AMERICAN HEALTH CONSULTANTS®

HOMECARE
Quality Management™

INSIDE

■ **Inserted in this issue:** VNA's admission checklist

FEBRUARY 2000

VOL. 6, NO. 2 (pages 13-24)

American Health Consultants® is A Medical Economics Company

Workplace injury rules could affect home health industry

Proposed OSHA ergonomics standard could create another burden

A proposed new workplace ergonomics standard could have a profound effect on home health agencies already buffeted by regulatory and financial winds.

In November, the Occupational Safety and Health Administration (OSHA) issued its proposed ergonomics standard for American workplaces. If the rules become final, they will require employers to put in place ergonomics programs for jobs described as manufacturing and manual handling, which is an area specifically defined to include patient handling, such as that received in a nursing home or by a home health aide.

Chandra Branham, associate director of regulatory affairs for the National Association for Home Care, says that because of the vagueness of the proposal, it's hard to know exactly how home health would be affected. But she said it's clear that aides are intended to be covered by the ergonomics rules.

"The initial reaction is we do feel that it's going to apply to at least to some jobs within home care, for example, home health aides," she says. "They refer to patient handling as a typical job that would be covered by this standard."

OSHA's goal is to combat crippling musculoskeletal disorders (MSDs) such as carpal tunnel syndrome, herniated spinal discs, tendinitis, sciatica, and lower back pain. **(See MSD Conditions, Symptoms on p. 14.)**

The proposed rules would require any employer with manufacturing or manual handling jobs to initiate a basic ergonomics program that includes these two elements:

1. Management leadership and employee participation. The employer would have to designate someone to be responsible for ergonomic issues and training. He or she also would have to ensure that employees know how to become involved in the ergonomics program and are not discouraged from reporting problems.

Getting informed, involved

Here's how to find out more about the proposed ergonomics standard:

• The text of the proposed standard is available on the OSHA Web site at www.osha.gov, or through the *Federal Register* at www.access.gpo.gov/nara (click on *Federal Register*). To obtain a free CD-ROM or print version, call (202) 693-1888.

• A public hearing will be held at 9:30 a.m. Feb. 22, 2000, in the auditorium of the Department of Labor (Frances Perkins Building), 200 Constitution Ave. N.W., Washington, DC. Hearings are also scheduled March 21, 2000, at the Benson Hotel, 309 S.W. Broadway, Portland, OR, and April 11, 2000, at James R. Thompson Center, State of Illinois Bldg., 100 W. Randolph St., Chicago. ■

2. Hazard information and reporting. The employer would have to provide information to employees about ergonomic risk factors, the signs and symptoms of MSDs, the importance of reporting them early, and other requirements of the ergonomics standard.

Employer checklist

If a job had a reportable MSD, the employer would have further obligations under the proposed rules:

• **Job hazard analysis and control.** The employer would have to analyze jobs for ergonomic risks, work with employees to eliminate or reduce them, provide protective equipment as needed, and track progress.

• **Training.** The employer would have to periodically train employees in jobs with reported MSDs, as well as their supervisors and staff responsible for the ergonomics program. Training would have to be in a language the employee understands.

• **MSD management.** The employer would be required to provide prompt response to an injured employee, and access to health care at no cost to the employee. The employee also would be entitled to work restriction protection during a recovery period (100% pay and benefits for an employee on light duty, 90% pay, and 100% benefits to an employee removed from work). Those protection benefits would last until the employee returned to work or the MSD hazards are fixed or six months have passed, whichever occurs first.

According to OSHA, those protection benefits can be offset by workers' compensation or similar benefits.

• **Program evaluation.** The employer would have to periodically evaluate the ergonomics program, consult employees on its effectiveness, and correct any deficiencies.

• **Record keeping.** An employer with 10 or more employees would have to retain ergonomics records for three years.

According to OSHA, an employer who has already implemented an ergonomics program may continue to use it, provided that it meets the basic requirements of the standard, and eliminates or materially reduces MSD hazards.

The standard would be implemented in stages, beginning 60 days after a final version is published.

Branham says she has not yet received many questions from home health agencies regarding the

MSD Conditions, Symptoms

Examples of musculoskeletal disorders to be covered by the proposed OSHA ergonomics standard:
- Carpal tunnel syndrome
- Epicondylitis
- Herniated spinal discs
- Tarsal tunnel syndrome
- Raynaud's phenomenon
- Sciatica
- Ganglion cyst
- Tendinitis
- Rotator cuff tendinitis
- DeQuervain's disease
- Carpet layer knee
- Trigger finger
- Lower back pain

Examples of MSD signs and symptoms:
- Deformity
- Decreased grip strength
- Decreased range of motion
- Loss of function
- Numbness
- Tingling
- Pain
- Burning
- Stiffness
- Cramping

Source: Occupational Safety and Health Administration, Washington, DC.

