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INSIDE

■ **Inserted in this issue:** Competency exam writing secrets

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Design stellar competency and assessment program for therapists

Expert describes how to meet all requirements

Medicare's Outcome and Assessment Information Set (OASIS) requirements have made it more important than ever that your entire home care team be capable of performing and documenting consistent and accurate assessments of patients.

A comprehensive OASIS assessment requires that a patient's medical, nursing, rehabilitative, social, and discharge planning needs be met. Since home care patients could be referred for therapy only, this means all therapists should be capable of performing a comprehensive assessment because a nurse might not be involved in a particular case, says **Linda Krulish**, MHS, PT, president of Acworth, GA-based Home Therapy Services, a home care consulting company that provides therapist training. Krulish spoke about improving therapist competence at the 18th annual meeting of the National Association for Home Care held in San Diego last October.

Home care quality managers and administrators first should review

Special Report: Checking Staff's Competency

It has become increasingly important that home care agencies ensure their staffs are competent at assessments and other duties. OASIS and prospective payment system requirements have made it essential that every clinician performing an assessment knows both how to do so correctly and accurately document what is observed. This issue of *Homecare Quality Management* includes tips on how quality managers can make sure their employees are well-trained in assessment documentation and are competent to perform assessments and other duties. ■

their state regulations and agency policies, as well as the competency level of each therapist, before deciding whether to require therapists to perform those comprehensive assessments, Krulish suggests.

Then, if therapists are going to be expected to conduct those assessments, quality managers should develop a training program that will ensure their assessments produce high-quality data. **(See related story on improving assessment documentation, p. 39.)**

Under the Medicare prospective payment system, the case mix will be determined by the OASIS data that home care agencies submit to the Health Care Financing Administration (HCFA) in Washington, DC.

"Poor OASIS data could result in under- or overpayment, and neither is good," Krulish says. "This is a critical time because we're looking at data collection from both the quality of care and reimbursement."

If an agency's staff collects poor OASIS data, this could lead to patients being assigned to an inappropriate case mix group, which means inappropriate reimbursement; or in a worse-case scenario, it could result in a federal fraud investigation, she adds.

Follow these guidelines

Poor assessment data will also affect patient treatment planning. "We also have HCFA's program memorandum to state agencies, which came out in November, that suggests that part of the Medicare survey process should have surveyors determine if an agency has appropriate program training in place to make sure all therapists and nurses who are performing comprehensive assessment are competent to do so," Krulish says.

Krulish provides these guidelines for assessing competency training needs:

1. Educate staff on regulatory requirements.

Quality managers could begin by discussing the Medicare Conditions of Participation, reviewing what HCFA requires of a comprehensive assessment. This inservice should include:

— What is the scope of the comprehensive assessment?

— How will it identify the patient's medical, nursing, rehabilitative, social, and discharge planning needs?

— What has the agency determined is a suitable comprehensive assessment?

— Which items on the assessment must be completed each time, and what are the different time points for conducting an assessment?

2. Obtain staff feedback.

Once therapists and the rest of the staff understand how to conduct the assessment, the quality manager should ask them for feedback, Krulish says. "This can be an informal process with a staff discussion of ongoing issues the staff brings up, or you can use a questionnaire asking, 'What are the things I can do and what are the things I need more training in?'"

3. Prioritize problem areas.

Competency assessments should provide a quality manager with a good idea of where major problems lie. For example, if certain questions on the OASIS tool are completed incorrectly by several clinicians, then the problem could be with the way the question is interpreted. Or the entire staff might need some updated education in that area.

Once a quality manager determines which are the problem areas, it's time to prioritize them and proceed with a plan to correct them.

Top priorities should include the areas in which clinicians have the most difficulty, as well as areas that have a high risk if they're not handled correctly. For instance, medication assessment is a high-risk area, so a quality manager might desire to make it a top priority.

Priorities also might be areas that most concern the staff. But as the priority list is made, quality managers should keep in mind that low-volume areas, even if they are high risk, might not be near the top of the list. For example, if an agency only has one wound care patient a year, then competency training in wound care treatment probably would be a low priority.

