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IN THIS ISSUE

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Ethical issues in home health warrant HH-specific ethics committee

Concerns may change when nurses are guests in patients' homes

Are the medications safely out of reach of children? Can the family caregiver handle tasks required to care for the patient? Are family members following the wishes of the patient as indicated before they developed dementia? Is the patient safe in the home setting? Is the employee safe in the patient's home?

Home health nurses, who may or may not have the support of an ethics committee within their agency, face these issues on a regular basis. Even when home health nurses have access to ethics committees, not many take advantage of the support, according to experts interviewed by *Hospital Home Health*.

"The origin of ethics committees was to provide support to health-care providers who were faced with an ethical dilemma for which they needed objective guidance," explains **Sigrid Fry-Revere**, PhD, JD, medical ethicist and president of the Center for Ethical Solutions in Lovettsville, VA. "The purpose of an ethics committee or ethics service was to provide peer-to-peer support to encourage open discussion without intimidation or fear," she explains. By creating an atmosphere

EXECUTIVE SUMMARY

Ethics committees are responsible for evaluating and updating or creating ethics policies needed by the home health agency, but many agencies are not using their ethics services to provide needed support for staff members.
- Keep the process simple and easy to access so that employees are not intimidated about asking for help.
- Create a committee membership composed of different types of staff members, so everyone's perspective is included.
- Give employees an opportunity to participate in informal discussions, even when they don't have specific issues about which they are concerned.
- Develop a home health-focused committee that is familiar with specific situations faced by home health staff.

of open discussion, an ethics committee was designed to help healthcare personnel work through ethical problems and come up with solutions, she adds.

Although ethics committees still exist, they have evolved into policy review or creation groups, or they only discuss specific cases when a problem is brought to their attention, says Fry-Revere. This evolution has made ethics programs appear to be a formal, difficult-to-access process.

Within a hospital setting, informal discussion of ethics issues can be held at the coffee pot in the employee lounge or at a nurses' station, says Fry-Revere. There is no nurses' station for home health employees, she says. "Home health agencies might address some issues at case conferences, but those meetings are usually so crammed with items to be covered that lengthy discussions are not practical," she points out. Home health personnel also are working independently, so they don't have personal contact with other nurses every day during which a conversation can comfortably take place, she says.

For these reasons, it is important to offer home health employees an opportunity to participate in ethics discussions in informal settings, says Fry-Revere. "Ethics rounds or ethics lunches that bring up issues for discussion in a 'what if' approach are very effective," she says. She suggests lunches to which people bring their own "brown bags" as a way to fit people's schedules and create a non-threatening environment for discussion.

Create home health specific committee

Even home health agencies that are owned by or affiliated with a hospital should offer an ethics service specific to home health employees, suggests Fry-Revere. "When a patient is in the hospital, the hospital staff has total control over the patient's environment," she points out. "In home health, we are visitors in the patient's home, and the patient is king of the castle," she says. This creates a different situation when a nurse or aide is faced with situations related to family, unsafe living conditions, or unsafe work conditions for the employee, she adds. **(See page 27 for list of typical ethics issues faced by home health staff.)** "Hospital personnel cannot relate to these situations if they are only familiar with compliant patients in a hospital setting," she says. **(For specific tips on how to design an ethics program that is home health-focused, see page 28.)**

Creating an effective ethics service might mean a change in the agency culture, points out **Leslie Kuhnel**, MPA, clinical ethics officer for Alegent Health in Omaha, NE. "Creating a culture that views ethics programs or committees as a valuable and supportive resource, rather than a disciplinary or punitive body, is the first step," she says. At Alegent, a variety of direct caregivers serve on the committee, she points out. Kuhnel has worked with managers to define the role of the committee and provide experiences for deliberation for their staff.

"The other key [to success] is to make the discussion relevant to the experiences of staff,"

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says Kuhnel. For example, invite staff to identify a case or situation from their own experience to present to the committee rather than using only hypothetical case studies, she suggests.

Another way to expand the understanding of an ethics committee is to let your community know that you offer this resource, suggests **Mary Miller-Hyland**, RN, BBA, NHA, administrator of Winona Health's Senior Services in Winona, MN. "Our ethics committee has had very few cases to hear in recent years, so we used a community event to increase awareness of the support we offer," she says. **(See page 29 for event details.)** Even when home health or hospice employees need help, they don't have to appear before the full committee. "They might just talk with one or two members of the committee who can walk the employee, the patient, or the family through the process of determining the best decision, Miller-Hyland explains.