SOURCE

- **Chandra Branham**, Associate Director of Regulatory Affairs, National Association for Home Care, 228 Seventh St. S.E., Washington, DC 20003. Telephone: (202) 547-7424. Fax: (202) 547-3540.

proposed standard, but is unsure whether agencies don't know about it yet, or simply believe their existing programs will be sufficient.

Her analysis of the standard has identified some possible problem areas for home health:

• **Direct observation of workers.** The job hazard analysis required of employers in the event of a reportable MSD directs the employer to "observe employees performing the job in order to identify which of the physical work activities, workplace conditions, and ergonomic risk factors are present."

"That's a particular concern for home care, because a lot of home health employees are operating very independently in the homes," Branham explains. "Home health aides are supervised on a regular basis, and I think that training would not be a problem as far as proper patient handling and those kinds of things. But the actual one-on-one observation would be, especially for employees spread out geographically in the community."

• **Vagueness of rules.** Branham says that because of the general language in the standard, employers who already have ergonomics programs in place may not be able to know whether they are in compliance.

• **Pay requirements.** The requirement to pay an employee up to 100% of pay and benefits while the employee may be restricted or even barred from working, could impose a severe financial burden on an employer.

Branham notes that this potential burden could come at a particularly vulnerable time for home health agencies. "We have PPS coming, which is going to completely revamp the payment system that home health has been operating under," she predicts. "We're expecting revised conditions of participation around the same time that PPS goes into effect. Surety bond regulations are going to come back, probably around that same time.

"I think it's just to the point where home health probably can't take one more burden that's going to cost them anything," Branham says. "We've already seen the closing of so many home health agencies these past two years. There may be some agencies who may say the cost of compliance is just too high with all of these regulations." ■

Develop your own compliance plan

Agencies can audit processes, take corrective action

Compliance planning doesn't have to be a drawn out, expensive process involving lawyers and consultants, says **Ruth Constant**, RN, MSN, EdD, CHCE, president of Ruth Constant & Associates of Victoria, TX.

Constant, whose company owns and operates three Texas home health agencies, says that a smaller agency not only can develop its own compliance plan, but should follow through with an ongoing process of implementation, review, and improvement to make it a real compliance program.

"You don't write a plan, put it in a manual, and stick it on a shelf. That is not a compliance program," she says. "I see the corporate compliance plan as your blueprint, your schematic. Your plan is your pattern to develop a corporate compliance program, which is a dynamic, ongoing process."

Creating that plan requires an agency taking a long, hard look at itself — how well it follows its own policies and how well those policies mirror existing law. Sometimes making such a detailed self assessment can be a little daunting to an agency.

"Some people say, 'No, we run a good organization; we don't have problems,'" Constant says. "They're in the position that they don't know that they have problems. But I would rather find out myself than let the surveyor come in and tell me, 'You're committing fraud.' Or, 'This is so bad we're going to take your license away,' or 'You're deficient in your survey.'"

Self audit

The agency's self-examination can take the form of an initial internal audit — a substitute for the expensive legal audit that a lawyer might do of the agency.

Constant suggests creating a large checklist breaking down the major components of the organization — generally clinical, operational, and financial — and checking them against all relevant regulations, including Medicare conditions of participation, Occupational Safety and Health Administration requirements, and state licensing rules.

In each case, she suggests asking two questions:

1. Do our policies address what the law requires?

2. Are we actually following our policies?

"The simplest way that I can suggest is to get your manual and look at it," she advises. "It's probably in sections — clinical sections, where you give care, administrative operational, and financial. All tie together, but they are separate little entities that have their own tasks and responsibilities."

In the billing section, for example, an agency would look at its billing processes, examining policies, and procedures. Is the agency waiting to bill for Medicare services until it has obtained a signed physician's order?

Another example would be to check to see whether nurses are asking patients about advance directives upon admission into home care.

"Are all your policies up to date?" Constant asks. "How long has it been since they were revised?"

Throughout the audit, the agency should be identifying areas of weakness and documenting them thoroughly. Although it would clearly be illegal to go back and change past documentation, an agency can show regulatory agencies that it identified a problem and corrected it.