4. Train staff and develop solutions.

After drawing up a priority list, a quality manager could select the competency and assessment issues for selective training, inservices, peer training and mentoring, or other problem-solving strategies.

Solutions might include a stronger checks and balance system. For instance, some home care agencies have a nurse review all drug profiles documented by therapists, and that sort of agency policy could improve regulatory compliance, Krulish says.

5. Reassess staff competency.

Once staff training and education are complete, it's time to administer the same competency tests that were used previously.

If the staff's skills were assessed through a simulated lab, and problems were identified and

handled with additional training, then the reassessment should also be a simulated lab.

"When a surveyor asks how you determined therapists were competent in competency assessment, you could go back to your files and show their improvements in testing," Krulish explains. "When you look at competency assessment in that way, it's very second nature, and it's common sense." ■

Ensure therapists are competent

Here are tips on testing assessment skills

Therapists and nurses need to excel in conducting the assessment thoroughly and competently and documenting their assessment findings on the Outcome and Assessment Information Set (OASIS) form.

"Competency in assessment skills and competency in documentation are two different tasks," says **Linda Krulish**, MHS, PT, president of Acworth, GA-based Home Therapy Services. "You may have clinicians who are good at assessments, but don't document well enough to take advantage of all the data they've gathered."

Special Report: Checking Staff's Competency

Or the problem could be the clinician may be unskilled at patient interviewing, history taking, or observation, and the problem is that the clinician needs to be trained to perform better assessments.

Ways to screen

Quality managers can measure how competent staff are at conducting assessments through these methods:

• **A self-assessment checklist:** This method is an easy way to screen for training needs.

Here, a quality manager could ask clinicians to identify areas they feel competent in and areas they need additional training.

For example, the self-assessment checklist could ask, "Can you complete the drug regimen review?"

The drawback to this method is that it relies on the test-taker's self-assessment of skills, and this has a potential bias. A therapist may want to look more competent and report assessment details that he or she doesn't follow, or the therapist could desire to appear less competent in hopes of not being asked to perform any assessments.

• **Verbal or written test:** This is an objective test that relies on their knowledge, but not their performance. For example, ask the clinician what the process is for determining if a patient is eligible for a Medicare home health benefit. Instead of asking them if they know how to do it, ask what the benefit is and how do you determine if a patient is eligible, Krulish suggests.

• **Patient/staff feedback:** An informal way to assess competency is to listen to what patients and staff have to say about a particular clinician's competency. For example, a patient might call to say that a therapist came to the patient's home and didn't know how to take a blood pressure reading, Krulish says.

"Or if two clinicians were in the home at the same time, one may observe that the other staff member was not competent in a certain skill," she adds. "This is more informal and cannot always be counted on, but it could be used to identify when there's a potential need for training."

• **A clinical record audit:** An agency looks at the OASIS data responses and compares them to other documentation on the patient's chart to see if they are consistent.

For example, a therapist or nurse might mark on an OASIS assessment that the patient did not have pain interfering with function. The chart auditor would review the clinical documentation of other care providers who saw the patient on or around the date of the OASIS assessment. If the documentation shows that the patient refused activities with the home health aide because of pain, then the auditor has identified a discrepancy which may be due to inaccurate assessment or documentation of OASIS data.

"What we're trying to do is assess whether OASIS data is accurate," Krulish says. "So if someone turns in a comprehensive assessment form with all this information about Mrs. Brown, how do we know this is accurate?"

• **A simulated setting:** The agency could set up a lab with a pretend patient who has specific diagnoses and problems. Then the clinicians would go through the process of evaluating the pretend patient.

"It's not as costly as having two people go out into the home for every clinician, but it's also not as realistic," Krulish says.

• **A clinical visit audit:** Two clinicians conduct a joint visit, where one clinician conducts the comprehensive patient assessment and both document the OASIS responses. After the assessment visit, the responses are compared and the reason for any discrepancies is investigated.

"In my opinion, this clinical visit audit is the most valuable auditing method because you can identify competency in assessment skills and documentation skills in a real-life setting," Krulish says. ■

Create tests measuring exactly what you want

Expert offers practical advice on writing tests

Competency testing is a difficult area for a quality manager to tackle because there are few standards and guidelines to light the way.

