Home Care Bulletin

March/April '99

American Association for Respiratory Care

Notes from the Chair

by Joseph S. Lewarski, RRT, RCP

If you are competing in today's home health market, the acronym "JCAHO" is a familiar and daily part of your business practice. Although an elective process, seeking accreditation through the Joint Commission on Accreditation of Health Care Organizations is as important to the home medical and respiratory business as pagers and cellular phones. Whether you are preparing for your first survey or have been accredited for years, keeping up with the Joint Commission's changes and staying compliant takes special effort. Words like "ORYX," "PI," "benchmarking," and "competency" keep us all scrambling to stay on the cutting edge of JCAHO policy and guidelines.

As 1999 takes us one year closer to the millennium, it brings with it an updated set of standards (1999-2000) from the Joint Commission. We are both proud and lucky to have David Gourley, RRT, a part-time home care surveyor for the Joint Commission who operates his own home health consulting firm (Horizon Health Services in Riverdale, NJ), as a member of the Home Care Section. By serving as guest editors for this issue of the *Bulletin*, David and his associate, Miriam Collins, RRT, bring us all up-to-date on the changes underway at the JCAHO.

Thank you David and Miriam. Your efforts are greatly appreciated. ■

Update on JCAHO Accreditation: ORYX and Performance Measurement

by David Gourley, RRT

By now, all JCAHO-accredited organizations should be familiar with ORYX, the Joint Commission's performance measurement requirement. All accredited organizations were required to submit their chosen performance measurement system (PMS) and their selected measures by December 31, 1998. The only exceptions were very small organizations (less than 120 patients per year), which are temporarily exempt from this requirement. These small organizations will be required to select measures from a list (available around October 1999) and collect data on these measures. Surveyors will evaluate the measures as part of the regular survey, and no data submission to the Joint Commission will be required. However, once core measures are approved, these organizations will be required to select a PMS and participate in the program just as larger home care organizations do now.

The Joint Commission Agenda for Change includes implementation of functional standards, improvement of the survey process, and integration of performance measurement into the accreditation process. The ORYX Vision is the establishment of a data-driven continuous accreditation process to:

- Increase the relevance and value of accreditation
- Support organizational process improvement
- Enhance comparative evaluation
- Strengthen and focus the standards development process

The December 31 requirement called for accredited organizations to choose a performance measurement system from the list of approved PMS. This list is in the Comprehensive

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Accreditation Manual for Home Care 1999-2000 and is available at the JCAHO web site. Accredited organizations were also required to choose at least two measures. The measures could be clinical/service measures or patient perception of care/service quality measures.

These measures must target at least 20% of your patient population. If 20% of the patient population is not reached with two measures, the organization is required to choose additional measures until 20% of the population is reached or a maximum of five measures is chosen. It is important to note that the Joint Commission did not require a signed contract with the PMS at the December 31 deadline. In subsequent years, the number of measures and percent of targeted population will increase.

Between December 31, 1998 and July 1, 1999, organizations will begin implementing the selected system and measures. If the organization wishes to change its selection, it must notify the Joint Commission before July 1. The PMS will collect and aggregate the data within its system and sets of performance measures. The organization will receive data from its PMS outlining its performance in the selected measures with the performance of other organizations choosing the same measures. At specified intervals, the PMS will submit this data to the Joint Commission. The Joint Commission has extended the date for data submission from the PMS to December 31, 1999. Originally, data submission was to begin on September 30, 1999.

The ORYX requirement should be part of the organization's overall performance improvement program, but it does not replace ongoing performance improvement activities. (Changes in the standards in the Performance Improvement function are described elsewhere in this issue.)

Expectations for the future include common measures for each accreditation program, data driven evaluation and accreditation, demonstrated improvement of performance, and public disclosure of meaningful outcome data. For more information on the ORYX requirement, contact the Joint Commission at (630) 792-5085 or visit the web site at *www.jcaho.org*. ■

Law and Regulation in Home Care

by David Gourley, RRT

Respiratory therapists working for home medical equipment providers are well aware of the multitude of laws and regulations impacting their companies. The following is an overview of the common regulatory bodies that apply to the medical equipment industry and home care organizations.

This overview is not meant to cover each specific organization's requirements but can serve as a guide in helping organizations stay in compliance. Each organization is encouraged to contact the specific regulatory agency to determine applicability to the services they provide. Also, these regulations are subject to change from time to time, so it is important to stay abreast of current regulations. The Joint Commission publication, "The Complete Guide to the 1999-2000 Home Care Survey Process: Home Medical Equipment and Clinical Respiratory Services," is also a good reference for additional information on these issues.