Having a home health employee on the health system's ethics committee is a big plus, says **Pam Slocum**, RN, director of home care and hospice for Winona Health. "Our social worker who serves on the ethics committee is often called upon by our staff to talk with families who might have to make the decision to move their family member from the home to another facility," she says. Because staff members are aware of the issues that might arise among family members, and because they know of the social worker's ethics committee experience, they can ask her to intervene at an early point in the process to minimize conflicts, she adds.

"It is important that employees realize that I am not the ethics police," says **Lucia Wocial**, RN, CCNS, PhD, nurse ethicist at Clarian's Charles Warren Fairbanks Center for Medical Ethics in Indianapolis, IN. "An ethicist doesn't tell someone what the right decision is; instead, an ethicist provides support while a person deliberates," she says. A good decision related to ethical issues is a decision for which a person can articulate how the decision was made, she explains. "Ethics is personal, but if people can get over their feelings that they have to defend their decisions and begin to have an open mind during discussions, reaching a decision will be less stressful," she says. "My job is to lessen the distress of people who care for other people." ■

Family issues, safety top ethical concerns

Ability to provide quality care may be hindered

One of the most attractive aspects of home health nursing is the constantly changing job — no two days are exactly alike. That same diversity also raises issues that hospital-based nurses don't face.

"The biggest difference between hospital care and home health care nursing is that I am inflicting my rules upon you in your home," points out **Lucia Wocial**, RN, CCNS, PhD, nurse ethicist at Clarian's Charles Warren Fairbanks Center for Medical Ethics in Indianapolis.

One example of a very touchy situation is a home health nurse caring for a patient on the liver transplant list. "What do I do if it is clear that alcohol has been consumed in the house, because there is an empty bottle on the table?" asks Wocial. "A nurse won't want to tell on her patient, because a patient who is still drinking is no longer eligible for a liver transplant," she explains. After deliberation and talking through the issue with someone, the nurse might decide to report only what she saw: the empty bottle. "In reality, the nurse did not see the patient drink, so it could have been consumed by someone else,"

she says. The importance of discussing issues in an ethics context is to help people avoid making decisions based on inaccurate information, incorrect perceptions, or untrue assumptions, she adds.

Most ethical issues for home health revolve around safety for the patient, the patient's family, and the employee, says **Sigrid Fry-Revere**, PhD, JD, medical ethicist and president of the Center for Ethical Solutions in Lovettsville, VA. A common concern when children are in the house with the patient is the children's access to medications, she says. There are times that families keep the medications out to make it easy for the patient or the caregiver, without thinking about the danger to children, she explains. "The nurse is a guest in the patient's home, so how far can she go when talking to family members about the danger of the medication?" she points out.

Unsanitary conditions for medications or for patients also raise questions for the home health nurse, who must decide if it is safe to leave a patient in a home with no water, no electricity, or no one to keep the home clean, says Fry-Revere. "Nurses have to ask themselves at what point does it become impossible to maintain the standard of care," she adds.

Safety of employees also can be a difficult issue for nurses. "Nurses want to take care of their patients — and they are reluctant to complain — but there are some circumstances that are dangerous for the employees," says Fry-Revere. "Aggressive dogs in the house, weakened or unstable flooring, or an intimidating family member, can create difficult situations," she says.

There are times, even when the family or patient initially may not agree, that care within a skilled nursing facility is the safest and best decision for the patient, says Fry-Revere. In these cases, talking about concerns with a third party can help the staff member figure out how to present the situation to a manager and to the family, she adds.

"One emerging issue that our home health ethics committee has discussed in recent months is emergency preparedness and surge capacity issues should care be diverted from hospitals to the home setting in response to a disaster or pandemic," says **Leslie Kuhnel**, MPA, clinical ethics officer for Alegent Health in Omaha, NE. "This discussion includes the ethical considerations related to the staff's duty to care in situations of increased personal risk." ■

Diverse committee and communication are key

Set up process that doesn't intimidate employees

An ethics service or ethics committee will look different in each home health agency, because the program should be geared to meet the specific needs of the agency, says **Sigrid Fry-Revere**, PhD, JD, medical ethicist and president of the Center for Ethical Solutions in Lovettsville, VA. "You do have to make sure the committee meets Joint Commission or other accreditation requirements, but be sure it will also address home health specific needs," she says.

