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New world of data collection revolves around patient count

It's no longer all about visit numbers

Home health agencies traditionally made it a priority to collect data on the number of visits made per month, quarter, and year. The results drove hiring, services expansion, and other growth decisions.

But it's a whole different data collection world now. The number of visits is far less important under the interim payment system (IPS) and the prospective payment system (PPS) than is the patient count. This means quality managers should brush up their data collection and decision-making processes if they are still mired in the old philosophy of counting visits.

"We paid little attention to the patient number in past years, and now that's the critical number," says **Celeste Roberson**, BSN, MPH, senior partner with Roberson, Muck & Associates in Wilmington, NC. Roberson has spoken at home care conferences about how to make data collection more efficient.

"We used to have agencies say, 'We have 40% growth now,' and it wasn't new patients causing the growth. It was more visits for every patient," she adds.

Since IPS put pressure on home care agencies to reduce the number of visits per patient, then all new growth is related to increasing the number of new patients. While most home care directors and quality managers understand this shift in focus, they may not have made all the data collection changes that will support the philosophical change. And this is where Roberson has some advice.

Suppose you want to increase your patient count by courting referral sources. Traditionally, that might mean basing a marketing campaign on reaching new potential referral sources and reminding current sources that your services are available. But under IPS, is this really the best and most efficient way to increase your patient count?

Before you answer, "Yes," consider this scenario: Doctors A and B habitually refer patients to you with chronic illnesses requiring long lengths of stay (LOS). However, Doctors C and D refer patients to you who can be treated and released within eight weeks. Under IPS, you

might desire to encourage Doctors C and D, and not spend as much time courting Doctors A and B, whose patients probably cost you more money than they bring in.

But you wouldn't even know this unless you have revamped your data collection system to include this type of information.

"We have all kinds of data coming out of our information systems, but have very little data that is analyzed or summarized for management," Roberson explains, "and that's where people are hampered. They can't develop programs to make for good management accounting."

Know what you seek

Here's a quick guide to solving this problem:

1. Define your data use.

You need to know what you're looking for and choose computer selection fields that reflect that.

This is trickier than it sounds. For instance, the selection field for LOS could mean different things, depending on your data collection system. In some systems, this means patient count. In others, this is based on the number of discharged patients in a particular period.

Here are some questions to find answers to before using a particular data relating to patient count:

- **Do you measure the number of patients receiving services in a particular period, or do you measure the number of patients discharged?**
- **How long of a period do you want to measure, and will your system measure for that length of time?**

"A lot of times providers never question a report if it says what it is," Roberson says. "But you should check a few, and if you want data for three months year-to-date, and the report says 120 days, which is longer than three months, then it's not giving you the information you want."

2. Get the bugs out.

One common mistake is an agency will include non-patients in patient count data. For whatever reasons, a patient who has received no visits during that year is continuing to pop up in the computer file that relates to unduplicated patient counts.

"You should take a look to see if there are any patients on the data sheet who have zeros across the visit column," Roberson advises.

Also, quality managers should be skeptical of any patients who are listed with only one nursing visit. If an agency has a significant number of these one-visit patients, it could skew the agency's LOS figures. "I encourage people to not spend hours, but to take a quick look and get a colored pen and highlight these patients," Roberson says.

3. Ask your computer vendor to help with data collection problems.

"People often buy a big computer package and don't feel they can approach the vendor for help," Roberson notes.

However, computer vendors usually want to improve and update their software packages, and they need input from consumers in order to do so. "It's not the vendor's intention to print data that you don't need," Roberson says. "Vendors can do patches and corrections on reports."

Approach the vendor in a non-antagonistic manner, she advises. Simply state how you are using the reports and what you need to have corrected.

4. Limit LOS data to a fiscal year of 365 days.

There are two ways to determine a patient's length of stay. One way is to count the number of full days for each patient, by taking the patient's start of care date and subtract it from the discharge date.

Or, to obtain a more accurate figure for a particular fiscal year, take that same figure and limit it to 365 days of the fiscal year. So, if a patient is admitted on Dec. 1, 1998, but is not discharged until Feb. 1, 2000, then the total number of days would exclude any days between December 1998 and January 2000.

The easiest way to adjust your data collection to reflect the number of actual days a patient is served within a particular year is to create a start of care date of Jan. 1 for all patients carried over from the previous year, and create a discharge date of Dec. 31 for all patients who will continue to receive services in the next year.

