new employees after that time. Access to data systems will not be allowed until this agreement has been reviewed and signed by the new employee having any access to the Clinical Link/Total Home Care system.
   c. Any employee who, by virtue of change in job description, gains access to the Clinical Link/Total Home Care system, will be trained regarding this agreement and signature obtained.
   d. This agreement will then be reviewed and signed annually by all associates having access to the Clinical Link/Total Home Care systems.
4. On the date chosen for implementation of the electronic medical record system, all active paper-based charts will have a notation made in them that as of that date, further documentation is contained only in the electronic medical record, with the exception of the following:
   a. Documentation requiring the patient's signature (i.e. Bill of Rights, Consent for Treatment, other written consents that may be needed).
   b. Documentation requiring the physician's and/or nurse's signature (i.e. 485s, verbal orders).
   c. Documentation from physical therapists, occupational therapists, and speech therapists whose services are contracted through vendor services (i.e. evaluations, progress notes, discharge summaries).
   d. Documentation from third-party payers.
   e. Documentation received from outside sources such as transfer forms, lab reports.
5. All paper documentation from any admission occurring on and after the electronic medical record implementation date will be kept in a modified chart system such as those currently used for discharged charts.
6. If there is a request for copies of the medical record as per agency policy, the Health Information Specialist or other designated person will print the requested documentation. At that point, the printed documentation will need to be signed by the person who entered the data, and any reviewer if so indicated on the documentation, and described in the Computer and Information Usage Agreement.
7. All policies addressing documentation and medical records will be reviewed, and when necessary, a second policy will be drafted reflecting the procedure in an electronic medical record system. These policies can be modified to include, but may not be limited to:
   a. Confidentiality
   b. Personnel Record Entry/Review
   c. Information Systems: Content Medical Record
   d. Information Systems: Clinical Records Confidentiality
   e. Information Systems: Individual Record
   f. Information Systems: Record Format
   g. Information Systems: Accessibility and Storage
   h. Information Systems: Authorized Personnel Record Entry/Review
   i. Information Systems: Release of Information: Request for Correction/Amendment to Health Information
   j. Information Systems: Release of Information: Revocation of Authorization for Disclosure of Health Information
   k. Information Systems: Release of Records
   l. Review of Discharge Records
   m. Billing audit
   n. Any and all Clinical Policies and Procedures related to Documentation in the Medical Record.
8. On an ongoing basis, the Quality Improvement/Information Systems departments will move forward on addressing the recommendations from the federal government on further design of the electronic medical record as contained in the document *Draft of Electronic Signaturing and Security Policy of Patient Electronic Health Record* of Sept. 4, 1998. This will include new measures needed, as well as integration of current policies and procedures so there is one cohesive document on Partners Home Care electronic medical records.

Source: Partners Home Care, Chicago.

SOURCE

- **Donna Escallier**, RN, Director, Continuous Quality Improvement/Education, Partners Home Care, 2835 N. Sheffield Ave., Suite 401, Chicago, IL 60657. Telephone: (773) 549-5822.

some of the therapy are not yet up on the system. "Our original plan was to set up remote sites at their offices and have them enter the data directly. But there has been trouble getting phone lines and terminals for them." Originally scheduled for April, that aspect of the electronic medical records program won't now be up and running until sometime this fall.

Escallier is a true technology convert and doesn't see any reason why an agency would try this. "It's a great idea," she says. "Most people I talk to fear the federal agency audits will turn up problems. But ours went well. And the nurses are so much happier. They wanted this faster than we could implement it. They see more patients and don't feel that time crunch. And everyone likes doing less paperwork." ■

Quick project improves patient satisfaction

Does your agency need a booster shot to improve customer satisfaction? If so, you might want to try the quick hit quality improvement project that helped Malden Visiting Nurse Association of Malden, MA, raise its patient satisfaction scores.

After implementing the project, the agency's overall patient satisfaction performance rose from 85.81% in March 1998 to 91.25% the first quarter of 1999, and then the second quarter 1999 results were 94.51%.