"Ninety-nine and nine-tenths percent of home health agencies are basically honest and want to do a good job," she says. "They may hire new people who somehow didn't remember when they were told not to bill until they had a signed doctor's order for those visits that the nurses made during the month."

Obtaining signed orders is a frequent problem Constant encounters when discussing other agencies' operations. Operators recognize that they need to have the orders before billing Medicare, but have trouble tracking down busy physicians in order to obtain them.

Corrective action — and beyond

Once problem areas have been identified, the plan must be developed to address them. Policies must be updated as needed, and necessary inservicing must be conducted to reinforce regulations that employees haven't been following.

Constant suggests creating a compliance team that includes the top managers from each department, and in a far-flung agency, from each office. Her agency has a corporate compliance officer, originally hired as director of program integrity. He heads the compliance council, is responsible for coordinating its activities, and handles complaints regarding compliance issues.

While some may suggest keeping an attorney on contingency to serve as compliance office, Constant says there are disadvantages to that approach. "Lawyers don't know all about how home health agencies operate. Even those who specialize in home health care really don't know as much as people who actually work in the organization."

She says it is important that a compliance officer be someone who is respected by peers as fair and principled, and he or she be given enough autonomy to do the job without interference. Ultimately, however, autonomy must go hand-in-hand with a top-down commitment to compliance by the entire organization.

"Compliance has to start at the top, certainly in family-held or privately held home health agencies," Constant says, noting that in her organization, she is not only the administrator, but the owner and president of the board of directors. "If I were dishonest, who would the compliance officer go to?"

The commitment to behaving ethically is disseminated throughout the company as a regular part of training. In Constant's agencies, not only are employees required to have continuing compliance education, but board members must also go back to the classroom yearly.

Employees are taught that falsifying documentation is a firing offense. "They know we don't falsify records, even a blood pressure," Constant says. "If a person makes a mistake, they may be counseled. But you don't go back and change records because you think you're going to be in trouble."

And every aspect of compliance — the audit, the education, implementation of the program — is copiously documented. At the mandatory compliance inservice, employees must sign in to show that they attended. The compliance officer keeps confidential records of any complaints, along with documentation of with their disposition.

Once a plan has been developed and implemented, the compliance program has just begun. In fact, Constant says, a good compliance plan should have built in mechanisms for review and updating, ideally every year.

The compliance officer keeps track of new regulations from state and federal agencies, making note of those that can wait till the yearly revision and immediately implementing important changes to documentation or procedures.

"You cannot write a policy today and two years from now, that policy remains the same,"

SOURCE

- **Ruth Constant**, Ruth Constant & Associates, 1501 E. Mockingbird Lane, Suite 404, Victoria, TX 77904. Telephone: (561) 578-0762. Fax: (561) 578-1567. E-mail: drc@rchh.com. Web site: www.rchh.com.

she says. "They're always being revised, even if it's just improving the way it is written."

She says that with every policy at her agencies, the manual notes when it was written, and when it was reviewed or revised. As with every other aspect of operations, agencies must be sure to follow their own requirements regarding policy review.

"If you say in a policy that you're going to review policies every year, then you document that you did it. You don't have to change a word, but at least you reviewed it." ■

Home care submissions, guidelines are sought

Jean Slutsky, MSPH, project officer for the National Guideline Clearinghouse, says the project is continuously searching for new guidelines to post for health professionals. She says the clearinghouse is especially interested in submissions pertaining to home care.

"Obviously, home health is a very important part of how clinical care is delivered in this country," she says. "It is an important industry and an important way of caring for patients."

Anyone who has developed guidelines and wishes to submit them to the clearinghouse for review should send two typed paper copies of each guideline, along with related background information, to Vivian Coates, NGC project director, ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462. An electronic version of the information should be sent as well, if possible. ■

Internet guidelines can be the key to improved care

Federal site offers free access to hundreds

As home health care becomes more complex, with nurses caring for more difficult cases, the Internet can be a handy source of clinical information — if, of course, you know where to look.

The federal government, in cooperation with health care organizations, has created an Web site that it hopes will provide health professionals with a trusted source of clinical practice guidelines.

The National Guideline Clearinghouse has been up and running for a year. **David Paulus**, MD, medical director of Shands HomeCare in Gainesville, FL, says the clearinghouse can be a useful resource for home health agencies.

"One of the difficulties we have in home care is we take care of patients with a broad variety of diseases, with a broad variety of drugs and other therapies, making it difficult for our clinicians to keep up," Paulus says. "I think the guidelines can be helpful, because it does represent the best thinking of the time, which you can use when you do your care plan."