Make sure that your committee includes representation from all service delivery areas and includes diverse professional representation in order to bring the variety of perspectives necessary for rich ethical deliberation, suggests **Leslie Kuhnel**, MPA, clinical ethics officer for Alegent Health in Omaha, NE.

"I think a home health agency could start educating staff members about the role of an ethics service by offering regular lunchtime discussions with a local ethicist," suggests Fry-Revere. The conversation should be run by a seasoned home health employee along with the ethicist, and it should be a free-flowing conversation about issues that might arise.

"Talk about the social worker who wants to do a favor for a long-time patient by taking her to a hair appointment for her 80th birthday," says Fry-Revere. "This action creates a liability risk for the agency, because transporting a patient is outside the social worker's normal job parameters," she says. In the conversation with staff members, ask them how they draw the line between professional and personal tasks without offending the patient or family members, she suggests.

A successful home health ethics program is less formal, focuses on education, involves peer mentoring, and channels questions to people who are open to discussing the issues with staff members, says Fry-Revere.

"Although information about the options for discussing ethical concerns should be covered in orientation, there is only so much you can do in an orientation program," says Fry-Revere. A better way to educate staff is to develop an ongoing, informal educational program that gives staff members a chance to attend even if they don't

have an issue to discuss, she says. "This increases the likelihood that the staff member will contact a member of the ethics committee when he or she does have an issue," she adds.

Home health agencies are stretched thin when it comes to resources and time for education, but Fry-Revere likes to describe ethics programs as a risk management tool. "Educate staff on situations that might arise and how they might handle them before they become a problem. By addressing ethical concerns proactively, you help employees learn to cope with difficult situations." ■

Take the medical ethics discussion to the people

Winona Health offers ethical support to members

Medical ethics is not the typical topic of free community health discussions, but the staff at Winona Health's Senior Services, as well as staff at Home Care and Hospice in Winona, MN, have found a welcoming audience for the talk.

"We had 12 people register for the program, then had a number of other healthcare providers come to the talk," says **Mary Miller-Hyland**, RN, BBA, NHA, administrator of Winona Health's Senior Services in Winona, MN. The speakers talked about professional conduct, advocating for patients' rights, and the importance of advanced directives. "Other people, who did not attend the program, contacted members of our ethics committee with questions," she adds. Information about the ethics committee at Winona Health was distributed with contact information for members of the committee.

Although staff members regularly receive information about resources available through the ethics committee, Miller-Hyland believes that home health agencies and other healthcare providers should let community members know that there is support for them as they face ethical dilemmas with decisions about family members. "Our goal is to help people have peace of mind about the decisions they make, and the best way to achieve that goal is to get folks together to talk about the issues. Having an objective, third party lead the discussion can make the discussion more productive." ■

Henshaw and Howard: Reform of OSHA is likely

Former OSHA, NIOSH heads predict change

Major reform of the U.S. Occupational Safety and Health Administration may be delayed by the ailing economy, but it is inevitable as the agency needs to adapt to the workplace realities of the 21st century, according to the former heads of OSHA and the National Institute for Occupational Safety and Health (NIOSH).

That is likely to mean tougher penalties and new standards, but also collaboration and flexibility, said **John Henshaw**, CIH, former assistant secretary of labor, and **John Howard**, MD, JD, LLM, former director of NIOSH, in a webcast by the American Society of Safety Engineers. Henshaw left OSHA in 2005 and now has his own consulting firm. Howard has been serving as a temporary senior adviser to Julie L. Gerberding, MD, director of the Centers for Disease Control and Prevention in Atlanta, who declined to reappoint him to his post last year.

Henshaw and Howard agreed that OSHA is likely to change significantly during an Obama administration — though probably not within the first two years — while stabilizing the economy takes priority. "The new OSHA needs to be reworked completely from stem to stern, and it needs to . . . [address] our current issues and our current work force," Henshaw said.

Some possible changes predicted by Henshaw and Howard:

- Tougher penalties for employers who violate safety standards.
- A revision of the permissible exposure limits for chemical exposures.
- A change in the balance between cooperative programs and enforcement.
- A new approach that requires employers to perform risk reduction but focuses less on standard setting.
- Greater involvement of employees in safety and health programs.
- A possible reduction in the OSHA resources devoted to voluntary programs.
- Restoring the requirement to report musculoskeletal disorders on the OSHA 300 log.