Department of Transportation (DOT) regulations are applicable in all states for:

1. Vehicles of 10,000 lbs. or more gross vehicle weight
2. Vehicles transporting a combined hazardous material of 1,000 lbs. or more

The following are general categories of DOT regulations:

- Placards for oxygen
- Vehicle decals
- Fire extinguishers
- Vehicle inspection
- Driver requirements and qualifications
- Controlled substances testing
- Emergency safety kit
- No smoking within 25 feet of vehicle carrying oxygen
- Driving rules
- Preventive maintenance
- Loading and unloading requirements
- Shipping papers
- Hazardous material training
- Inspection and testing of cylinders

The Food and Drug Administration (FDA) is responsible for ensuring the quality, purity, and traceability of drug products. Common FDA regulations for HME providers include:

- Registered as repackager (if involved in liquid or cylinder transfilling)
- Written procedures in accordance with Current Good Manufacturing Practices (CGMP)
- Maintenance of a consumer complaint file for oxygen
- Written recall procedure
- Lot or batch number tracking
- Appropriate testing for liquid oxygen and compressed gas
- Appropriate oxygen analyzers and calibration of analyzers
- Liquid oxygen scales (when applicable)
- Oxygen concentrators (adherence to manufacturers'specifications)
- Oxygen storage and transfilling area conformance

The Occupational Safety and Health Administration (OSHA) is the federal agency responsible for ensuring employee safety. The following are OSHA regulations applicable to the HME industry:

- OSHA 200 Form (exempt for ten or fewer employees)
- Blood-borne pathogens exposure

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Home Care Bulletin

is published by the
American Association for Respiratory Car e
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Kelli Hagen
AARC communications coordinator

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair and Editor
Joseph Lewarski, RR T, RCP
(440) 255-4468, ext. 106
joerrt@aol.com

Medical Advisor
Alan Plummer, MD (ACCP)
(404) 321-0111, ext. 3367
FAX (404) 248-5984
e-mail: alan_plummer@emory.org

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control plan
- Evidence of hepatitis B vaccination or declination
- Emergency Action Plan (exempt for ten or fewer employees)
- Right-to-Know Plan (exempt for ten or fewer employees)
- Material Safety Data Sheets (MSDS) on all hazardous materials used in the work environment.
- TB Risk Assessment Program
- Evidence of TB testing for at-risk employees
- Required postings
- Required training programs
- Suitability of work environment
- Fire extinguishers
- Personal protective equipment

In addition to these federal regulatory requirements, the respiratory therapist must be cognizant of other applicable laws and regulations.

Respiratory care practice acts in some states are very specific regarding home care delivery. Some states require licensure or registration for HME providers or require pharmacy licenses to provide specific services. These issues become particularly problematic when an HME provider services more than one state and is subject to varying requirements in the different jurisdictions. Additionally, providing services across state lines without the appropriate licenses will result in a Preliminary Non-accreditation or Conditional Accreditation decision from the Joint Commission. ■

Staff Competence

by David Gourley, RRT

In the Human Resources Management function of the Joint Commission home care standards, there are two standards related to staff competency. These standards have been challenging for HME providers. The first standard, HR4, requires that the organization assess, maintain, and improve the competence of all care and service staff members. The second standard, HR4.1, requires that the organization collect, aggregate, and analyze data on staff competence to identify and respond to staff learning needs.

The Joint Commission requires organizations to develop a competency assessment program to comply with these standards. The process must be objective, measurable, and systematic. To prevent confusion, the terminology "competency" and "proficiency" are synonymous for the purposes of this discussion.

The organization must define the competencies for each job category based on the care/service provided and the population served. Competencies must be evaluated by the conclusion of the orientation process. Organizations will need to determine how often the ongoing competency assessments will be performed. Additionally, competency assessment will have to occur whenever a new procedure is introduced or if updated technology or equipment is used. Some examples of competency assessments are CPR certification for competency in CPR, a written quiz on blood-borne pathogens, or a supervisory visit to the home to assess a respiratory therapist on a clinical skill, such as a tracheostomy tube change.

The organization must determine the method of assessing competency. Some skills may require direct observation during a home visit. Others may be assessed in a mock scenario or skills lab in the organization's facility. Written tests or quizzes may also be appropriate. If the organization is going to waive assessment, it must have a method for determining when education, training, or experience is acceptable as evidence of competence.

The organization must also identify the individuals who are qualified to perform competency assessments. In small organizations, it may be necessary to look outside the organization for an individual capable of reviewing specific competencies.