It is important to know a patient's annual LOS because this is the number used in calculating an agency's average LOS under IPS. However, quality managers may want to run reports on patients' total LOS as well, because this information more clearly tells them how many visits the agency is taking for patients of different diagnoses.

One of the more common and least useful LOS data fields is when a computer program divides LOS into categories of 30 to 60 days and 61 to 90 days, etc., Roberson says.

"It looks like an accounts receivable report, but you look at that and say, 'Who knows what it means?' and you don't know what your average is."

5. Learn your unduplicated patient count.

"The unduplicated patient count is more important than it's ever been," Roberson says. "You need it to gauge new patient growth and to see if that growth is coming from the referral sources you want, and to compare it with related cost data."

For example, suppose a quality manager wants to collect numbers for stroke patients. First, the manager will need an unduplicated patient count of people who are stroke patients, and then the manager will divide this number into the total cost of stroke patients for that period of time. If the cost per case turns out to be $5,000, it will give managers an important piece of information.

They can decide perhaps that a $5,000 per-case cost for stroke patients is reasonable. But if the data showed that the agency's cost per congestive heart failure (CHF) case was also $5,000, administrators might decide the cost for a CHF diagnosis is excessive, and a quality improvement project should be started in that area.

By knowing an agency's unduplicated patient count, quality managers can better decide which projects to tackle next. "Look at practice patterns. Look at what the numbers tell you, including what kind of LOS the agency has and what kind of patient mix," Roberson says. ■

Tracking wound care can lead to better outcomes

Strive to keep LOS under 60 days

A hospital-based Kansas home care agency discovered an interesting trend among its wound care patients after tracking their progress and outcomes in the past year. Most of the patients either were successfully treated within 60 days or their wounds took more than 150 days to heal.

"That tells you that I can either get you healed within one Medicare period of 60 days or you're going to be with us for a long time," says **Martha McCabe**, administrator of the home health department of Susan B. Allen Memorial Hospital in El Dorado, KS.

That piece of information, which the agency learned through consistent data collection on wound care patients, helped McCabe and other managers decide where to focus.

The information also confirmed the agency's success in treating wounds. Of the 48 new wound cases the agency began in 1998, 32 cases were discharged by the end of the year because the wounds had healed. Another six were discharged before the wounds had healed because the patients desired to be discharged or the patients were no longer homebound. The remaining 10 cases that continued to receive wound care treatment in 1999 involved people who had a chronic wound history because of diabetes, multiple sclerosis, or other illnesses. Still, in nine of these cases, the patients were healed and discharged by June 1, 1999, McCabe says.

"The one we have remaining is a multiple sclerosis, bedbound patient who has recurring skin breakdown," she adds.

Develop new protocols

The wound care data have reinforced how important it is for the agency to aggressively promote faster healing and lower the patient's length of stay through the use of new technology, more persistent patient/caregiver teaching, and better staff training, McCabe explains.

"Our philosophy and goals remain that if a patient needs a service and the doctor orders the service, we'll continue to provide the service regardless of the cuts in reimbursement," she adds. "But we're more aggressive and we'll use products that have quicker outcomes; and if there are caregivers in the home, we'll try to teach them how to do a clean dressing change."

Here are brief descriptions of some of the changes the agency has made to improve its wound care patients' outcomes and to lower their length of stay:

- **Develop new protocols.** All registered nurses and managers met at an annual planning meeting to brainstorm about ways to improve the agency. "We have big boards where we list all the great things we did this year and all the things we need to improve," McCabe says.

  While there, the staff decided to focus on wound care and develop new wound care protocols.

  Later, McCabe revised the protocols and presented them for suggestions and approval at a staff meeting. The staff looked at the new protocols and then discussed, debated, and revised them. The final product had to be approved by the entire staff. **(See new wound care protocols, p. 109.)**

- **Educate nurses and aides about wound care.** The agency sent all nurses and a physical therapist to three days of intensive wound care workshops in 1998.

Also, the agency holds a wound care inservice each year for the entire staff. Typically this gives the staff an update about new wound care treatment and is a free service provided by a pharmaceutical company representative.

Plan weekly meetings

Since the agency's new protocols call for aides to make more clean dressing changes than they had been expected to do before, the agency also started holding inservices for home health aides on wound care. The aide inservices included information on clean dressing changes, how to recognize infections, and basic infection control.

