

Tracer Methodology and the New Joint Commission Home Care and Hospice Survey Process

Part 1

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Unless you've been living under a rock for the last year, you probably know the Joint Commission survey process has changed for home care and hospice organizations. What you may not know is how the new tracer methodology works, what to expect, and how you should prepare for a survey under the new process. If your home care or hospice program is a department of a hospital, you may be unsure of what home care's role will be as the new survey process is integrated.

The new home care and hospice survey process will be addressed in this and the next two Accreditation Strategies columns (appearing in the November and December issues, respectively). Parts 1 and 2 describe the new survey process and tracer methodology. Part 3, in the December issue, focuses on changes in the new survey process and its impact on hospital-based home care and hospice providers.

Scheduling the Survey

The survey process begins when the Joint Commission receives the home care and hospice organization's request for survey and processes the application. If the survey is scheduled before December 31, 2005, the home care and hospice organization will receive at least

30 days notice of the first day for an announced survey because as of January 1, 2006, all surveys will be unannounced. Approximately 30 days in advance, the Joint Commission's account representative will send the survey agenda and the surveyor(s)' biographical sketch via e-mail to both the organization and all scheduled surveyors.

Presurvey Phone Call

The surveyor will still call the contact person identified on the survey application several weeks in advance of the scheduled survey to discuss travel logistics and the scope of the survey. When the presurvey telephone call is made more than 2 weeks out from the first day of survey, the surveyor will *not* be able to discuss the selected Priority Focus Areas (PFA)s and Clinical Service Groups (CSG)s, as they will not have been released from the Joint Commission's central office yet.

The reason that PFAs and CSGs are released only two weeks in advance of the on-site survey is the Joint Commission is trying to reduce the "getting ready" that historically has gone into preparing for a survey. This has also been the impetus for all Joint Commission accreditation surveys to be unannounced in 2006 and beyond.

Tracer Methodology

Tracer methodology is a term that describes the new survey process for home care and hospice surveys effective January 1, 2004. This survey style focuses the surveyor's activities on areas that the Joint Commission has determined to be paramount to assure high-quality, safe care. These survey focus areas are individualized to the home care and hospice program and based on output from the priority focus process tool that generates the patient categories that the surveyor should select to "trace" through their home care and hospice experience.

Tracing the patient through their care experience, the home care or hospice surveyor will further focus on standards that are applicable to the priority focus areas (PFAs) that are pre-selected by the Joint Commission's central office. Based on these PFAs, the surveyor follows the patient's care from start of care to the patient's current status. These are called *individual patient tracers*.

The surveyor will also conduct *system tracers*. These survey activities focus on processes, systems, and functions that are influential to the patient's care experience while also considering the outcomes and findings from the individual tracer activities. In the new survey process, many survey activ-

ities are the same (staff and family interviews, home visits); however, the specific activities and processes that comprise the tracer methodology and new survey process are different than the activities and processes of prior years.

Priority Focus Process Tool

Both the organization and the surveyor will receive the CSGs and PFAs electronically 2 weeks prior to the survey. Organization information is gathered and analyzed electronically using a set of defined automated rules or algorithms to produce the CSG and PFA outputs. For home care and hospice organizations, the following information is inputted into the Joint Commission's electronic priority focus process tool:

- Previous Joint Commission survey findings,
- complaint and sentinel event information that the Joint Commission is aware of,
- application for survey information, and
- if the organization is a Medicare-certified home health agency, data generated from Home Health Care Compare.

Home Care and Hospice Priority Focus Areas

If you were ever fortunate enough to have won the equivalent of the Joint Commission lottery and were selected to undergo a random unannounced survey (RUS), you'll recall that five grid elements were preselected for the surveyor to focus activities on during the 1-day survey. The concepts of focusing on a specific set of standards or PFAs are similar to

that of a RUS, except in a RUS all the grid elements were pre-set per calendar year and the PFAs are individualized for the organization. Similar to the grid elements of years past, are PFAs listed in Figure 1.

Two weeks prior to the on-site survey, between four and six PFAs are selected for the surveyor(s) to focus survey activities on during the individual patient tracers and system tracer activities. PFAs are the processes, systems, or structures within a home health agency or hospice that, according to the Joint Commission, can significantly impact the quality

What if a standard, not related to a targeted PFA, is found to be noncompliant? Does that mean that surveyor cannot "write them up"?

No, all standards have the potential for review and, as necessary, scoring. Under the new survey process, if an individual or system tracer activity does not identify any process or system vulnerabilities, the standard/PFA does not need to be investigated further. An example is the testing of the on-call system. If the surveyor does not identify any issues with the on-call system, the on-call system need not be tested.

Gone are the days when the director gave a formal "stand up" presentation with computer images to the surveyor(s). In the new survey process, information is to be shared as an interactive discussion and more conversational than a stand up "performance."

and safety of care and if not functioning properly, can create the greatest risk for a negative outcome (JCAHO, 2004b, GL-16).