When the agency first received its 85.81% score, managers knew they had a problem, says **Marjorie Cook**, RN, MBA, CNAA, director of performance improvement for Hallmark Health Home Care in Malden. The Malden VNA is a part of Hallmark Health. "We were below the national database average of 91% and we knew that if we couldn't improve customer service, we would have a problem," Cook says. "That's the cornerstone of any business."

Here's how the agency improved customer satisfaction:

1. The performance improvement team set up an action plan.

The team first set a benchmark goal of reaching 93% overall satisfaction and compared the agency's survey results to the top 10% of agencies that used the same survey, called the Fazzi Patient Satisfaction Survey. The team developed an action plan, which included:

- **Beginning in August 1998, an office employee would call 50% of the new admissions within one week of the start of care.** The employee followed a phone survey tool to assess patient satisfaction and identify any problems. The entire call takes about five minutes.
- **Patients who make unsatisfactory comments are referred to the performance improvement department, and an adverse incident form is completed by the person who did the survey.** The performance improvement department contacts these clients to resolve their problems.

"The call is to reach out to clients to let them know we're here and if there are any problems, we're here to listen," Cook says. "That's the whole purpose of the call."

2. The team modified the plan to further improve the satisfaction level.

After the performance team reviewed the September 1998 results, the team made some changes to the process, including:

- **The team changed the telephone satisfaction survey to clarify two of the questions, including the question about patients' rights and responsibilities, and the question relating to home safety.**
- **The team asked the surveyor to probe clients for the names and disciplines of providers with whom the patient has a complaint so that the agency can provide better follow-up to the problem.**

Then, in early 1999, the agency passed the national average of 91% overall patient satisfaction. And then in the second quarter of 1999, the agency surpassed its 93% goal with a 94.51% satisfaction rate.

On March 25, 1999, the team decided to have the surveyor call 70% of newly admitted patients with the goal of raising the patient satisfaction level an extra 2% to the 93% goal. The agency will continue to monitor patient satisfaction until the 93% overall satisfaction rate is maintained for three consecutive quarters.

The phone calls, although a simple QI measure, have really done the trick, Cook says. "It's so unusual to get a call like that from a provider,

SOURCE

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that patients feel better about Malden VNA than they do about the home care agencies that don't call them." ■

Pain care, documentation are improved by training

Make sure nurses understand all pain definitions

Home care agencies and accreditation organizations are increasingly focusing on the pain management of home care patients. And at the same time, more surgery patients, who are experiencing pain, are being sent into home care after increasingly shorter hospital stays. It may be time to take a look at pain management as a separate performance improvement (PI) project.

Providence Home Health Care in Novi, MI, selected pain management as one of the two areas to focus on in the past year. The hospital-based agency, which serves southeastern Michigan, is one of the 50 agencies that for the past three years had been using the Outcome and Assessment Information Set (OASIS) tool as part of the national demonstration project.

Agency's peers' outcomes were better

The agency had slightly worse outcomes for pain management than had other agencies involved in the demonstration project, and the agency's outcomes for pain management had fallen from the previous year, says **Barbara Harlow**, RN, acting director.

About 65% of Providence Home Health Care's patients showed an improvement in pain, compared with about 68% nationally. During the previous year, 71.3% had improved. The results of the agency's yearlong project won't be known until its 1999 OASIS report is released later this summer.

The national data was risk-adjusted, so the comparison was fair. However, the performance improvement team soon learned that the decrease from the previous year was mostly due to a big change in the agency's patient population. "We doubled the number of our short-term patients from a mastectomy program in which patients went to outpatient surgery and then we provided home care service for them," Harlow says.

The number of mastectomy surgery patients increased from 57 to 95. "We found that those patients didn't score as well on pain control, and the reason was that it's hard to measure an improvement in pain when you only see a patient for one or two visits," Harlow explains.

Still, the agency wanted to improve its pain management and documentation, so this is how the performance improvement program worked:

1. The PI team reviewed charts.

The team pulled charts of all patients who had poor pain management results according to the OASIS report.

Then the team developed a chart audit tool to use in identifying trends and problems with pain management and its documentation. The tool, which was revised several times, has 12 questions relating to OASIS and pain assessment. **(See pain control audit tool, p. 99.)**

2. The team identified trends and problems.

Using the tool, the team found some common and recurring problems.