• **Improve team communication.** At the annual planning meeting, the staff decided that better team communication was necessary. The agency added two 15-minute meetings to the weekly schedule. One is 8 a.m. on Mondays to discuss what happened with patients over the weekend, and the second is 8 a.m. on Fridays to discuss what patients are being admitted and discharged over the weekend.

"They meet in my office and discuss new patients and patients who are being discharged, and this helps the nurses who are on-call for that weekend," McCabe explains. "We have found that communication with those two little short meetings has saved more confusion than ever before."

The agency also holds team meetings on wound care patients at a minimum of every two weeks, although these sometimes can be held once a week. The team reviews the patient's progress in healing and discusses any treatment changes that might be necessary.

• **Use new medicines and treatments.** Patients are treated with collagen-alginates. And some physicians have begun to order Regranex, which is a topical cream treatment for leg and foot ulcers. It works well for diabetics, McCabe says.

Nurses document wound care patients' progress, even using photographs to show before, during, and after pictures. When a wound appears to be healing too slowly with one medication, they will call the patient's physician and recommend a change.

"We use different products, and if something is not working, we'll make a change," McCabe says.

The agency also has had some bedbound patients try some of the newer types of mattresses to reduce skin breakdown.

• **Improve patient/caregiver education.** Caregiver and patient education continues to be a major area of focus in wound care, McCabe notes.

"Probably the best thing we've done for wound care patients is to be more aggressive with them in teaching them how to deal with their condition," she explains.

Nurses teach patients upon admission about the homebound rules governing Medicare home care patients. "We're even more up front than we used to be," McCabe says. "We put an explanation in the admission packet about homebound status, and we tell them, 'If you drive just once, we'll discharge you. If you go out of your house more than once or twice a week, you're discharged.'"

Nurses further explain that to receive home care services, a patient has to have an inability to leave his or her home.

They also tell patients that the agency's goal is to help patients become independent again, and preferably to help them recover and begin moving around and enjoying life within four to six weeks, depending on their health problems.

Basic patient wound care education also includes information about infection control and handwashing. Although that may seem basic information, McCabe says, nurses have often discovered that patients don't understand how important it is to prevent infections by washing their hands. The introductory packet also includes educational material about handwashing.

"We go over that with wound care patients on every visit," she states.

Finally, whenever possible, nurses teach caregivers how to care for a patient's wound. Previously, nurses would change all dressings, but under the prospective payment system, this is too costly a policy to continue.

"If there are caregivers in the home, we try to teach a willing caregiver how to do a clean dressing change," she says. "If it's a sterile dressing change, then the nurse still has to go in daily to do that."

For example, the agency recently had two patients whose wounds stemmed from recent surgeries. Both patients had caregivers who were willing to be taught how to change their dressings.

On the nurse's first visit, she taught them how to change the dressings. She also taught them the signs and symptoms of infection, handwashing for infection control, and how to contact the nurse in case of an emergency.

Then, the nurse continued to see the patients twice a week, monitoring the surgical sites, infection risk, and making sure the caregivers were properly making the dressing changes. Because

of the caregivers' assistance, the agency's cost in caring for these patients is much less expensive, and the patients probably will be discharged within four weeks, McCabe says.

"We're trying to empower people to take charge of their situation, and we're very clear with our patients that home care is a part-time, intermittent program," she adds.

• **Allocate staff time more prudently.** When a patient has no willing caregiver to assist with dressing changes, the agency will provide the service. However, the agency decided last year that it was too costly to continue having registered nurses provide simple dressing changes, so aides now provide the service.

"The RN makes weekly visits to document, assess the wound, and make sure the standard of care is being carried out," McCabe says. "But we've found that a lot of the wounds have gotten to the point where they're using a clean dressing or gauze dressing, and the aide can do this at a much lower cost than the RN."

The agency also made it a standard practice to automatically make a dietary referral when a patient has an open wound. This helps to improve outcomes and expedite healing since elderly wound care patients often have not been receiving adequate nutrition for healing. ■

New wound care rules prompted by troubles

All staff signed off on new protocols

When Susan B. Allen Memorial Hospital Home Health of El Dorado, KS, was surveyed last year by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO), there was one problem.

It was one of those fluke, accidents-happening-close-to-home problems, where your staff know the patient so well that it's easy to forget standard procedures. "We all felt like kicking ourselves," recalls **Martha McCabe**, administrator for the hospital-based agency.