While the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires accredited agencies to provide competency testing, JCAHO leaves the details and definitions up to the provider.

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"For the most part, you have to define it yourself and set your own standards, developing a program around it; that's time consuming and difficult to do," says **Marilyn Hanchett**, RN, MA, CPHQ, director of performance improvement for Express Scripts Infusion Services in Maryland Heights, MO. Express Scripts is a pharmacy benefit management company, and Hanchett works in the home IV therapy division.

"At a point in time when most providers are very financially strapped, and resources are limited, you kind of start off at a disadvantage," Hanchett says.

Still, quality managers cannot shortchange the competency test-writing process, she adds.

"The biggest mistake I see people make is they say, 'OK, I have an employee who is an RN and I want to test her for competency,' and then they jump from looking at the rule to wanting to write the examination," Hanchett explains.

This will result in the test writer skipping the important steps of writing a detailed analysis of the employee's job and analyzing the employee's expected skills level and knowledge of tasks in various categories.

Also, it's not a good policy to use a generic competency exam for a licensed clinician. "What an RN is doing in St. Louis may be different from what an RN is doing in Chicago," Hanchett explains. "It ultimately needs to be tailored to that agency's particular job description."

Plus, JCAHO expects agencies to customize their competency exams and correlate them with their job descriptions. So even if an agency chooses to buy a generic competency exam, it will need to be adjusted according to that agency's particular needs and job descriptions.

So if a quality manager chooses to use a generic test without adjusting it, then the completed competency exam likely will not accurately describe a particular employee's skills level, which is what the JCAHO surveyor will want to see, Hanchett says.

What makes a good question?

Quality managers and administrators who have little experience in test writing might contact a professional organization, such as the National Association for Healthcare Quality in Glenview, IL, to see when they will offer the next test-writing seminar or workshop, Hanchett suggests. "They teach you what goes into a good question, and it's very hands-on information."

Hanchett offers these suggestions on how to write a competency exam that will fairly and accurately assess an employee's skills and knowledge:

1. Write a thorough job description.

The job description is crucial because it will describe exactly what tasks are required of a particular job.

"A well-written job description can help you analyze the categories of duties, so when it comes time to develop a program and prepare an exam, the exam should tie in with the job description," Hanchett says.

For example, if a home care aide's job is mostly to provide personal care or support for activities of daily living (ADLs), then 80% of the job description and exam should address those tasks, she adds.

In writing the job description, managers should consider whether the professional staff will function within a generalist model or a more specialized model. And keep in mind that if clinicians are expected to be generalists, then it's

Clip these competency item writing reminders

Everyone who has ever taken a high school or college test has had some complaints about how the test was written so poorly that no one could have understood what it was the teacher wanted them to know.

Those complaints weren't simply sour grapes over a failing grade. Many tests are poorly written because the instructor or test-writer hasn't taken the time to make sure the test items were properly written.

Marilyn Hanchett, RN, MA, CPHQ, director of performance improvement for Express Scripts Infusion Services in Maryland Heights, MO, offers these suggestions for writing fair and relevant competency test questions:

- **For each item:**

— expose the item to expert review;
— use correct grammar;
— avoid irrelevant sources of difficulty;
— use an efficient format;
— eliminate irrelevant clues.

- **For the stem (statement description):**

—use clear and simple language;
— avoid technical or difficult vocabulary;
— present a single, clearly formulated problem;
— avoid negative wording;
— avoid questions relating to definitions;
— put as much wording as possible into the stem;
— avoid "window dressing";
— include all of the information or qualifications needed to choose the right answer.

- **For options and distractors:**

— select and develop the distractors with care;
— make certain that the key is correct AND clearly the best;
— make the distractors attractive to the uninformed;
— arrange the responses in a logical order;
— do not use "all of the above" or "none of the above";
— make the distractors independent;
— make all options grammatically correct and parallel. ■

much more difficult to write a competency exam, Hanchett says. "A nurse who is handling very complicated infusion therapy and chemotherapy at the patient's home might never have touched any pediatric patients."

If the agency suddenly wants to send her to do a pediatric assessment, a quality manager has to wonder how thorough the nurse will be when dealing with a type of case she rarely handles.