Shands HomeCare, which is affiliated with the University of Florida, is now in the process of equipping its nurses with laptop computers that will be used in the field. While the technology will assist in documentation and collection of OASIS data, it should also provide nurses with a link to the Internet, says **Shirley Sleeker**, CCRN, CNAA, senior associate with Curran Care and executive director of Shands HomeCare.

"There's a lot that nurses deal with on a day-to-day basis that they don't have ready access to from their own knowledge — a pathway or a certain protocol," Sleeker says. "This provides them with information that could be more current, as well as more accessible to them."

Guidelines fill important role

The Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) of the Department of Health and Human Services developed the clearinghouse in partnership with the American Association of Health Plans and the American Medical Association.

In its first year of operation, it amassed and reviewed more than 650 guidelines in areas ranging from acute care to home care.

Jean Slutsky, MSPH, project officer for the clearinghouse, says her agency's goal was to fill a void in the area of up-to-date, accessible, peer-reviewed guidelines.

"It's really hard to capture clinical practice guidelines because they're not cataloged," she says. "Often, you don't know who developed them or how old they are. Many are of good quality, but some aren't. There was no one central repository with exclusion criteria that would set the floor for what would be in it. There was a need that the agency found was important to fill."

While most of the guidelines are available free of charge, there are some developed as proprietary documents for which the agency offers summaries and ordering information.

To date, the site, www.guideline.gov, has received more than 800,000 hits. While it's impossible to know how many home health agencies have used it, Slutsky says there are a number of guidelines in it that would be useful in home health.

"There are guidelines covering chronic illness, as well as geriatric complications," she says. **(See related story, below.)**

The site is continually updated, and guidelines are revised or removed as more timely information becomes available.

As visitors make suggestions about guidelines they'd like to see, the clearinghouse solicits developers to submit them.

Paulus says the financial pressures on home health agencies can make the Internet an economic resource.

"Home health agencies have a couple of forces on them: One, they're losing money; and second, they don't know where to go for help," he says. "They're unwilling or unable to develop these guidelines and pathways. There are expensive conferences you can go to, but actually most of the information is on the Internet."

Paulus says guidelines can be used by an agency in two ways — to establish and develop an agencywide approach to a particular condition or as a reference for nurses on individual cases.

At Shands HomeCare, Sleeker says education would begin with managers, so that they can be comfortable with the technology and sites such as the clearinghouse that Paulus has identified as being useful and credible.

"Clinical managers would have ready access to it to help support the field in answering their questions," she says. "And then we get those in the field more involved."

She hopes to have staff trained and laptops in use in the field by this summer.

"It [Internet access] can give us some clinical direction in terms of the assessment that we're providing on the client," Sleeker says.

It can be used to prepare for a visit and provide information on a particular diagnosis. "That helps them focus on their assessment collection; and once they collect it, it helps them in developing their plan of treatment," she says.

Using the clearinghouse

The guideline clearinghouse is similar to other Web-based databases, using a search engine to allow quick access to needed information. You can search based on a keyword found in the document, or by disease, intervention, or submitting organization. Paulus says the results are listed in order of relevance to the keywords typed in.

For each guideline, the site provides a standardized abstract, explaining how the guideline was developed and naming the developers. Contributors include professional organizations such as the American College of Chest Physicians, as well as other research bodies.

The clearinghouse provides access to the full text, if available, and comparisons to guidelines that cover similar topics.

Guidelines available

Here is a selection of some of the guidelines available through the National Guideline Clearinghouse at www.guideline.gov:

- Evidence-based guidelines created by the American College of Chest Physicians for patients with chronic obstructive pulmonary disease. Outlines a multidisciplinary approach to pulmonary rehabilitation. Includes patient information.
- Guidelines for treatment of pressure ulcers developed by the Agency for Health Care Policy and Research. Includes interventions, education and quality improvement suggestions. Includes bilingual patient education resources.
- Nutritional recommendations and principles for patients with diabetes, submitted by the American Diabetes Association.
- Guidelines for mechanical ventilation in the home, developed by the American Association for Respiratory Care.
- Recommendations for family involvement in the care of patients with dementia, developed by the University of Iowa Gerontological Nursing Interventions Research Center. ■

SOURCES

- **David Paulus**, MD, Medical Director, Shands HomeCare, and Professor, Department of Anesthesiology, University of Florida, P.O. Box 100254, Gainesville, FL 32510-0254. Telephone: (352) 846-1309. Fax: (352) 392-7029. E-mail: paulus@ufl.edu.
- **Shirley Sleeker**, Executive Director, Shands HomeCare, and Senior Associate, Curran Care, 3515 N.W. 98th St., Gainesville, FL, 32606. E-mail: ssleeker@aol.com.
- **Jean Slutsky**, NGC Project Director, Agency for Healthcare Research and Quality, Center for Practice and Technology Assessment, 6010 Executive Blvd., Suite 300, Rockville, MD 20852. Telephone: (301) 594-4042. Fax: (301) 594-4027. E-mail: jslutsky@ahcpr.gov.