The titles of the PFAs can be misleading as one PFA can cross multiple chapters and numerous standards and does not just include one chapter or one subset of standards in a chapter. For example, the Infection Control PFA is not just limited to the standards in the Surveillance, Prevention, and Control of Infections chapter; it also includes standards from the chapters of Provision of Care, Treatment and Services, Improving Organizational Performance, Management of the Environment of Care, Management of Human Resources, and Management of Information.

That's right; *the surveyor doesn't have to test the on-call system*. Previously, the survey process was very predictable and everyone knew that the surveyor would test the on-call system between the opening conference and the last day of the survey. If the surveyor were to test the on-call system, the timeframes would be the same, but there is now the *option* of testing the system.

Clinical Service Groups

Clinical Service Groups are another output from the priority focus process tool. CSGs are categories of patient services, selected by the Joint Commission, to focus the surveyor's activities during the individual pa-

tient tracers (JCAHO, 2004b, GL-3). During the surveyor planning session the CSGs identified will be used to select the tracer patients from the active patient list. The CSGs for home care and hospice are as follows:

■ **Home health:**

- Home health services.
- Home personal care/support services.

■ **Hospice:**

- Facility-based respite care.
- Facility-based symptom relief.
- Hospice in-home care.

■ **For Medicare-certified home health agencies:**

patients having:

- acute care hospitalizations,
- confusion difficulties,
- emergent care,
- pain interfering with activity,
- stabilized bathing.

patients needing:

- ambulation improvement,
- bathing assistance,
- oral medication management,
- toileting assistance,
- transferring assistance,
- upper-body dressing assistance.

Opening Conference

The on-site survey process begins with an opening conference that lasts approximately 15 minutes. At this time the surveyor(s) make introductions and become acquainted with the organization's staff. Then the surveyor(s) will discuss the PFAs and CSGs preselected and briefly describe the scheduled survey activities, review the agenda, and answer any questions.

When there are multiple surveyors, all surveyors are to begin the survey together at the same time; all are present for the opening conference and organization orientation so no duplication of survey activities occurs. The survey agenda will be developed as an overlay so that all survey activities and times are coordinated.

The length of the scheduled survey will vary by surveyor and in some cases the surveyors will not end at the same time. At times (due to surveyor illness, etc.) changes may need to be made, but the intent is for all surveyors to begin day one of the survey at the same time.

There's nothing to bring to the opening conference, except a smile.

Orientation to the Organization

Orientation occurs after the opening conference and lasts approximately 45 minutes. This activity is similar to the former leadership interview that occurred on the first survey day and is meant to provide the surveyor(s) with baseline information about the organization's structure to help focus subsequent survey activities.

In the surveyor's orientation, the participants should be prepared to discuss the following topics:

- organization structure;
- services provided direct and under contract;
- mission, vision, goals;
- strategic plans and goals;
- planning and decision making;
- governing body oversight and responsibilities, including involvement in safety issues;

- operational management;
- resource allocation and monitoring;
- contract management and oversight;
- patient safety initiatives, including selection of Failure Mode and Effects Analysis (FMEA) topic(s);
- implementation of National Patient Safety Goals;
- emergency management planning;
- performance improvement planning, priorities established, ongoing measurement initiatives, and improvements gained and maintained;
- allocation of personnel to participate in performance improvement activities to include adequate time, information systems, data management, and staff training; and
- if applicable, approach to the Periodic Performance Review and methods used to address areas needing improvement.

Obviously all these topics cannot be thoroughly discussed in 45 minutes. Don't be surprised if discussion on some topics is addressed during other survey activities.

Besides the home care director, others participating in this orientation should include at least one governing body member, the home care director's supervisor, and any other key home care leaders.

Surveyor Team Meeting/ Planning Session

The surveyor planning session, which includes the following surveyor activities, follows the opening conference and orientation:

- Review data and information about the home care and hospice services to decide how the PFAs will be evaluated;
- select the tracer patients based on the CSGs identified and set times for patient tracer activity based on home visit schedules; and
- plan survey activity assignments when there is more than one surveyor.

The time allotted for the initial planning session varies based on the organization's size and scope and survey length, but generally lasts from 1 to 2 hours.

There is no longer a separate agenda item called a document review session, although there is a review of documents. The surveyor planning session is a "modified" document review session. During the surveyor planning session, the following data and information (for the applicable track record time period of either 4 months or 12 months) should be made available for review:

- An organization chart;
- list of programs/services provided;
- performance improvement data;
- infection control surveillance data;
- ORYX data (OASIS data for Medicare-certified home health agencies);
- for facility-based hospice care, Statement of Conditions Plans For Improvement;
- most recent state licensure/Medicare certification survey report;
- requests for a Public Information Interview;

- follow-up document from its Periodic Performance Review, if applicable; and
- a list of all scheduled home visits for all survey days and for the locations included in the survey's scope. In the list include the patient's start of care date, diagnosis, discipline scheduled to visit the patient, service/skill to be performed by the scheduled discipline, and driving distance from the office.