Documentation of competency assessment is required. The organization may develop its own process for documentation. If individual staff competency is identified as problematic during the competency assessment process or performance improvement activities, appropriate actions must be taken.

The second competency standard requires organizations to collect data on staff competence. The data must be aggregate and analyzed to identify patterns, trends, and needs. This information will be helpful in planning staff education and training needs, in-service education, and changes to the orientation program. For example, if a review of quarterly data from competency assessment forms shows that a majority of employees are having difficulties with OSHA regulations, OSHA training should be included in the next in-service program.

The last requirement regarding staff competence calls for the information collected on staff competence to be forwarded to the leadership of the organization. The important point to remember is that the ultimate goal of competency assessment is not to satisfy the Joint Commission requirements but to improve the quality of care and service that the patients receive.

For additional information on staff competence, refer to the Joint Commission publication, "Home Care and Hospice Staff Competence: Examples of Compliance." ■

Care Planning

by David Gourley, RRT

While care planning seems to come naturally to some health care professionals, respiratory therapists usually do not receive any formal training in the care planning process and are generally apprehensive at the mention of care planning. Care planning should not be a threat to any practitioner. It is probably something all of us have been doing for years – we just haven't called it "care planning." The Joint Commission has specific standards in the Care, Treatment, and Service function related to care planning.

Care planning is a planned approach to providing care, treatment, or service. This approach begins with the physician's order. Once we have received a physician's order, we begin the assessment process to identify specific problems and needs of the patient related to the provision of the care or service

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dered by the physician. The respiratory therapist will then set goals for solving the identified problems or eeds. Lastly, the therapist will implement an action to meet the set goals.

The following factors are common are planning issues for home medical quipment and clinical respiratory service providers:

Patient compliance with physician's orders
Educational needs
Safety/infection control
Environmental issues
Functional limitations
Activity restrictions
Communication barriers
Equipment maintenance

Care planning issues and patient goals need to be monitored on an ongoing basis. When issues are not resolved, adjustments need to be made to the care plan so that the goals can be met. This may include additional patient education, consultation with the physician, or referral to another appropriate organization such as a visiting nurse agency. New problems or needs that are identified during the course of providing care or service to patients must be dealt with as well. Goals will need to be set and actions taken to address the newly identified problems and needs.

The care plan should be reviewed and revised if any of the following situations occur:

1. Changes in the patient's condition
2. Changes in the psychosocial status
3. Lack of goal achievement
4. Changes in prognosis, treatment, equipment, limitations, or precautions.

If none of these occur, the therapist should review the patient's care plan within a preset minimum time frame.

An important point to remember is that care planning is not a form or document. Care planning is a process to be followed to achieve quality patient care and service. While it is essential that the HME provider develop an information management process for care planning, the mere documentation of a care plan does not mean that proper care planning has occurred.

For more information on care planning, the Joint Commission has an excellent reference, "Care Planning: A Guide to Home Care and Hospice Organizations." ■

.999-2000 Comprehensive Accreditation Manual For Home Care: Key Standard and ntent Changes

y Miriam F. Collins, RRT

A new chapter dealing with ccreditation Participation Requirements has been added to all manuals ublished by the Joint Commission. lthough these "participation requirements" are not standards, each organization must be in compliance with all these specific requirements to gain nd maintain accreditation status. The ome care organization must:

Provide the Joint Commission with all official reports and records, e.g., FDA licenses and/or inspections, pharmacy licenses, OSHA records, etc.

Notify the Joint Commission in writing within 30 days of any significant change in its organizational structure, e.g., changes in ownership or administration such as the CEO or clinical director, mergers or acquisitions, the addition or deletion of a new site or service, etc.

Permit the Joint Commission to gain access to information and conduct a survey even if it's an unscheduled or unannounced visit.

Comply with all ORYX initiatives, which are extensively detailed in numerous JCAHO publications.

Properly notify the community, its patients, and its staff of an upcoming initial or triennial survey.

Allow the surveyor to conduct any public information interview requested; if the person requesting the interview (patient, caregiver, member of the community, staff) wishes to remain anonymous, that request will be honored. The organization will be made aware of the concerns or issues raised during the interview but not the identity of the individual interviewed. In addition to the availability of the surveyor for public interview during initial or triennial surveys, the public may request to meet with the surveyor during any mid-cycle survey, such as a focus or extension survey.

- Provide the Joint Commission with factual information throughout the entire accreditation process; the truthfulness of the information provided begins with the application process and continues throughout the survey process and during the accreditation cycle.
- Accurately state or advertise its accreditation status and scope of services.

Non-compliance with any of the above participation requirements will result in at least a special Type I recommendation.