The problem occurred during the survey week. A home health aide provided daily cream ointment, soap, and water treatment to a diabetic, double-amputee patient, who had been receiving the agency's services for about three years. During one visit, the aide noticed that the patient's skin breakdown had exacerbated, and so the aide reported the problem to the patient's home health nurse.

The nurse, who was very familiar with this particular patient's skin breakdown problems, took an unfortunate shortcut and neglected to visit the patient herself before calling the physician for a change in treatment. It was a big mistake.

"A home health aide is not certified or licensed to assess wounds; it's the responsibility of the RN to make that visit that day, assess it, and then make a call to the physician," McCabe explains.

The Joint Commission surveyor noted this omission and gave the agency a Type 1 violation in wound care. "We were all stressed out with the surveyor around, and busy with our regular patient visits, so it was one of those things that she forgot to do," McCabe says. "But she should have done it."

Protocols described

After the survey results came in, the agency re-educated staff on wound care treatment and procedures, and tightened the wound care protocols. As a result, the Joint Commission has accredited the agency, and wound care outcomes have improved, McCabe says.

The new protocols outline for staff exactly what they need to do regarding patient care, documentation, assessing problems, and follow-up care.

Here are the new wound care protocols:

SUSAN B. ALLEN HOME HEALTH SERVICES
WOUND CARE MANAGEMENT

• **Patients with diagnosed compromised skin integrity, including all classifications of wounds, will be managed by an RN.** The RN will be the coordinator of all services for the patient, which includes the evaluation of care and treatment for wounds and skin conditions, as well as routine evaluation of healing / progress of wounds and compromised skin conditions. All disciplines must follow the care plan as written by the RN, and all orders as signed by the physician. Any changes in wound care / treatments must be initiated by the RN, upon approval with verbal and written orders by the patient's physician.

• **At any time other disciplines in the home assess a change in the patient skin or wound condition, they must immediately notify the RN case manager, any staff RN, or the on-call RN.** The discipline then must document the contact to the RN regarding change in patient condition. It

SOURCES

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is the responsibility of the RN to make a home visit before the end of that day of the report, assess the condition, recommend any continued or changed treatment, and receive verbal orders from the physician before the change occurs. It is the responsibility of the RN to document the approved physician order changes to the chart and the care plan immediately.

• **Because chart information is maintained electronically as well as in written format, it is the responsibility of every discipline to review the care plan for the patient prior to any treatment or care.** Changes reflected in wound or skin care will be reflected in updated care plans as prepared by the RN. Should other disciplines have questions regarding treatment or care of patient wounds or skin, they are to contact the RN case manager as appearing on the chart and as appearing on the last update of the care plan. Disciplines may not change treatment or care without prior approval of the RN, who in turn must receive verbal or written orders prior to such change.

• **If the discipline providing simple, clean dressing changes is a home health aide, prior to the first home visit the aide must receive verbal instruction from the RN case manager on the specific dressing care to that specific patient.** The care plan must be reviewed with the aide as well as prior to the first home visit. Home health aides who encounter problems with completing the dressing change, (i.e. dressings stuck to the skin; dressings not adhering over covering the size of the wound), as set forth in the care plan, must contact the RN case manager or another staff RN IMMEDIATELY from the home in order for the RN to come to the home to make an assessment of the problem. Failure of the RN to make a home visit on that day will result in absence of meeting the standard of care of the agency, and disciplinary action per the organization policy will be applied to the RN. The physician will also be notified. The failure of any other discipline to report a change in condition for patient will also result in disciplinary action.

• **As well at the time of home visits, if disciplines assess new wounds, i.e. skin tears due to falls, or exacerbation of existing wounds and skin conditions, or excessive drainage, then they must contact the RN case manager or another staff RN IMMEDIATELY in order for the RN to assess the condition and recommend change of treatment upon consultation with the physician.**

• **The clinical supervising RN of the agency will review wound protocols at the time of admission, every 60 days, and when necessary as to evaluate the progress of wound/skin healing among the entire patient population.** It is the responsibility of all disciplines to consult with the RN, as well as each patient RN case manager, at any time there is a question in care for the wounds, skin, or condition in general for each patient. All disciplines are to document to the chart consultations, verbal contacts, and telephone contacts with all staff RNs. ■

Education without fear

How not to scare patients about Y2K

Listen to almost any newscast, read almost any newspaper on any day of the week and you are bound to read something about the year 2000 (Y2K), the millennium bug, and the potential problems it might cause come Jan. 1, 2000. There are some people who are so sure that modern society will come to a screeching halt and chaos will reign that they have retreated to rural hideouts, storing great quantities of food, water, and fuel. So how do home care agencies ensure patients are prepared without causing unnecessary fear?