"That's how we found that a lot of the cases were mastectomy patients who had very short home care stays," Harlow says.

There also were other cancer patients whose pain did not improve, and another group included those who had a total joint replacement diagnosis.

Team members also found that most of the patients who had a longer length of stay showed improvement in the intensity of their pain. But they continued to score their pain as "daily, but not constantly" on discharge.

The PI team decided there was very little the agency could do to improve pain for surgical patients whom the staff visited once or twice.

But there was another problem that could be addressed. The agency's nurses and therapists were using two different pain measurement scales, which led to inconsistency in the scoring and pain assessment.

Also, nurses were interpreting pain control methods inconsistently. For example, one OASIS question reads: "Intractable pain: Is patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical and emotional energy, concentration, personal relationships, emotions, or the ability

Pain Control Chart Audit Tool

Patient ID Number: _____

Primary Diag (MO230):_____

Location of pain: _____ Cause: _____

		Comments
1. SOC OASIS and DC OASIS done by same person? Indicate what discipline did SOC and DC:	Yes No	SOC = DC =
2. Intractable Pain (MO220) pg. 2	❑ prior pain?	
3. Prognosis (MO260) pg. 3	0 = poor 1 = good/fair uk= unknown	
4. Rehab Prognosis (MO270) pg. 4	0 = guarded 1 = good uk= unknown	
5. Life Expectancy (MO280) pg. 4	0 = >6 months 1 = <6 months	
6. Risk Factors (MO290) pg. 4	Positive for: ❑ 1 smoking ❑ 3 ETOH ❑ 4 drugs	
7. Does patient have assisting persons? (MO350) pg. 5	1 = persons outside home 2 = persons in home 3 = paid help 4 = none of the above	
8. Intractable Pain (MO430) pg. 8	0 = no 1 = yes	
9. Frequency of Pain (MO420) on SOC pg. 8	0 = none or doesn't interfere 1 = less often than daily 2 = daily, but not constantly 3 = all the time	
10 Anxiety Level (MO580) pg. 14	0 = none 1 = less than daily 2 = daily, but not constantly 3 = all the time 4 = patient unresponsive	
11. Management of Oral Meds (MO780) pg. 18	0 = independent 1 = assistance required 2 = unable 3 = no meds	
12. Does the patient have pain meds? (med sheet)	❑ yes ❑ no	

Source: Providence Home Health Care, Novi, MI.

or the desire to perform physical activity?" The question must be answered either "yes" or "no."

But the problem is some cases fell into a gray area. If a nurse had a patient who was on a morphine drip and didn't have pain while on morphine, did that qualify as intractable pain that is not easily relieved? The team called the Denver-based Center for Health Services and Policy Research to find out the correct answer, and learned that if the pain was relieved by the morphine, then it did not count as intractable pain.

And team members decided the entire staff needed to learn a more consistent approach to pain control instruction and documentation.

3. Team members developed and implemented strategies to improve pain management.

The team selected a list of best practices to follow from current medical literature on pain management, and members developed pain control guidelines. **(See pain control guidelines, p. 100.)**

One of the first changes involved having the entire staff use one pain assessment scale that described pain from zero, meaning there was no pain, to 10, meaning the pain was the absolute worst. The agency's therapists have already been using a zero to 10 scale, but the nurses had to be taught the new scale.

Then the team developed a pain control tracking tool, using ideas from other research material. The tool is a one-page sheet that staff can hand to patients. On the tool, patients will see a drawing of a thermometer that's divided into 10 sections. Each section pertains to a number, and the chart gives word descriptions of five different pain measures, as follows:

- **2 = mild pain;**
- **4 = moderate pain;**
- **6 = severe pain;**
- **8 = very severe pain;**
- **10 = pain as bad as it could be.**

Nurses or therapists show the tool to patients and have them point to where their pain would be on the thermometer scale. Then the staff member fills out a chart to the right of the thermometer diagram and records the date and time, the pain score before medication, medication and dose taken, and pain score after 30 to 60 minutes.

The chart also has room for pain control orders

Clip this box on controlling pain

Providence Home Health Care in Novi, MI, developed these pain control guidelines for patients:

1. Don't wait for pain to become severe before taking pain medications.

2. Refill pain control prescriptions when you have at least three days of pain medication left.

3. Talk to physician about any side effects you may be having.

4. Most pain medications cause constipation. Take a stool softener or ask your doctor about an appropriate bowel program.