Those types of possibilities should be addressed in the job description. If the nurse is expected to be competent primarily in infusion therapy and chemotherapy, then the job description should reflect that the person's focus will be primarily in that area.

2. Write the exam.

The exam should be tailored from the job description, Hanchett says.

If the job description states that a particular job requires primarily Skill A, about half as much of Skill B, and a little of Skill C, then the quality manager could assign a percentage to each of those skills, i.e.: 60% of Skill A; 30% of Skill B; 10% of Skill C.

Next, take those percentages and write competency exam questions that fall into one of those three categories, with 60% of the questions pertaining to Skill A, and so on.

"That's one way of organizing it to make sure you're covering all the areas in the job description," Hanchett explains.

Now it's time to decide what type of questions to write. The easiest questions to write and answer are the simple recall questions that test a person's memory. Application questions are a little more difficult because they ask a person to figure something out, such as a mathematical equation, and the third type is analysis questions, which require the test-taker to user higher cognitive thinking skills in determining an answer. **(See test-writing tips, inserted in this issue.)**

"A good test should cover all three types of questions and cover all the content in the job description in proportion relative to the job role," Hanchett says.

The written exam typically is between 50 and 150 questions, with 100 being the average. The more complex the job description and the higher the level of skills for a particular job, the more questions are needed to assess competency.

Another simple rule to follow is that the competency exam should include mostly multiple

choice questions. These are more time-consuming to write, but true/false and fill-in-the-blank questions are a less precise measure of competency, Hanchett says. **(See competency item writing reminders, p. 41.)**

Competency exams also should include an equally important second part, which is the performance-based part of the test. This is where a supervisor provides one-on-one, hands-on observation of how an employee handles various job tasks.

3. Assess the test results.

"You have to test the test and sit down and analyze how people performed on those questions," Hanchett says. "If you have people routinely doing poorly on the exam or falling short, then it's entirely possible there is something wrong with that testing instrument."

To assess the test, a quality manager could subject it to a peer review process, giving it to other managers for comment. This is a little tough on the ego because there's likely to be criticism of how various questions are written, but it's one way to make sure the test is as objective as possible.

The ultimate assessment of a competency test is when it's given to staff and scored. The scores shouldn't be uniformly high, which may indicate the test is too easy. And there shouldn't be a greater-than-expected number of poor results.

One check and balance of the written exam is the performance exam. Clinicians who do well on the written part of the test should also do well on the performance part, and vice versa. If a quality manager notices a trend that indicates the staff are doing well on the written part but not on the performance part, then this means there's a problem with the written part of the test.

For example, suppose a nurse answered all the questions correctly about caring for an indwelling urinary catheter. But when tested in the field, the nurse couldn't perform the task correctly. This type of discrepancy means there's a problem with the test, Hanchett says.

"You may have to explore the content of those questions because maybe they're too easy or they're asking things that are not linked to the performance aspect of the job," she says. "The questions have to provide the springboard to actual performance and skills in patient care."

This is another reason why a good competency exam includes more than simple recall/memory items. Some of its questions should include trouble-shooting scenarios, such as, "You arrive at a home and saw this sort of problem with a catheter, so what would you do first?" Hanchett says.

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"You're not just testing the ability to remember, you're testing the ability to think through and problem solve," she adds. "Granted, on a piece of paper you can only do that to a limited extent, but you're building a platform of knowledge so that the next time the employees go into the field, they're at least doing that from a stronger basis."

4. Retest staff.

After analyzing test results and revising questions that appeared to be too easy or unnecessarily difficult, a quality manager could retest employees to again assess the test's objectivity and ability to assess competency. Or, at least, the quality manager could have the employees who failed to make the passing score retake the test after they have received additional training in their deficit areas.

"If a person doesn't pass, this is a trigger for individual training, so you might assign a preceptor or do formal classroom training," Hanchett says. "The competency assessment is never intended to be a punitive exercise; it's to benefit employees in terms of professional and paraprofessional development."

The passing score could be 90% or 80% to 85%, depending on the skill level of a particular job.

"In an ideal world, you want the scores to be as high as possible, and after that it is a strategic management decision," Hanchett says.