Many would say they are providing staff and patients with material prepared by the American Red Cross **(for a copy of the Red Cross Y2K material, see p. 111, call your local Red Cross chapter, or visit the Red Cross Web site at www.redcross.org/disaster/safety/Y2K.html)**.

Teri Reed, RN, administrator at Alexanders Home Health in Merced, CA, says there is a fine line between readiness and overreaction. "We really didn't want to cause fear among our patients," she says. Unfortunately, before Reed could even ready her clients, she had to make sure her 25 nurses were educated on the issues.

"We did manage to scare them, though" she recalls, laughing. "The problem is that something

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Y2K: WHAT YOU SHOULD KNOW

For more than 100 years, the American Red Cross has been at the cutting edge of disaster relief activities, helping people prevent, prepare for, and cope with disasters and other emergencies. That's why your Red Cross has published the following information about Y2K — its potential effects and what you can do to be prepared.

FREQUENTLY ASKED QUESTIONS

What is Y2K and why are people concerned? The year 2000 technology problem, or bug, as it is sometimes called, was created in the early days of computers, when memory in computers was scarce and expensive. Programmers took shortcuts whenever possible to save space. Instead of using a four-digit code for year dates, a two-digit entry was used. This practice persisted, long after the need for saving space was eliminated. The two-digit code was also used in embedded chips, which exist in many devices that control processes, functions, machines (like cars), building ventilation systems, elevators, and fire and security alarm systems, which are part of our everyday lives.

When the year 2000 comes, programs that have been coded with two-digit year codes will not distinguish between the years 2000 and 1900. If the program includes time-sensitive calculations or comparisons, results are unpredictable. No one knows what problems may occur, how widespread they may be, or how long they will last. The good news is that federal, state, and local governments, banks and other financial institutions, retail businesses, and every other group affected by this problem have been working to resolve it, and a great deal of progress has been made.

When could Y2K problems happen? Most people anticipate Y2K problems may happen Dec. 31, 1999, at midnight. Many experts predict that the problem is more likely to be a persistent one over a few years rather than a single "crash."

For example, there may be a computer-based problem with other dates, such as April 9, 1999, which is the 99th day of the year, or on Sept. 9, 1999. In the past, a series of nines was used to indicate termination of a computer program, and some experts believe that when all nines show up in a date sequence, some computer systems could read it as a program termination command. There also is some concern regarding fiscal year 2000 dates in those organizations with fiscal years that start earlier than Dec. 31, 1999. Also, the year 2000 is a leap year, and the leap year date 02/29/00 may be a problem for some computer programs as well.

What kinds of things could happen as a result of Y2K problems? The President's Council on Y2K Conversion, established by the White House, as well as a special Senate committee, have focused their attention on defining the scope of the Y2K problem. Hearings have been conducted by the U.S. Senate Special Committee on the Year 2000 Technology Problem and have focused on the following eight areas:

1. Utilities and the national power grid;
2. International banking and finance;
3. Health care;
4. Transportation;
5. Telecommunications;
6. Pension and mutual funds;
7. Emergency planning;
8. General business.

The potential effect of the Y2K technology problem on any of those areas is unknown, and the situation continues to change as federal, state, and local governments, industries, businesses, and organizations, as well as the general public, take actions to reduce the problem. Experts who spoke at the Senate hearings believe that there may be localized disruptions. For example, in some areas, electrical power may be unavailable for some time. Manufacturing and production industries may be disrupted. Roads may be closed or gridlocked if traffic signals are disrupted. Electronic credit card transactions may not be processed. Telephone systems may not work.

Because no one can be certain about the effects of the Y2K problem, the American Red Cross has developed the following checklist for you. These are some easy steps you can take to prepare for possible disruptions. All of these recommendations make good sense, regardless of the potential problem:

WHAT YOU CAN DO TO BE PREPARED

Y2K Checklist

___ Check with manufacturers of any essential computer-controlled electronic equipment in your home to see if that equipment may be affected. This includes fire and security alarm systems, programmable thermostats, appliances, consumer electronics, garage door openers, electronic locks, and any other electronic equipment in which an embedded chip may control its operation.