5. For surgical patients, try splinting the surgical site with a pillow before coughing.

6. Relaxation exercises:

• Breathe in slowly and deeply.

• As you breathe out slowly, feel yourself beginning to relax; feel the tension leave your body.

• Now breathe in and out slowly and regularly, at whatever rate is comfortable for you. You may wish to try abdominal breathing.

• To help you focus on your breathing and to breathe slowly and rhythmically: breathe in as you say silently to yourself, "in, two, three." Each time you breathe out, say silently to yourself a word, such as "peace" or "relax."

• You may imagine that you are doing this in a place you have found very calming and relaxing, such as lying in the sun at the beach.

• Do the first four steps only once or repeat the third and fourth steps for up to 20 minutes.

• End with a slow deep breath. As you breathe out, say to yourself, "I feel relaxed and comfortable." ■

and the patient's name.

"A lot of patients like the tool because it's something concrete they can look at," Harlow says. "And it gives everyone a more consistent idea of where the patient's pain level is."

The, the team changed the agency's critical pathways for pain control to include these suggestions:

• **Over-the-counter medications to titrate down to when able;**

• **Recommendation to call physician if pain level is four or greater after medication use;**

• **Relaxation and breathing exercises, and imagery used;**

• **Bowel regime with use of pain medications explained.**

The team decided that only physical therapists should teach total joint patients about the timing of pain medications in relation to their exercise.

4. Staff members attended inservices and received more training.

Then the team implemented a major part of the pain management change by beginning new staff instruction on assessing, documenting, and managing pain. The inservices covered the agency's lower-than-desired scores on pain management, why the PI team wanted the staff to focus on improving these, and the team's plan to make these improvements.

"We have field staff members on the PI team, and we had the staff's peers present the plan to them," Harlow says. "We try to have staff members — not management — do the presenting because it comes across a lot better from their peers."

It's all relative

The inservices included general documentation guidance, showing staff how important it is that everyone interprets different OASIS questions the same way.

For example, instructors explained how different nurses were interpreting the OASIS question on intractable pain in different ways, and this would lead to inaccurate outcomes data. Besides the confusion over morphine drips, some nurses thought that a patient was experiencing intractable pain if the patient had to wake up in the middle of the night to take pain medication. But again the correct answer was that this does not signify intractable pain unless the medication gives the patient no relief from the pain.

"We told the staff that no matter what their personal opinion of what intractable pain is, this is the correct answer for this documentation, and they could add other details about the patient's pain to other parts of the form," Harlow says.

Then the team had an oncology nurse teach the staff how to help patients control cancer pain.

Finally, staff members held special inservices on how to help a patient alleviate pain through alternative methods, such as relaxation and visualization techniques and holistic medicine.

One employee even developed a relaxation tape that nurses could give to patients to help them cope with their pain. ■

Try this QI refresher on advance directives

Improve documentation, patient education

Your nurses probably have often heard this refrain from patients: "Yes, I've got an advance directive, but I don't know where it is."

That leaves your agency stuck in a documentation maze. You have to prove to state regulatory or accreditation officials that you have spoken with the patient about advance directives, and then you might have to obtain a copy for the patient's chart. For example, the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations requires all appropriate home care staff become aware of a patient's preferences and the patient's intent with regard to an advance directive.

But when you track down the doctor, the hospital, or the son whom the patient says might have the form, you discover that the patient was confusing the advance directive form with their estate will or even a "do not resuscitate" order.

At least that's the problem that faced Citrus Memorial Home Health Agency in Inverness, FL.

"We had problems getting copies on the chart because usually the patient had no clue where the advance directives were, and they don't have copiers at home and don't want to let go of their personal documents," says **Lisa Place**, RN, BSN, quality improvement supervisor for the hospital-based agency.