The Joint Commission has reformatted the standards into clearer, more user-friendly language; examples have been expanded and are more specific to the services provided.

Rights and Ethics

This chapter contains the only truly new standard in the Comprehensive Accreditation Manual for Home Care (CAMHC) 1999-2000, RI4.2. The intent of this standard is that clinical decisions be based on the patient's health care needs and not on financial decisions that affect the organization.

The organization's policies and procedures must guarantee that the patient comes first; policies must address services provided and any financial incentives to staff, managers, and physicians, if such an incentive program exists.

RI3, which deals with ethical issues in marketing, admission, transfer, and billing practices, is now an "A" standard.

RI5, RI6, and RI7 standards, which address issues in facility-based hospice organizations, are no longer "A" standards.

Assessment

Two standards, PE1 and PE1.1,

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which define the activities that comprise the patient assessment function, have been combined into one standard, PE1.

PE6, PE7, and PE8 standards, which address the assessment of specific patient populations, are no longer "A" standards.

Care, Treatment, and Service

The grid element Medication Monitoring has been changed to Patient Monitoring. This new grid element, which combines standards of medication monitoring and care plan monitoring, now measures the patient's response to care in all aspects of care and services. This grid now applies to all services and disciplines.

Two standards, TX2 and TX 2.1, which address physician orders, have been combined into one standard, TX2. TX2 focuses on obtaining a valid and complete physician's order prior to providing care or services or dispensing medications. The order may be verbal or written but must be complete as stipulated by law and regulation. The signature requirement for verbal orders has been moved to IM9.15, and the signature requirement for billing is at RI3.

The new TX2.1 standard states that a qualified individual must review all orders and prescriptions for accuracy and appropriateness prior to the delivery of care. The intent of the standard clearly states that it applies to all services and disciplines.

TX3 has been expanded and includes the statement that the organization provides care or services according to accepted standards of practice and *law and regulation.* Thus laws and regulations dealing with the provision of care and services will be scored here at TX3 and not in the Leadership chapter.

TX5.1 (formerly TX6.3) has an added element in its intent that addresses the medication preparation process. It deals specifically with the inspection of ingredients and final product by the pharmacist to avoid dosage and formulation errors.

Two standards, TX7.6 and TX7.7, which relate to reviewing and reporting adverse drug reactions and medication errors, have been moved to PI4.3.

TX5.2, TX6, and TX7 are now "A" standards.

TX9, TX10, TX11, TX11.1, TX11.2, TX11.3, TX11.4, TX11.4.1, and TX11.4.2 are no longer "A" standards.

Due to fewer standards in each aggregation group, it will be easier to get a Type I recommendation, especially in the "B" group of standards.

Education

PF4.9, the standard that addresses patient education regarding use of medications, is now an "A" standard. It is easier to get a Type I recommendation in this chapter.

Continuum of Care and Services

CC4.3.1 and TX5.1, which relate to communication of relevant patient information to the physician, have been combined into CC4.3.1.

CC1, CC5, CC5.1, and CC6 are now all "A" standards. It is easier to get a Type I recommendation in the "C" group of standards, which addresses coordination of care.

Improving Organizational Performance

The concepts in this chapter have not changed, but rewording and new scoring is present throughout. The essential processes formerly known as Design, Measurement, Assess, and Improve have been renamed Design, Data Collection, Aggregation and Analysis, and Performance Improvement.

PI1 and PI1.1 have been rewritten to emphasize the responsibility of leadership in the performance improvement process. These standards will be scored in the Leadership chapter at LD13.2 (formerly LD12.2).

PI2, PI2.1, and PI2.2 address the design of performance improvement processes.

PI3, PI3.1, PI3.1.1, PI3.1.2, and PI3.1.3 clearly identify the specific areas that should be included in the performance measurement.

PI4, PI4.1, PI4.2, PI4.3, and PI4.4 detail the quality of aggregating and analyzing performance measurement data.

In 1999, all home care organizations must now measure the following:

1. Any new or modified process (PI2.2)
2. Needs, expectations, and satisfaction of patients and family (PI3.1)
3. Medication use (PI3.2)
4. Care/services provided to high ris populations (PI3.2)
5. Areas targeted by the company fo further study (PI3.3)
6. Areas where improvement wa achieved to determine if it was sus tained (PI3.4)

Furthermore, data measured as pa of ORYX must be incorporated int the PI process for analysis (PI4.2 Some of these are new requirement for 1999. The new PI standards als require organizations to include review of the literature on commo sentinel events when designing ne processes (PI2); conduct a root caus analysis of all sentinel events (PI4.3 create an action plan to prevent futur sentinel events (PI4.4); and sustai any improvements once achieve (PI5).