___ Stock disaster supplies to last several days to a week for yourself and those who live with you. This includes having nonperishable foods, stored

(Continued)

water, and an ample supply of prescription and non-prescription medications that you regularly use. See your family disaster supplies kit for suggestions.

___ As you would in preparation for a storm of any kind, have some extra cash or traveler's checks on hand in case electronic transactions involving ATM cards, credit cards, and the like cannot be processed. Plan to keep cash or traveler's checks in a safe place, and withdraw money from your bank in small amounts well in advance of Dec. 31, 1999.

___ As you would in preparation for a winter storm, keep your automobile gas tank above half full.

___ In case the power fails, plan to use alternative cooking devices in accordance with manufacturer's instructions. Don't use open flames or charcoal grills indoors.

___ Have extra blankets, coats, hats, and gloves to keep warm. Please do not plan to use gas-fueled appliances, like an oven, as an alternative heating source. The same goes for wood-burning or liquid-fueled heating devices that are not designed to be used in a residential structure. Camp stoves and heaters should only be used outdoors in a well-ventilated area. If you do purchase an alternative heating device, make sure it is approved for use indoors and is listed with the Underwriters Laboratories (UL).

___ Have plenty of flashlights and extra batteries on hand. Don't use candles for emergency lighting.

___ Examine your smoke alarms now. If you have smoke alarms that are hard-wired into your home's electrical system (most newer ones are), check to see if they have battery back-ups. Every fall, replace all batteries in all smoke alarms as a general fire safety precaution.

___ Be prepared to relocate to a shelter for warmth and protection during a prolonged power outage or if for any other reason local officials request or require that you leave your home. Listen to a battery-operated radio or television for information about where shelters will be available.

___ If you plan to use a portable generator, connect what you want to power directly to the generator; do not connect the generator to your home's electrical system. Also, be sure to keep a generator in a well-ventilated area — either outside or in a garage, keeping the door open. Don't put a generator in your basement or anywhere inside your home.

___ Check with the emergency services providers in your community to see if there is more information available about how your community is preparing for any potential problems. Be an advocate and support efforts by your local police, fire, and emergency management officials to ensure that their systems will be able to operate at all times.

The American Red Cross helps people prevent, prepare for, and respond to emergencies. We're in your neighborhood every day, providing disaster preparedness information and teaching classes in first aid and other lifesaving skills, to help keep families like yours safer. For more information, please contact your local Red Cross chapter.

Source: American Red Cross, National Headquarters, Arlington, VA.

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probably will happen. It might be as minimal as your garbage not being picked up. But the fact that you are telling your patients that they have to be prepared for something is a little frightening."

Another issue is how to make sure patients are prepared when many of them are on fixed income and really don't have the money to prepare as much as they might want. The danger that they would forgo food or medicine in order to stock up on other provisions or have ready cash available is real.

Reed is happy with the Red Cross flyers, which Alexanders is distributing to patients along with lists of local resources — information numbers for local shelters. A small discussion of the issue takes place during the general safety portion of an intake visit, Reed adds.

Alexanders is also updating its general emergency preparedness plan and working on coding patients so that staff can check up on those at highest risk if anything happens on New Year's Day. The agency is also working with city and county authorities to make sure that patients who need to be evacuated to a shelter — for instance, if the electricity goes out and it's cold — will be transported.

As the Y2K approaches, Reed says staff will make sure that patients have flashlights, batteries, radios, and adequate food on hand.

Getting ready early, but not too early

The fact that we are still three months from any problem has proved troublesome for **Phyllis Rizzo**, RN, BS, CHCE, director of home care services at the hospital-based St. Elizabeth Home Care Services in Lincoln, NE.

Initially, Rizzo made use of the Red Cross product, as well as information from her hospital. Its public relations department provided a fact sheet on Y2K that was distributed to staff. The PR staff also wrote a letter about medical equipment

SOURCES

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that was sent to patients. It stated that if the patient had any equipment issued by the home care agency or the hospital, it would be made compliant. If the patient leased the equipment from another provider, the patient should contact that company; and if they had purchased any medical equipment, patients should contact the manufacturer.

"We got those letters out to patients, included information in admissions packets, and educated the patients on the issue," Rizzo says. "But it took so much time, and people wanted to talk about it. But many of those people won't be our patients when the time comes."

As a result, that initial effort was halted and won't resume until the autumn. Then the same information will be provided, with some items highlighted for special attention. For instance, nurses will stress that patients shouldn't use outdoor grills inside, that those with cars should keep their gas tanks full, and that everyone should have some extra batteries on hand.