The surveyor planning session is primarily time for the surveyor(s) only. The staff's involvement will be limited to providing additional clarifying patient and home visit information to assist the surveyor in selecting patient tracers, for at least the first day of survey.

Surveyors will meet on an ongoing basis to share findings, coordinate activities, and make plans for the next day. If there is only one surveyor, the surveyor will use this time to plan subsequent tracer activities and survey strategies.

Selection of Patient Tracers

From the list of patients regularly scheduled for a home visit for days of survey, the surveyor will use the CSGs and PFAs to select individual patient tracers. To expedite the patient tracer selection process, someone with an in-depth knowledge of the patients should be available to answer any questions. This person may be a home care or hospice scheduler, coordinator, or supervisor. When there are multiple surveyors, the surveyors will coordinate the tracer activities to avoid duplication of patients or overlap of home visits.



Figure 1. Home Care and Hospice Priority Focus Areas.

1. Assessment and care/services
2. Communication
3. Equipment use
4. Infection control
5. Information management
6. Medication management
7. Organizational structure
8. Orientation and training
9. Rights and ethics
10. Physical environment
11. QI expertise and activity
12. Patient safety
13. Staffing

Data from: Joint Commission on Accreditation of Healthcare Organizations, (JCAHO). 2004. 2004-2005 Comprehensive Accreditation Manual for Home Care. Glossary. (pp. GL-16). Oakbrook Terrace, IL: Author.

When the home health CSG has been identified, the surveyor will review the list of patients scheduled for home visits and use the following additional criteria to determine if there is a patient:

- less than 18 years old,
- taking a high-risk medication,
- using medical equipment, or receiving
- oxygen therapy,
- end of life care,
- ventilator care,
- maternal/child care,
- alternative complementary care,
- infusion therapy,
- blood or blood components,
- acute care following home care services, or
- personal care and support services (JCAHO, 2004a).

When one of the hospice CSGs has been identified (e.g., a patient receiving facility-based respite care, symptom relief, or in-home care), the surveyor will

Tracer Methodology Terms

Clinical Service Groups (CSG): Categories of patient services, selected by the Joint Commission, to focus the surveyor's activities during the individual patient tracers.

Priority Focus Areas (PFAs): The processes, systems, or structures within a home health agency or hospice that, according to the Joint Commission, can significantly impact the quality and safety of care and, if not functioning properly, can create the greatest risk for a negative outcome.

Individual Patient Tracers: Using the selected PFAs to follow individual patients through the organization's systems and processes, ideally in the sequence experienced by the patient.

System Tracers: Survey activities that focus on processes, systems, and functions influential to the patient's care experience while considering the outcomes and findings from the individual tracer activities.

Data from: Joint Commission on Accreditation of Healthcare Organizations, (JCAHO). 2004. 2004-2005 Comprehensive Accreditation Manual for Home Care. Glossary. (pp. GL-16). Oakbrook Terrace, IL: Author.

review the list of hospice patients scheduled for staff visits to determine if there is a patient less than 18 years old; and/or receiving:

- facility-based care within the past 12 months,
- continuous care,
- respite care,
- infusion therapy,
- alternative complementary care, or
- pain management therapy for uncontrolled pain (JCAHO, 2004a).

Individual Tracer Activity

A focal point in the new home care survey process is the individual tracer activity. The title is new, although the concept is not. The survey process has always focused on observing staff render patient care and conducting interviews with the patient and family. What is differ-

ent now is the focus on the PFAs selected, by following individual patients through the organization's systems and processes, ideally in the sequence experienced by the patient. Depending on the type of home care services provided by the organization, the surveyor may "trace the patient's care" within multiple home care departments.

Each surveyor will conduct several individual tracers per survey. The number of patient tracers conducted depends on the organization's size and the number of surveyors. For a home care organization undergoing a 2-day survey, four patient tracers would generally be conducted, time permitting.

Once the patient tracer is selected and the patient verbally consents to a home visit, the surveyor will review the patient's clinical record. The record is reviewed not to score the documentation but to ob-

tain details on the care the patient received and the patient's response to the care or services. Then the surveyor will "trace" the patient's care throughout the home care organization. This may lead the surveyor to the intake staff, billing staff, scheduler, coordinator, supervisor, and, of course, the staff rendering care and to the patient themselves.

Individuals involved in the patient's care are interviewed focusing on standards pertaining to the targeted PFAs. Interviews are specific to the patients and how the organization's staff provided care or services to/for that patient. The surveyor will also assess the communication, integration, and coordination among disciplines and, when applicable, departments, to determine whether there were any "vulnerabilities" in the care process.

Look for part 2 in next month's issue that completes the overview of the new survey process and tracer methodology. In December, Part 3 will focus on survey changes and their impact on hospital-based home care and hospice providers. ■

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