Many of the guidelines are not specifically written for home care, and in some cases, Paulus recommends carving out the portion of a guideline on, say, congestive heart failure, for which the agency can be responsible.

Sleeker says that an agency should work with a medical advisor who can help determine which sites and information are useful to the agency.

"Not just somebody who does record review, but who takes an interest in the development of the staff and the quality of services that they provide and how to keep them moving up the ladder," she says.

Education is also important, she adds, noting that many nurses have never needed computer skills in their work before. "There are many people who are not comfortable with that yet, even using the keyboard," she says. "If they had a computer in their home, then obviously, they're more skilled. But for some, there is a learning curve."

No money, no excuse

While laptop computers in the field may be out of the reach of many home health agencies, Paulus says budgetary restrictions are no longer an excuse for failing to tap the Internet's resources.

"Unfortunately, agencies can get themselves into a self-defeating proposition, saying it would be awfully expensive to put computers in every nurse's car," he says. "But you can buy a cheap system and get access. You can go to the public library, a university library. If I wanted to access the Internet and didn't want to pay anything, I'd just go to the library and do it.

"It's pretty hard to argue these days why you don't have access to the Internet. I think those excuses are going away." ■

Give nurses a checklist to help their admissions

Agency sees major paperwork improvements

The Visiting Nurse Association of Johnson County, based in Iowa City, IA, set a major goal in last year to become more efficient and accurate with documentation.

"We looked at what we had on the old forms and tried to combine these to do the essentials," says **Joyce Eland**, BSN, quality manager of the agency which serves a county in southeast Iowa with an average of 3,000 visits a month.

Due to OASIS, the field staff spent additional time with documentation, and this caused some frustration. The agency worked to streamline charts and documentation, including updating one of the most helpful tools, an admission checklist.

The checklist serves two major purposes, Eland says. First, it is a set of guidelines to remind nurses about the agency and Medicare's admission criteria and how to check to make sure the patient meets those criteria. Secondly, it reminds nurses to present important information to patients, such as a patient-rights sheet. **(See the VNA's admission checklist, inserted in this issue.)**

The admissions checklist has helped nurses improve documentation in many different areas, including how they ordered home care aide services, consistently writing down patient demographics, and having patients sign all necessary forms, Eland says.

Supervisors regularly do chart reviews to make sure the checklists are completed, and they'll talk to nurses when they find items that have not been checked.

Checklist highlights

Here are some of the guidelines included in the checklist and how they have improved documentation and quality of care:

• **Consistent admission procedure.** The agency first developed the admissions checklist six years ago in response to staff members having problems remembering everything they were supposed to do when first seeing a patient.

"We found that we kept writing out these instructions to guide people," Eland says, "and we thought, 'Why do we keep doing this every time? Why not keep it consistent with a checklist?'"

The first checklist mostly included a list of forms nurses were supposed to complete at the first visit, along with instructions on who would need a copy and what they should do after the visit.

• **Admission criteria.** As Medicare's concerns about fraud and abuse escalated in the late 1990s, the agency altered the checklist to include information about determining the appropriateness of admissions. This section now has nine steps a nurse must follow to determine if a patient is appropriate for admission, and this section is first on the checklist.

For example, the admission criteria include:

— Have physician and medical orders.

— Patient / family / private caregiver willing to provide care between visits.

— VNA care doesn't duplicate other care: outpatient cardiac rehab or therapy-assisted living services.

"This was a way of reinforcing the criteria," Eland says. "We had some admissions of patients we thought weren't really appropriate to admit, and it's difficult to go back to a patient and say, 'We really don't think we should have admitted you.'"

Make that call

The checklist's admission criteria have made the staff more aware of government rules regarding home care service, and they have encouraged nurses to call in to the office to speak with a manager whenever they encounter a patient whose home care qualifications are questionable.