"There are some who we tell this to and they just don't care," Reed says. "The ones who care, though, are the ones who worry."

Rizzo agrees. "They either don't care or they panic and develop a Chicken Little mentality," she says. "I really don't think the problems are all going to be on Jan. 1st. I think that it's more likely that there will be some issues a few months down the line. Foreign companies that aren't as prepared may cause manufacturing or shipping problems for supplies that we get. And maybe there will be some problems with hoarding of supplies."

Rizzo hopes that the plain speaking style of the Red Cross pamphlet will help to quell some worry and avoid a lot of questions. She is also counting on the three-month lag between St. Elizabeth's first efforts and later ones will allow other agencies — such as the local Office on Aging — and area newspapers to provide some more education to patients. ■

A helping hand from the community

Volunteer program steps in where home care can't

In an era when reimbursement for home care seems to be getting cut to the bone, many home care agencies are finding it difficult to provide the services their patients really need and still get paid. Yet the very nature of home care — and of the nursing profession — makes that reality hard to stomach.

Forsyth Home Health and its related hospital, Forsyth Medical Center in Winston-Salem, NC, have come up with a way around that: the Neighbors volunteer program. It has provided needed services to mostly elderly patients, improved patient and staff satisfaction, and may improve outcomes, too.

Service, but no cost

Because Novant Health, the parent organization of the hospital and home health agency, had a mission to promote health in the wider community, the hospital auxiliary brainstormed for something it could do to achieve that mission, explains **Elizabeth Warden**, RN, CNA, MS, director of nursing at the hospital. "We wanted to provide social contact for those patients in home care that didn't have daily contact with people."

Velma White, RNC, the home health nursing supervisor for Forsyth Home Health, says that while providing a service without incurring a cost was definitely a positive aspect of Neighbors, more important was making sure the patients got as much care as they could for the funds available. "Our nurses were getting increasingly frustrated," White says. "There were waiting lists and a lack of funding for things like chore workers."

Getting oriented

Neighbors was created by a group including members of the hospital auxiliary, the hospital chaplain, the hospital vice president for patient services, and one of the home health supervisors.

Volunteers go through an orientation that includes discussion of issues such as how to say no to requests that are outside their purview, how to provide emotional support, and communicating in difficult situations. They also receive training on

common health conditions, such as diabetes and congestive heart failure and are also schooled by a physical therapist in body mechanics so that they can safely and effectively move and transfer patients.

After some of the initial visits, there were some changes to the orientation, says Warden, including more information on dealing with situations that can't be changed and how volunteers can respond to situations "when they really don't know what to say." The chaplain was instrumental in this part of the training, adds White.

Volunteer impact

The home care agency refers most patients to the program, which currently has about 15 volunteers. Others come to Neighbors through word of mouth. Area houses of worship and volunteer organizations have been notified of the program as well.

Most of the volunteers' work involves simply talking and visiting with patients. They might do some light housework, prepare a small meal, or play a game with the patient.

The impact of this simple program has been great in many cases. Warden worked with one patient, a 61-year-old who had had a stroke. "She was very depressed and despondent. She didn't want to eat or exercise," recalls Warden. "Home care thought with more social contact, she would be more cooperative with her exercise program."

The first couple of visits didn't produce much improvement, Warden admits. "But on the third visit, we talked about how important it is to follow the instructions the nurse gives her," she says. "I asked her to demonstrate some of her exercises. Sine then, she has made so much progress. She hadn't been outside for a long while, and she started to go out. She smiled. It was a really wonderful experience."

Positive results for all involved

White says the home care agency nurses love the program. "They are real patient advocates and like to get all they can for their patients," she says. "This has increased their job satisfaction, and they feel they have another set of eyes and ears on their patients. They feel a lot less helpless and a lot less like they are leaving people in the lurch."