Henshaw and Howard noted that today's workers are more diverse and older, more likely to be independent contractors, and less likely to stay with a single employer over their lifetimes.

That is far different from the employment scene in 1970, when the Occupational Safety and Health (OSH) Act was passed.

Over the years, a number of bills have been introduced to reform OSHA. As a U.S. senator, Barack Obama had co-sponsored the "Protecting America's Workers Act," which would raise the penalties for all OSHA citations and would provide for possible criminal penalties for willful violations that result in "serious bodily injury" to employees. The maximum penalty would be $250,000 and 10 years for a willful violation resulting in employee death.

The bill, sponsored by Sen. Edward Kennedy (D-MA), also would extend OSHA coverage to public employees and would provide greater whistle-blower protections to employees.

"I encourage some of the reform legislation, as it pertains to criminal sanctions and increased penalties," said Henshaw. "The companies that are not performing should be hit with the proverbial two-by-four to get them to change."

But he added, "OSHA's objective is not to cite and penalize. Its overall objective has to be to create change, which means a safer workplace [that's] in compliance."

Rethinking the role of OSHA

A new direction for OSHA ultimately will require a new statute, contends Henshaw. "We're tinkering with a process or a statute that is out of date. While the tinkering may be useful long-term, it's not going to serve us well," he said.

OSHA also has been hampered by legislative actions, administrative review panel rulings and court decisions. It can take 10 years for OSHA to promulgate a new standard. There must be a mechanism for responding to new hazards that doesn't require lengthy standard-setting, Henshaw said.

"I do not believe, because of the dynamic nature of our workplaces today, that we can expect any agency to write enough standards to cover all the risks that workers are subjected to," he said. "Our best way to deal with that is coming up with some generic processes or systems that will ensure continuous improvement, continuous risk reduction beyond a specific standard."

Henshaw suggested that might be a standard that requires employers to have an injury and illness program and identifies risks and works to eliminate them.

A standard of that type exists in California, where Howard once headed Cal-OSHA, the state's worker safety and health program. He suggests a "hybrid" approach that includes some standard-setting but also relies on employers to assess and address risks.

Neither Henshaw nor Howard expect to see another comprehensive ergonomics standard similar to the one struck down by Congress in 2001. But Howard asserted that OSHA will need to address MSDs, which are the leading workplace injury. Action may range from increased education and assistance to employers to requirements for risk reduction or increased use of the "general-duty clause" to provide a workplace free of serious hazards.

"OSHA will become irrelevant if it can't handle this most prevalent of recordable injuries," says Howard. ■

Regulatory changes top list of 2009 challenges

PI activities, data collection, frequent surveys

The year 2009 will represent a year of change for hospices with new conditions of participation, greater scrutiny of claims, and new requirements for data collection. What is not known is how the economy, along with sociological and political changes, will affect the industry.

Political changes and the new administration might signal a focus on uninsured and underinsured adults as well as children, says **Jonathan Keyserling**, JD, vice president of public policy and counsel for the National Hospice and Palliative Care Organization (NHPCO). If President-elect Obama is able to implement changes that affect coverage of Medicare and Medicaid patients, similar changes will be seen in the private sector, he predicts.

As health care reforms are evaluated, hospice can be used as an example of integrated care model, Keyserling says. "We have 30 years of experience of providing care coordinated among different providers," he adds.

Susan Levitt, executive director of CNS Home Health and Hospice in Carol Stream, IL, says, "I'm not sure that a new administration means many changes for hospice because there is so much competition for Medicare dollars to support new programs." The change that is definitely coming is related to new regulations that hospice managers

learned about in 2008, along with more regulatory changes that should follow quickly, she says.

"Hospice managers have not had to face significant regulatory changes in 20 years, and there are many organizations that are not ready for change," Levitt admits. "We saw a good example of how unprepared many hospices are in July 2008 when we had to begin submitting visit data." Hospices that are affiliated with a home health agency, or hospices with managers that have a home health background, fared better in July and will be able to prepare for changes more easily because of the constant changes home health has faced in recent years, she says.

"Hospice managers that had no experience with reporting visits had to find ways to create reports and collect data that had never been collected," Levitt explains.

Meeting several requirements of the new conditions of participation (CoPs) will be a struggle for many hospices, she says.