"I'm not saying we don't have situations that come up, but we can catch it quicker than we used to, and we like that," Eland says.

• **Verbal order for care.** About two years ago, the agency added a brief line, "Before Visit," where nurses must check whether there was a verbal order for care.

"We added that because there was a lot more concern about the verbal orders, and we found a few problems," Eland explains.

Although nurses were making the appropriate phone calls regarding care, they weren't always documenting these calls. By adding this simple section to the checklist, it solved that problem.

• **Emergency plan.** The agency added a check-off box for an emergency plan to the category, "If Appropriate for Admit, complete the following."

"We have a skeleton of an emergency plan, and it really relies on the staff writing in some information that's individualized for patients to make it a good plan; that was a reminder to them to do that," Eland says.

• **OASIS.** The checklist reminds nurses to turn in their OASIS assessment within two days after the last visit, and it forces them to examine whether various OASIS information is accurate, including the payer source, diagnosis order, and qualifying service for Medicare.

• **Demographics.** The staff had not been consistently completing the patient identification sheet. For example, they didn't always write out the directions to the patient's home or give the names of the pharmacy or agencies involved in the case.

"And that's our place of communication for those things," Eland says. The agency added a reminder about demographics to the checklist. It reads, in part: "Emergency contact? Other Agencies? Pharmacy? Directions?"

Since this was added last year, the staff have improved their documentation of patient demographics, Eland adds.

• **Home care aide/homemaker services.** This is another area that was added in 1999 because of performance improvement concerns.

"We were discovering on some of our audits that nurses forget they are responsible for home care aide orders," Eland says. "They were changing the frequency of home care aide visits or putting a home care aide on a case, and we had an omission of orders for home care aide services."

In other words, nurses didn't get the doctor's order on the initial plan. The checklist now reminds them to do so with the terse instructions: "HCA / HM services: Call office to schedule; write care plan (orig - office; copy - patient). Write order HCA!!"

The problem has improved since the reminder was added to the checklist, Eland says. "On the initial plan, we're doing well, and we've made progress on it if there are any changes in service; but we still have a few isolated incidents and are working on some other ways to correct those."

• **Psychiatric consent.** Another new addition to the checklist is under the Supervisory Review section. The last category notes several areas that should receive special attention, and one is "Specific Consent Mental, HIV, Substance."

"One thing we noticed last year is that we have a fair number of patients with psychiatric concerns, and there were frequent requests for information," Eland says. "When we went back to the consent form, we didn't always see that they had a mental health-specific consent form signed or initialed, so that's an area we did an inservice on." ■

ID agency's review prevents fraud, abuse

Home care quality managers have long have claimed that most of the so-called fraud and abuse problems discovered in Medicare claims are really the result of unwitting errors on the part of home care staff.

This means it is more important than ever that quality managers develop a chart review process that's designed to identify and correct those errors before they are submitted as claims.

Gritman Home Health in Moscow, ID, has developed a chart review process that serves this purpose. Already, it has found some errors that Medicare would have labeled "fraud," says **Pat Lucker**, RN, quality manager.

For example, the chart review process has discovered a few simple errors that were caused by a billing employee keying in the wrong dates or a field staff worker writing down the wrong date on the daily chart.

"I check the note against the billing, and if there is a discrepancy there I point that out so we're not billing for a day when a visit isn't made," Lucker says. "It's ridiculous, but they put people out of business for those types of mistakes, so it's a very real threat."

Some other examples of errors included instances where a home care aide arrived at a patient's house solely to give the patient a shower, and the patient refused the service. Although the home care completed documentation that said the patient refused the shower, somehow the documentation was filed as a billable visit, Lucker explains. "But it wasn't a chargeable visit, since the shower wasn't given and the patient refused any kind of personal care."

Capture lost revenue

The chart review process also has uncovered nursing and therapy visits that were made and documented, but not charged, thus giving the agency some income that otherwise would have been lost.

Here's how the chart review process works:

1. The quality manager reviews an entire case file. The case file contains all that has been filed by the staff, along with physician orders and nursing notes. Lucker pulls out a chart review tool and uses this to checklist everything she will review in the file. In all, Lucker reviews 50 charts a month, which takes her a total of eight hours, spread over two or more days. Since the agency is small, with only 700 to 800 visits a month, she is able to review all the charts.

2. Check billing charges. Lucker checks to make sure the Medicare 485 form is signed and dated and submitted within the 30-day time limit. The review process also includes checking all verbal order documentation to make sure those are signed and dated, especially when they're pertinent to treatment or change of discipline or visit routine. Then, she compares the field staff notes to the charges, again checking dates to see how many visits were made each week.