"Generally, the higher the level of technical skills, the higher the expectation level on the exam; so a generalist nurse might have a passing score at 70% to 75%, but an IV therapy nurse might have a passing score at 80% to 85%."

The second test could be exactly the same as the first one, or it could have the same components, mixed in a different order to avoid the problem of a person scoring well due to good recall of test answers. Quality managers also could change the phrasing slightly. ■

Agency's efforts combine quality, education

QI program part of efforts to improve wound care

A recent wound care improvement program at HealthReach HomeCare and Hospice, based in Waterville, ME, is dovetailing neatly with the agency's emphasis on wound care in its annual competency for nurses.

Both are steps in HealthReach's ongoing efforts at improving wound care, which have included appointing a wound care consultant to work with nurses in the agency's three offices in central Maine.

Jennifer Wing, RNC, HealthReach's wound care consultant, was also named staff educator in last June. She says the decision to focus on wound care education was a natural fit.

"I could make myself available to the various offices in our agency throughout weekly visits to help them assess difficult wound care patients, so it tied in with that," she says.

Audits revealed problems with documentation

Judy Marshall, RN, quality improvement reviewer for HealthReach, says the decision was made to merge the selection of wound care as the nurses' annual competency with this year's quality improvement project.

She says chart audits showed problems with the documentation of wound care visits, particularly in the area of patient education.

"We weren't really sure when we were teaching wound care whether the client was really ready to learn or understood what they needed to do," Marshall says. "It was because there was inconsistency in documentation. Nurses go over this with the clients, they go through the teaching process, but it just somehow or other doesn't get documented consistently, so they can really say what the patient is learning."

It also can lead to communication problems between the patient's primary nurse and per diem nurses who perform subsequent visits.

"The problem is that perhaps the right hand doesn't know what the left hand is doing sometimes," Marshall says. "Something was discussed with a client or a change was made and it wasn't written, so the next person coming in wasn't aware of the change. If the change was written, perhaps the nurse didn't read the last two notes and pick up on something new.

"Those are the kinds of things we're trying to get people to think about to concentrate on," she adds.

Begin with education

After the chart audit, which looked at records from October through December 1999, the next step was Wing's education program, held in January and February for all nursing staff.

Beyond the general overview of wound care — reviewing different types of wounds, including surgical, diabetic, and pressure ulcers — the education component also would look at documentation issues.

"[Wing] and I did meet and we did come up with some criteria, certain things we did want to look for, mostly on our documentation," Marshall says. "We wanted to have the nurses write a standard wound assessment, with wound descriptions. We want them doing certain things on every visit, such as taking a temperature."

Marshall says a wound measurement is to be done weekly by the primary provider, and that provider is responsible for making any changes in the plan of care.

"She would be responsible for calling the doctor rather than having per diems going out and seeing a patient and deciding that maybe a change needs to be made here. A per diem would have to go through the provider."

Another priority was measuring and documenting a client's readiness to learn, which is accomplished through recording comments made by the patient and noting any necessary demonstrations. Responses such as "I can't do that" or "I don't feel comfortable taking care of that" would raise a red flag, requiring follow-up, Marshall says.

"We want the providers after every visit to make a follow-up plan and we'll be looking to see whether the plan is followed on the subsequent visit in the clinical note," she says. "The nurse might document ongoing teaching and support, and four or five days later there may be a response in which the client says he or she might consider trying to do the wound care."

Wing says the emphasis on documentation composed the meat of her program. Most of the information was review for staff, including a discussion of sterile vs. clean techniques in wound care.

"Because a lot of our clinicians are coming from an acute-care facility where sterile technique

is the gold standard, we did talk about that," Wing says. "In dealing with chronic wounds, it hasn't been proven any more beneficial to use sterile technique over clean technique. In home care, it's been pretty much the standard that we use clean, no-touch technique."

Wing distributed an educational packet that included nutritional handout, a glossary of terms, and a magazine article discussing sterile vs. clean technique.

The packet also included a list of various wound care products. Marshall and Wing say there are no plans to immediately change the types of supplies currently in use at HealthReach. That inventory was reviewed about a year ago, Marshall says.