Warden first got involved in Neighbors as part of a master's project that required her to look at and analyze data. Her project has provided some statistical proof that this program works, too. Among the findings:

- **Fewer patients were depressed after they started participating in the program than before it started.** While more than a fifth of patients said they were sad or somewhat sad before the program, none did after.
- **Patients felt physically better after their volunteer visits started.** Forty percent of patients felt bad or somewhat bad prior to the Neighbors program. After, none felt bad, and only 17% felt somewhat bad. Those feeling OK increased from 20% to 68%.
- **Patients not only believe that their volunteer will make a difference in their lives, but they feel that they will have a positive impact on their visitor's life, too.** Prior to the program, two-thirds of the participants believed that they would make some difference to their volunteers, and the remainder thought they would make a lot of difference. After the program, 17% of patients thought they would make some difference, and a whopping 83% thought they would make a lot of difference in the lives of volunteers.
- **Home care nurses reported several positive outcomes.** They noted that their patients seemed to have an improved sense of well being and they had positive comments to make about the program. Nurses also noted personal satisfaction with how patients were served by the volunteers, and that they were very comfortable sharing the plan of care with them.

Other impacts of the program include getting patients hooked up with other needed services, such as Meals on Wheels or respite care, and making physical changes to the home environment, like adding a shower attachment and bench to a bath to ease personal care chores.

"This kind of community outreach is really

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SOURCES

- **Velma White**, RNC, Home Health Supervisor, Forsyth Home Health, and **Elizabeth Warden**, RN, CNA, MS, Director of Nursing, Forsyth Medical Center, 3333 Silas Creek Parkway, Winston-Salem, NC 27103. Telephone: (336) 718-5000.

priceless," Warden says, noting that much of the success of Neighbors is predicated on the notion that human contact — even something as simple as human touch — is important to physical and emotional well-being.

While Warden would make few changes to the program, she wishes she had gotten the word out to area churches and volunteer agencies more effectively. "At first, there were some who were a little leery of going into a stranger's home," she says. "I would have liked to have found a good way to overcome that."

White says there is a need for more volunteers — especially more male volunteers — but she quickly adds that there is little that could be done to improve on this program. "This builds on great relationships. It meets a need, particularly when there is no family around." ■

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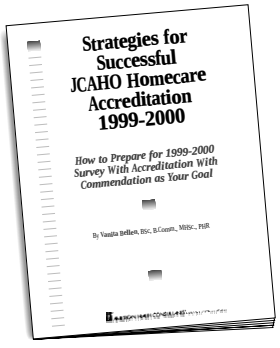

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NEWS BRIEF

JCAHO halts advance notice of random surveys

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in Oakbrook Terrace, IL, will stop giving notice of random unannounced surveys to organizations starting in January. It is one of several major changes to the Random Unannounced Survey Policy that JCAHO made during its July board meeting.

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Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

Other changes include creating a nine- to 30-month window of time after a triennial survey during which random unannounced surveys can be conducted. JCAHO also announced that the scope and focus of review during an unannounced survey will vary from organization, and will be based on information relating to recommendations made during the organization's previous triennial survey, known sentinel events, and other relevant information regarding the organization's performance.

Until January, the policy remains the same: Unannounced surveys will happen at the midpoint of an accreditation cycle; they will be preceded by a 24-hour advance notice; and standards to be reviewed will be communicated prior to the survey.

"These changes stem from research conducted with accredited organizations, various groups who rely on Joint Commission accreditation decisions, and Joint Commission surveyors," says **Dennis S. O'Leary**, MD, president of JCAHO. "We believe they will make our overall accreditation process more meaningful and credible."

Other accreditation process improvement initiatives discussed by the Board of Commissioners at its July meeting include:

• **The development of a pre-survey information packet that will provide surveyors with specific information about the health care organization's performance and permit exploration of any performance issues during the survey.**

• **Pilot testing of the extension of the on-site survey to evening, night, and weekend periods.** Currently, Joint Commission survey activities, including most unannounced surveys, are conducted during regular daytime hours. The pilot testing of off-hour evaluations will begin during the last quarter of 1999 and extend through the first quarter of 2000 and involve a 10% sample of the triennial accreditation surveys during that period.

• **The creation of guidelines that will permit the more specific evaluation of peer review and credentialing processes.** Some of the specific issues to be examined by surveyors will include the organization's definition of the circumstances requiring peer review; the participants included in the review process; and the timeframes in which the review must be conducted and results reported.

In addition, the Accreditation with Commendation Policy is under review by the Accreditation Committee of the Board of Commissioners. Earlier this year, the Committee discussed options for revising or eliminating the Accreditation with Commendation accreditation decision category and then sought input from the public and accredited organizations. The market research generally supported recognition of exemplary performance. However, it also reflected tolerance for a change in the current approach to recognition.

The Committee is currently considering various alternatives for recognizing outstanding organizations. The Board of Commissioners is expected to review and act on the Committee's final recommendations in November. ■

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