3. Check medication profile, lab report, and supplies. Lucker looks at the patient's medication profile to make sure it's updated. While this paperwork is out, it's also an opportune time to make sure the physician's order has been copied and included with the update.

Next, she'll check to see if the lab reports are included on the chart that month. Again, this means checking the doctor's orders to see what has been ordered, and then looking at the nursing note to see the date it was done. If any charts are missing this information, Lucker will print it out to show the nurse.

Also, Lucker will check whether the patient's supplies have been charged and documented on the nursing note.

4. Check nurse's aide care plan. The chart review process includes making sure the nurse's aide care plan is followed, with supervisory visits made every 14 days according to regulatory requirements. Lucker allows a little leeway in this area. "They say every 14 days, and that's really difficult sometimes, and if we get a little out of whack on that I can't do anything about it because there are times that nurses can't get out there or want to go later in a week," she says. "It might be 16 to 17 days."

5. Confirm homebound status. The chart review ensures that nurses are documenting the patient's homebound status, using the four-pronged approach on the OASIS assessment tool. They must ask and answer whether a patient has a breathing problem, a problem with locomotion, a problem with transportation, and whether the patient can leave the home to do the shopping.

If nurses have answered those four questions correctly, then the homebound status is met. If the nurse has had difficulty determining homebound status based on those questions, then

agency rules ask them to consider whether the patient has a normal inability to leave the home. "For instance, does the patient's leaving the home require a considerable and taxing effort, and are absences from the home infrequent and of short duration?" Lucker explains.

6. Check the billing preliminary report. The agency has a worksheet that includes all of a patient's charge information for a month. Toward the end of the month, Lucker audits this report to see whether the frequency of visits is appropriate, that skilled care was provided, and all physician orders were followed.

Again, this includes checking skilled care services and orders against what was billed. And all of this is briefly checked again when the final billing report is issued.

7. Note all problems on chart audit tool. Lucker jots down notes about every discrepancy or problem she spots in the chart. She also records potential red flags. For example, if the Medicare 485 form is not in the chart, but a copy of it is in the chart, she'll note that the 485 is a copy.

"If there's nothing on the chart to indicate the 485 has been started or done, I write 'zero' so I know how to make sure the 485 is at least in the works and hasn't gotten lost somewhere along the line, which sometimes can happen." ■

Medical errors top list of public's concerns

Arizona agency has QI project that reduces them

Health care organizations received an ego blow at the end of 1999 when an Institute of Medicine (IOM) report claimed that between 44,000 and 98,000 Americans die each year from medical errors.

These errors occur in all areas of health care and also result in permanent disabilities, according to **William Richardson**, chairman of the IOM committee that wrote the report.

The report followed quickly on the heels of an October 1999 jury decision in which a Texas man's family was awarded $450,000 after the man died when given a drug to treat high blood pressure. He had been prescribed a drug for chest pain, and the pharmacist misread the cardiologist's handwriting. Both the Albertson's pharmacy in Odessa, TX, and the cardiologist, Ramachandra Kolluru, MD, were sued, and the verdict required them each to pay half the damages.

Other reports suggest that drug errors are on the rise. One study showed that medication errors nearly tripled from 1983 to 1993, and deaths from medication errors increased from about 3,000 in 1983 to more than 7,000 in 1993. The same study suggests that shorter hospital stays and a shift toward outpatient care have led to those medication problems.

Due to those alarming reports, President Clinton announced last December a list of initiatives to reduce medical errors and improve medication safety.

Home care staff are in a position to prevent some of those mistakes because they have access to patient's medicine cabinets and can find out more about what the patient is taking than what any one physician might know.

"We find an accumulation of medications, and lots of times the doctor doesn't even know what they're taking," says **Loretta Wellborn**, RN, MS, director of Northern Arizona Homecare in Flagstaff, AZ.

Northern Arizona Homecare has taken a series of quality improvement steps to prevent medication and other medical errors. These include:

- **Create medication profile.** Nurses, using laptop computers for documentation, create a medication profile of each home care patient. They list all of the patient's prescribed and over-the-counter drugs, based on what patients say they are taking and what nurses observe during a home care visit.

Once those profiles are logged in, the software program creates medication teaching sheets that nurses can review with patients. The program also alerts nurses to any potential food-drug or drug-drug interactions.