Part of Wing's role is to be available to nurses to consult on complex cases, Marshall says. If a wound hasn't shown signs of improvement or the nurse has a question, Wing can accompany a nurse on a visit and offer suggestions.

Following up on education

With the new emphasis on documentation, revisions are under way to the clinical note to include a specific area for teaching, a place to record the patient's response to teaching, and a space to note a plan for the next visit.

A post-audit also is planned to gauge how well nurses are responding to the education.

Marshall says supervisors will conduct assessments as part of the competency, visiting homes with nurses so they can demonstrate appropriate wound care, assessment, interventions, and patient education. "We'll be looking to see if the procedure is explained to the patient and family. We'll certainly be looking for hand washing — that's a big thing."

Those assessments will continue through 2000, she says.

Although information isn't available yet from postaudits, Marshall says she's already seeing anecdotal evidence that HealthReach's ongoing wound care efforts have been successful. "Overall, it's been very beneficial for the nurses. I think that it's certainly made a difference for some clients who have had some of the more severe chronic wounds."

Marshall says agencies looking to make changes in wound care should make efforts to tap expertise they have on staff.

"[Wing] has been a tremendous help to the clients and to us," she says. "She provides that direction that sometimes we need [when a nurse is unsure of the next step to take with a difficult case]. Now we know we can consult with her and she can really give us her professional opinion."

For her part, Wing hopes to revisit wound care on a yearly basis to keep staff up to date with rapid advances in wound care products. She'd also like to conduct a wound care vendor fair so that vendors could show staff newer products and how to use them.

"I think it would be beneficial to revisit that yearly because there are new products out there that we're probably going to be using more and more, with the coming [prospective payment system]," she says. "We'd also try to tie it in with documentation, so we can continue to do thorough assessments and documentation." ■

SOURCES

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CA agencies fighting nursing shortage

Dearth of RNs, LVNs to widen in next few years

Just as California tends to lead the nation in lifestyle trends, the state's home health industry is experiencing the leading edge of a nationwide shortage of nurses.

The state currently ranks near the bottom of the nation in the ratio of RNs to population. And it stands to only get worse. A study conducted by the California Nursing Work Force Initiative predicts continued shortages in all sectors, including home health, where the demand for RNs is anticipated to grow 11% by 2002. Home health demand for licensed vocational nurses is expected to increase by 41% during the same period.

Several factors are causing and exacerbating the shortage, say **Connie Little**, RN, MS, senior vice president, and **Kerry Rodriguez Messer**, director of policy, advocacy, and public affairs for

the California Association for Health Services at Home, a nonprofit group representing the state's home health providers.

First, even compared to an overall booming U.S. economy, California is doing particularly well, driven by the high-tech industry.

"When that happens, other opportunities open up for those who maybe traditionally would have gone a caregiver path," Rodriguez Messer says. "They may take another path because there are industries that are booming so much where the compensation is very high."

Meanwhile, state law requires one year of experience for home care nurses at licensed agencies, while other employers such as hospitals can hire nurses right out of school. Only recently did the state allow foreign experience to count toward that one-year requirement.

And other health care employers are upping the ante by offering such incentives as signing bonuses — an option home health agencies rarely have with today's tighter budgets.

Little says the crunch is causing agencies to get creative. "Our members are trying to recruit at churches, at the vet, at the manicure shop, anyplace that people sit and talk. They have their staff recruit other nurses or LVNs [licensed vocational nurses]."

Coping with the crunch

Two California agencies — Pro-Care Home Health Services in Sacramento and Angeles Home Health Care in Los Angeles — that are weathering the tight job market use a variety of methods to reach out to nurses and retain the ones they have.

David Dial, Pro-Care's owner, CEO, and administrator, calls retention a big part of his recruitment plan. "Obviously, if you keep your employees, you don't have to recruit. The biggest efforts are usually made to replace employees that unfortunately you've driven off."

Among his retention tools are monthly birthday lunches for employees, an employee of the month program, a "safety bingo" game offering prizes for injury-free workdays and a year-end party with dinner and dancing.

"We spend thousands of dollars on it. I would guess it's the largest company-paid party of its kind in the Sacramento area in home health," Dial says. "There's an awards presentation for employees of the year and we give out 15 superior effort awards."