Florida requires home care agencies to document that patients were told about advance directives, and mandates that copies of these be put in the patient's charts. However, the home care agency found through a chart review that many case files were missing the advance directive forms, says **Janice Powers**, RN, BSN, director. The agency tackled the problem, finally achieving 100% compliance with the advance directive requirement, by initiating these quality improvements:

• **The quality staff conducted a chart audit on all patients to see how many advance directives had documentation and were included in the chart**, asking such questions as: "If a patient showed an interest in advance directives, was it clearly documented that the nurse answered the patient's questions?"

• **Then, the agency revised the advance directive documentation form to make it easier for nurses to use.** Now it's a one-page check-off form with two simple sections. One section lists the forms a patient has and the other section lists the forms the patient does not have and whether or not they want a particular form.

Also, managers put yellow sticky notes on any papers in the admission packet that need to be followed up on.

• **Then, managers educated the staff about advance directives and how correctly documenting these are necessary.** They found that employees were unsure what these forms meant, so they taught them the correct definition. For instance, an advance directive form may include a living wills, a durable power of attorney form, and/or a health care surrogate form. The education took place in staff meetings.

• **Quality staff conducted two more chart reviews and found the changes had resulted in improved documentation.** Within a year, the agency reached its goal of achieving a 100% compliance with advance directives regulations.

"We are very compliant now because of the process where we're reviewing everyone," Powers says. ■

SOURCES

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Resource sharing could be a dream come true

Nurses, clinicians work where, when needed

In an era when continuous cost cutting is as prevalent as continuous quality improvement, finding ways to save on personnel expenses while expanding services may seem like a dream come true. But two projects are getting under way which, in time, may prove that it could become a reality.

Gary Cripps, PhD, administrator of Home Health Concepts in Smithville, TN, has started working on plans to open an outpatient physical therapy center. While that expansion of business

will give him a line to an entirely new group of patients, one of the real benefits to his seven-nurse home care agency will be the ability of staff to move between the two parts of the business as needed. And if there is a particularly slow time, Cripps hopes to be able to use underutilized clinicians to contract with other small agencies. "I'll hire them full time, but part of their salary will be paid for by contracting organizations."

Creating your business

In addition, some of the PT skills that the center will have — such as massage therapy — can then be offered to home care patients, he says. "You have to have the space, the personnel with the right skills, and a stable referral base," says Cripps. "If you have all that, you have the makings of a business."

Carl Rowe, PharmD, managing member of Integrated Care Communities Marino Valley, CA, is also starting a project that could prove staff sharing will work. Ground was just broken on a facility in nearby Riverside that will include a hospital, a long-term care facility, an assisted living complex, physicians offices, and a home care agency — among other things. Rowe believes the whole concept of providing a continuum of care for the growing tidal wave of elderly people will force the health care industry to look for new ways to provide that care.

In the public/private partnership on which he is working, one of the main goals is to deal with the problem of fluctuating staff needs at various health care facilities. "Organizations that are going to survive are going to have to focus on efficiency and increasing market share," says Rowe. "They will have to increase their sphere of influence." One way to achieve that goal is form alliances and create partnerships that provide for their patients and their payers with a complete continuum of care.

By partnering with various rungs on the health care ladder, Rowe adds, they can move both patients and staff seamlessly from one level to the next. If the patient census at the hospital is low, perhaps an outpatient rehabilitation facility needs a therapist, or a home care agency needs some nurses. Rowe is also toying with the idea that nurses can follow patients from one part of the continuum to the next — caring for the patient in the hospital, following to the rehab facility, and then into the home.

He recommends that agencies interested in forging the kind of partnerships that will allow resource sharing talk to government and volunteer agencies in your market. The local Office on Aging will have information on what kinds of services are needed and what parts of the post-hospital market are underutilized.

Cripps cautions that in large markets, you may have more access to the kinds of resources that will allow a sweeping program like that which Rowe is developing. In smaller markets, you might have to curtail your vision a bit.

You should also speak with your nurses, therapists, and aides to see how they feel about resource sharing. Rowe says he would be surprised if they weren't excited by the idea, but don't leave them out of the discussions.

"There is a window of opportunity before the baby boomers swell the ranks of the chronic geriatric population," says Rowe. "If you have underutilized resources and see a need for vertical integration, if you need more revenue, then this is a practical approach to reaching those goals."