- **Have pharmacist review med profile.** The

agency has its own staff pharmacist who reviews the medication profiles to make sure there are not any potential problems. For example, if a patient is prescribed the drug Coumadin and the patient also takes aspirin, there could be a significant drug interaction, Wellborn explains. "We end up being a detective in home health."

Nurses will also consult with the pharmacist when the patient experiences problems that could be side effects from one or more medications. The pharmacist is often in the best position to determine whether a drug is causing a side effect, Wellborn says. "It could be from a drug the patient was prescribed earlier; and since everyone has different doctors these days, with one specialist for one medication and another specialist for another medication, we try to monitor that closely."

• **Investigate all adverse reactions.** Whenever patients have an adverse drug reaction, the home care nurse fills out an adverse drug reaction form that the pharmacist reviews and uses in launching an investigation.

For example, Northern Arizona Homecare has home infusion clients, and sometimes one of those patients will experience a skin rash or begin vomiting after being started on a new medication. When this happens, the nurse completes the adverse drug reaction form, gives it to the pharmacist, and the pharmacist begins the investigation by calling the patient's physician.

The pharmacist determines whether the patient truly had an adverse drug reaction, and if so, then the case is reported to the FDA.

Even minor drug reactions are investigated. Wellborn once had a patient who was receiving a medicated infusion. The patient felt fine, but whenever Wellborn started the infusion, the patient began to hiccup. Although the hiccups certainly weren't life-threatening, Wellborn filled out an adverse reaction form and gave it to the pharmacist. The patient's physician told the pharmacist that it could be due to the medication, and the pharmacist researched the drug further and determined that the hiccups were caused by the drug. However, as long as the patient didn't mind the hiccups, the agency continued the medication.

• **Monitor patients' medication issues.** The agency's pharmacist calls infusion patients regularly to ask how their supplies are holding out and how they're doing on the medicine. Usually the pharmacist places those calls each week, but sometimes more frequently, Wellborn says. "The pharmacist is talking to one caregiver every three to four days because the patient is very ill."

SOURCES

- **Joyce Eland**, BSN, Quality Manager, Visiting Nurse Association of Johnson County, 2953 Sierra Court, Iowa City, IA 52246. Telephone: (319) 337-9686. Fax: (319) 337-5566.
- **Pat Lucker**, RN, Quality Manager, Gritman Home Health, 700 S. Main St., Moscow, ID 83843. Telephone: (208) 883-2237.
- **Loretta Wellborn**, RN, MS, Director, Northern Arizona Homecare, 1200 N. Beaver St., Flagstaff, AZ 86001. Telephone: (520) 773-2238.

Since the pharmacist has computer access to the patient's visit notes and medical information, those calls give the pharmacist an opportunity to update any information. Also, the pharmacist regularly receives a copy of all laboratory reports of patients.

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.

Subscription rates: U.S.A., one year (12 issues), $299. Approximately 18 nursing hours annually, $349. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies. $179 per year; 10 or more additional copies, $120 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $50 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Jim Stommen**, (404) 262-5402, (jim.stommen@medec.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@medec.com).
Production Editor: **Nancy McCreary**, (404) 262-5458.

Editorial Questions

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

The pharmacist's monitoring practice helps the agency improve the quality of care and it prevents waste, Wellborn says. "We've had a couple of situations where we needed to use an out-of-town pharmacy for Medicaid patients. So, that pharmacy has to ship the medication supplies to the patient's home, and it may or may not get there."

These other pharmacists may never call to check to make sure the patient has the correct amount of medication, and so there often is a waste, particularly when the physician changes the medication, and the pharmacy had already sent a large supply of the old drug. Northern Arizona Homecare's pharmacist keeps close tabs on the medication supply, so those problems do not occur when the agency's pharmacist is handling the case. ■

Reports now document home health changes

The Health Care Financing Administration Customer Information System released data late last year that show a 38% drop in Medicare home health payments from 1997 to 1998. Total payments fell from $16.7 billion to $10.5 billion as a result of Medicare cuts under the Balanced Budget Act of 1997.

The same database shows that home care visits during the same period decreased by 40%. The number of Medicare beneficiaries served by home care agencies declined by about 500,000. ■

CE objectives

After carefully reading this issue of *Homecare Quality Management*, readers will be able to do the following:

1. Understand how to prevent documentation errors that could be called fraud and abuse.
2. Describe practices to prevent medication errors.
3. Create a compliance plan that addresses regulatory issues faced by home health.
4. Employ the National Guideline Clearinghouse to find and use clinical practice guidelines. ■