Beyond the material offerings to employees, Dial says he makes a point of letting his employees know how much they are valued. It's not lost on him that many who come to Pro-Care from other agencies do so because they feel underappreciated.

"On Fridays, when most of the nurses come in, we all make serious priority efforts to get out there and greet them and let them know they're doing a good job," he says. "A lot of respect for the nurses and pats on the back and some programs to let them know they're important and you've just almost cut your recruiting expenses at least in half, if not by 75%."

Mary Dete, PHN, director of professional services for Angeles Home Health Care, says she's heard similar complaints from prospective employees about lack of respect from other health care employers.

"The more hospitals mistreat their nurses, the better we do," she says. "When they play havoc with their schedules — the 10-hour day, the 12-hour day, when they don't do things that enhance the practice so the nurse can build a niche — then they're asking for it."

To help keep nurses, Angeles hired an extra scheduler, to work out scheduling problems and offered the option of a modified part-time plan for staffers. "I think it's helped us retain a number of individuals who had come on intending to work full time, who'd had family life changes — either child care or parent care or work requirements for spouses, something that they couldn't control and hadn't anticipated," Dete says.

At Pro-Care, building and maintaining a good relationship with the nurses turns them into enthusiastic recruiters, spurred on by incentive programs that reward them for referring a nurse who signs on to the company, Dial says. The incentive usually is a few hundred dollars if the referral is hired and stays with the company for a specified length of time. "I have one nurse who's brought me six people who have been with us now for over a year."

As a result, Dial says he spends no money advertising for recruitment and has managed to fill needed slots in his agency for all the major specialties that he needs.

At Angeles, an intensive orientation program prepares recruits for what they'll find on the job. It includes a one-week, 40-hour classroom component and a one-week mentorship in the field, where the nurse is paired with an established employee who can demonstrate how things are done and sign off on return demonstrations.

After that, the employee spends 90 days in probation and his or her paperwork is reviewed by

educator or a designated nurse.

"Our goal is to build them right and keep them," Dete says. One idea she's seen used elsewhere and would like to implement at Angeles would be a ride-along day in which the prospective employee spends a day with a mentor just seeing how her day goes. The idea is to give recruits a true picture of what a job in home health is like, so they know what they're getting into.

"People who don't drive much, who don't know how to organize and manage time very seldom come up to speed on those skills," Dete says.

Strategies for a more diverse workplace

One recommendation from the California Nursing Work Force report was to enhance cultural diversity in the work force, to help provide care for an increasingly diverse population. While the report specifically points to a lagging percentage of Hispanic/Latino RNs, Dete says there are other shortages, as well.

"In terms of a language subspecialty, we need those who are fluent in Korean or Farsi," she says. "That was new for us. I think we now have about 12 bilingual Korean RNs and three or four Korean-speaking home health aides. The Farsi population is beginning to increase both numerically in LA and in our staff. Those nurses tend to be at a premium; they are in very short supply."

Dial says his already diverse work force will be bolstered by plans to recruit overseas, specifically in the Philippines. A recent lawsuit forced the state to accept foreign experience toward the one-year home health requirement.

He says that with the help of a good immigration lawyer to obtain needed professional visas, it's a fairly simple process, and not even that expensive since the nurse pays her own travel and living expenses.

"I'm lucky in that our director of nursing, who's also my wife, is from the Philippines, so we go there once a year anyway," Dial says. "You simply go down to the hospitals there and ask if they want to go to the United States. You'll have 150 people lined up and you can take your pick from the cream of the crop of RN-level experienced nurses. Finding them is a no-brainer."

Dial says he hopes to be ready to make the first recruiting trip in the next few months. ■

SOURCES

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Discharge planning helps patient independence

Part 1 of a 2-part series

The pressures being brought to bear by the imminent change to the prospective payment system (PPS) have home health agencies talking about discharge planning and its role in keeping visits down and costs under control.

For two Texas agencies, the emphasis is on early discharge planning — beginning at admission — to help patients understand their role in taking control of their conditions and becoming independent.