Cripps agrees. "The future of health care is in providing the entire spectrum of services and cross staffing personnel to shift overhead to where the work is," he says. "In home care, we have to find ways to increase our patient load, diversify our services, and control our costs. This is one way to do it." ■

SOURCES

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- **Carl Rowe**, PharmD, Managing Member, Integrated Care Communities, 11751 Davis St., Marino Valley, CA 92557. Telephone: (909) 243-5129.

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NEWS BRIEFS

On again, off again, on again OASIS is back on track

For all those agencies that were holding off on collecting OASIS data while the Health Care Financing Administration (HCFA) worked on some privacy issues, it's time to start collecting, encoding, and transmitting that data again.

The June 18 *Federal Register* states that Medicare/Medicaid recipients of skilled nursing care had to begin providing OASIS data beginning July 19. That data was to be immediately encoded and transmitted not later than Aug. 24. Non-Medicare/Medicaid patients getting skilled care will have to provide the data now, but encoding and transmission for them won't happen until next spring. Those patients getting personal care services won't only start participating until next spring, and those receiving chore services, pre- or post-partum care, and patients under 18 years of age are excluded from participation.

The relevant *Federal Register* document, on pp. 32,989-32,991, is titled "Medicare and Medicaid Programs, Mandatory Use, Collection, Encoding and Transmission of OASIS." You can get further information by looking at HCFA's OASIS Web site, **www.hcfa.gov/medicare/hsqb/oasis/hhregs.htm**. ▼

JCAHO simplifies ORYX rules for agencies that are small

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has given home care organizations with an average annual census of fewer than 120 patients an easier set of ORYX requirements. The new rules state that the agencies no longer have to select measures

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

Subscriber Information

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

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exclusively from Joint Commission templates. Rather, they may select measures from any relevant source, including literature, performance measurement systems, or internally developed measures.

The move is in response to comments from organizations that the measure templates artificially limited their ability to choose meaningful performance measures. The simplified requirements will enhance organizations' abilities to choose measures that are most relevant to their patient populations and strategic measurement objectives.

Under the simplified requirements, small organizations can choose their measures and report them to the Joint Commission by the end of this year. A form will be mailed to all eligible organizations. For more information, contact the ORYX Information Line at (630) 792-5085, or e-mail: oryx@jcaho.org. ▼

FDA issues Y2K problem list

Recent surveys of health care organizations indicate that most think they will be ready for any potential problems related to the year 2000 (Y2K) computer bug. But according to the Food and Drug Administration (FDA), some biomedical equipment you may have may not work — or may not work correctly — come Jan. 1.

To help the medical community deal with the problem, the FDA has developed a list of types of computer-controlled, potentially high-risk medical devices that have the potential for the most serious consequences for the patient should they fail because of date-related problems.

The list **(see Classified Devices, inserted in this issue)** is very comprehensive, and the FDA notes that inclusion on the list doesn't mean that the device has a problem, or if they are not Y2K non-compliant, that they might pose a risk to patients. For most home care agencies, the infusion and IV therapy equipment will be of the most concern. The FDA plans to use the list to audit manufacture claims of compliance and later issue a list of non-compliant devices.

The equipment in this list includes items that are used in the direct treatment of a patient where device failure could compromise the treatment or could injure the patient; are used in the monitoring of vital patient parameters and whose data are immediately necessary for effective treatment; or is necessary to support or sustain life during treatment or patient care.

That information can be found at the FDA Web site, **www.fda.gov/cdrh/yr2000/classification.html**. For those devices cleared for market through the Premarket Approval application process or which have not yet been classified, no classification regulation number is given.

The Web site also includes links to the Federal Y2K Biomedical Equipment Clearinghouse Search — **www.fda.gov/scripts/cdrh/year2000/y2k_search.cfm** — to determine the compliance status of medical devices, as reported by the manufacturers. An additional link is provided to the Manufacturer Registration Database — **www.fda.gov/scripts/cdrh/cfdocs/cfrl/registra/search.cfm** — which contains names and addresses of manufacturers who have registered with the FDA. ■

CE objectives

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

1. Explain the difference between restraining and driving forces.
2. List forms that are included in the term "advance directives."
3. Understand the definition of "intractable pain," according to the OASIS tool. ■