All standards in this chapter ar now "A" standards.

Leadership

LD2.3.1 now requires all organiza tions to have an annual operating buc get, whether or not law and regulatio require it.

Although the standard LD5 (forme ly LD8.2) continues to require leade ship to comply with laws and regula tions, its intent has been rewritten t limit scoring issues to those relating to

- Individual and facility licensure
- Certification
- FDA, OSHA, and DOT regulations
- Health Care Financing Administration regulations
- National Fire Protection Agency regulations
- Violations that were known or shoul have been known by leadership

Recommendations regarding med ical gases, including liquid oxyge will no longer be scored here; they wi appear at EC1.5, which addresses haz ardous materials and waste.

LD8 (formerly LD7) deals wit written contracts and has additions t its intent statement. However, scorin related to missing elements of the writ ten contract will no longer exceed score of "2." The written agreeme must now also contain the role an responsibilities of the organization an the contracted individual or provide in:

- Admitting patients
- Assessing patients, including who responsible for initial and ongoin

"Key Standard" continued on page

"Key Standard" continued from page 5

assessments
- Care planning, including who is responsible for the care planning process
- Coordinating, supervising, and evaluating the care and services provided
- Scheduling visits or hours
- Discharge planning

LD13, the standard that deals with leaders setting expectations regarding Performance Improvement, and LD13.2, which is related to leaders adopting an approach to PI, are now "A" standards.

There is a new standard in the Leadership chapter, LD13.4.2, that was approved after the CAMHC was printed but still went in effect January 1, 1999. A copy of the standard can be found in the Jan./Feb. issue of the Joint Commission's "Perspectives" and on the JCAHO web site (www.jcaho.org). LD13.4.2 relates to having a sentinel event management program and requires a documented process to define, identify, and report (internally and externally) any sentinel event. This standard is also an "A" standard.

It is easier to generate a Type I recommendation in the "B" standards group of the Operations grid element.

Environmental Safety and Equipment Management

EC1 contains a more detailed explanation of the organization's environment and specifically includes delivery vehicles and staff cars.

EC6 is the standard that addresses an organization's incident reporting process. A definition of an "incident" and details of the activities that should be included in its process are now included in the manual.

EC10.1 and EC10.2 relate to the need for backup equipment when equipment malfunction may threaten the patient's health or life. Although there are no changes in these standards, there has been a further clarification in the intent statement.

EC1.5, implementation of the organization's hazardous materials and waste plan, is now an "A" standard.

EC2.1, the implementation of the organization's emergency preparedness plan, and EC11, (formerly EC10), which deals with the receiving and storage of medical equipment, are no longer "A" standards.

It will be easier to receive a Type I recommendation in the "B" group of standards, planning for environmental safety.

Management of Human Resources

HR3.2.1 has been eliminated, but its concept is included in HR3.2.

The competency assessment of staff has been moved from HR6 to the new HR4 and will address the competency of all staff, including home health aides and personal care and support staff.

HR4, as discussed above, is now an "A" standard.

HR5, which deals with the orientation of staff, is no longer an "A" standard.

It is now easier to receive a Type I recommendation in the "C" group, staff orientation, continuing education, and evaluation of staff.

Management of Information

The accuracy of data has been placed in two standards. The statement that the organization's data is accurate is scored at IM3.1, while issues regarding the falsification of data are scored at the new standard, IM3.1.1.

IM9.15 contains the signature requirements as outlined in TX2. As noted in the intent statement, each order must be signed and must include the date of signature. The 30-day requirement for authentication is no longer required, but the organization must continue to be in compliance with any time frame established by law and regulation and organization policy. The intent statement also states that the organization must establish a system for the timely receipt of authenticated physician orders when required by law and regulation. The organization will not be held responsible if physicians do not return orders, if it can show that it consistently followed a system to obtain the authenticated order.

The new standard, IM3.1.1, is an "A" standard.

It will be easier to receive a Type I recommendation in the "B" group of the Information Management Planning grid element and in the "B" and "C" groups in the Patient Specific Data and Information grid element.

Surveillance, Prevention, and Control of Infection

IC3, IC4, and IC5 are no longer "A" standards.

It will be harder to receive a Type I recommendation in the "C" group of standards, which deals exclusively with facility-based hospice care. ■

Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs).We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer-reviewed literature to support those suggestions.

Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at dhess@partners.org or fax them to 617/724-4495.

You will find copies of all the CPGs published by the AARC at:
http://www.rcjournal.com/online resources/cpgs/cpg index.html

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