"At the beginning, from day one, we talk to them about the fact that we are going to admit you and help you manage your care with the goal that

COMING IN FUTURE MONTHS

- ■ When the goal is patient independence, these tips will help
- ■ Expert offers advice on how to improve patient adherence
- ■ Use these tips to decrease medical errors
- ■ Teaching tool reduces stress for caregivers of dementia patients
- ■ Here's a plan to increase patient compliance with medication

you're going to be discharged and taking care of yourself," says **Lucy Lee**, RN, BA, MHA, CHCE, owner of Lee Health Care in Hamilton, TX.

"At the same time, knowing you can call us any time, even if you're not our patient actively, we'll still be there for you," says Lee, who is also president of the Texas Association for Home Care. "We give the reassurance that we're not going to leave them high and dry, but we're going to work with them toward their reaching a point of independence so they can be discharged."

Agencies also need to be very creative in helping patients piece together support systems of family, friends, and others to maintain that independence, says **Emily Tripp**, RN, MED, CHCE, group vice president for home care and hospice for the Visiting Nurse Association of Texas in Dallas.

It's particularly important now, as the population ages, she says. "The average age of our patients is 85. If their children are 65, they may be very healthy and able to help. But we have a number of people who are in their 90s or 100 or more, and *their* children are in their 70s or sometimes 80s. They maybe are sick or becoming more frail themselves, and it's not easy for them to take care of their family members."

Insight into PPS

The participation of Lee's rural agency in a PPS demonstration project has given her insight into the effects of PPS on an agency's resources. Her nurses have had to adjust accordingly.

Among the resulting improvements since the project began in 1996 — nurses are becoming more adept at quickly sizing up patients' abilities to participate in their own care and enlisting them in the drive toward independence.

From the first contact, nurses are trying to determine who can help with the patient, and how well the patient can follow directions.

"That's one of the things we look at on the first visit: What can the patient do for himself? What can he learn to do for himself?" Lee says.

She says that despite concerns about possible loss of assistance, patients can respond well to efforts at improving the efficiency of home care, if it's put to them properly.

"While before, patients enjoyed being dependent, now we can speak positively of independence and they like it," Lee says. "And we have found that families and community people, neighbors, are more willing to help than we thought they were."

SOURCES

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- **Emily Tripp**, Group Vice President for Home Care and Hospice, Visiting Nurse Association of Texas, 1440 W. Mockingbird Lane, Suite 500, Dallas, TX 75247. Telephone: (214) 689-0077.

She says staff have responded, as well. "I have learned nurses can turn on a dime and they want to please and they want to do what's right, so we gave it to them from that perspective. This is what we're doing now and it's going to be better for the patient when they are more independent and more involved in their own care."

Although there is not separate documentation directed at discharge planning, it is an element of

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the admission process. The goals for care include a plan for discharge within a certain length of time.

"We may not reach that goal, but then we'd set another goal that we would probably attain," Lee says. "And after a few months, we were much better able to see with accuracy when we thought we could discharge them."

Those forecasts, of course, vary radically depending on the type of patient being cared for:

• A patient being admitted while waiting to be transferred to a nursing home might require fairly intensive care for a brief period, from a few days up to a few weeks, Lee says.

In the meantime, the agency can provide personal care, nursing assessments for safety and sometimes needed therapy.

"It can be a pretty intensive plan of care, but the plan is always to discharge them to a nursing home when everything gets in order for that."

• For patients such as diabetics, who would be expecting to live at home indefinitely, it becomes necessary to assess their ability of self-care, including injecting themselves with insulin or using a glucometer.

"If it's a person who is pretty lucid and able to learn, then we can anticipate we can keep them on for a couple of months, teach them about the disease and about the injection routine," she says. "If it's more involved, at least we teach them to monitor their blood sugar, we give them the tools for recording and checking it."

• Patients with comorbidities, such as dementia or conditions affecting motor skills, have a much harder time learning self-care.

(Next month, Part 2: Social workers help find alternatives.) ■

CE objectives

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

1. Create education and quality improvement programs to improve wound care.
2. Employ recruitment and retention strategies to address nursing shortages.
3. Describe strategies for assessing staff's competence.
4. Understand the reasons agencies need thorough competency assessment and documentation. ■