"Measuring quality in hospice care is important, but it differs from home health because the patient's outcome in hospice is always death," she says. The performance improvement requirement in the COPs has some hospice managers asking themselves what to evaluate and improve upon, Levitt says. Improving the quality of care will require hospice staff members to evaluate clinical issues such as pain control, as well as education and family support, she adds.

Hospice rate reform will be a priority for the Centers for Medicare & Medicaid Services (CMS) in upcoming years, and the Medicare Payment Advisory Committee (MedPAC) recommendations should be watched carefully, suggests Keyserling. CMS has begun and will continue efforts to collect data from hospices to develop a reformed payment system, he says. "I hope that as we move forward, CMS will wait until there is enough data to develop a fair payment system," Keyserling says. "To move forward without complete data would be irresponsible."

The economy and budget concerns will create intense pressure on all health care providers to protect their reimbursement, he says. Associations such as NHPCO are taking steps to monitor and take action when needed. In fact, NHPCO filed a lawsuit to block implementation of a CMS rule that would reduce the hospice wage index and cut payments to hospices. Although the lawsuit has been dismissed, NHPCO and member hospices are evaluating other options to protect reimbursement, he adds.

Another effect of the economy will be fundraising for hospices, says Levitt. While large donations and grants still might be available, her hospice is seeing a drop in memorial gifts, she says. "This may also be due to a shorter length of stay for patients as they are referred later to us, so that they don't develop the same relationship with us as families that we serve for longer periods of time," Levitt says.

The downside to lower levels of giving will be the expected increase in requests for charitable care, she notes. "Our charitable care is completely funded by donations; so, if we receive fewer gifts, we won't be able to support as many patients," Levitt explains.

A positive change in the health care industry will be the growth in palliative care programs, says Levitt.

"We have a palliative care program that is separate from our hospice program, but benefits both our hospice and home health program," she says.

Hospices ideally are positioned to provide palliative care services to patients that are diagnosed with a potentially life-threatening condition but still are seeking curative treatment, Levitt says. "It is necessary to set the program up separately, with its own staff and medical director, and to bill through the home health program, but hospice managers have the experience with palliative care to develop and oversee it," she says.

Hospices that don't have an affiliation with a home health agency easily can partner with an existing home health agency to handle billing, suggests Levitt. "I certainly don't recommend that anyone start up a home health agency now," she emphasizes.

The key to surviving the challenges of 2009 and the following few years will be flexibility, says Levitt. "We have to learn to adapt, and we have to learn managerial skills that we haven't needed before and that we didn't learn in nursing school," she says. ■

Worker health doesn't stop at the hospital door

NIOSH promotes integrated WorkLife approach

One employee comes into your office with back strain due to patient lifting. Another is identified by the wellness program as having

uncontrolled high blood pressure. Those two issues may seem completely unrelated. But with its WorkLife Initiative, the National Institute for Occupational Safety and Health (NIOSH) is urging employers to integrate workplace safety with personal health promotion.

"Our fundamental message is if you are concerned about workforce health and well-being, think about work as a place to intervene," says **Greg Wagner**, MD, senior advisor for NIOSH and an adjunct professor of environmental health at the Harvard University School of Public Health. Wagner is leading the NIOSH WorkLife Initiative.

Employers are increasingly interested in promoting employee health as a way to reduce medical costs. Smoking cessation and fitness programs are commonplace. Yet those efforts will have limited success if they are not part of a broader emphasis on health and safety, says **Michael Silverstein**, MD, MPH, clinical professor of environmental and occupational health sciences at the University of Washington School of Public Health in Seattle and founder of French Loop Associates, a safety and health consulting firm in Olympia.

Silverstein served on a workgroup that developed a set of NIOSH recommendations, *Essential Elements of Effective Workplace Programs and Policies for Improving Worker Health and Wellbeing* (www.cdc.gov/niosh/worklife/essentials.html).

"Let's say you have a workplace where workers are exposed to hazardous chemicals or to smoke. The employer comes in one day and says, 'I'm introducing a smoker cessation program and I want everyone to participate,'" relates Silverstein.

"Unless efforts are made to address the kinds of exposures and hazards people face on the job, they may not feel very inclined to participate in an off-the-job risk," he says. "If we're going to be successful with public health at the workplace, we have to address both the workplace hazards and the hazards that exist when someone is off work."

There are many natural links between workplace health and personal health, says Wagner. For example, employees who drive at work and adopt work-related safety measures will maintain enhanced safety on the roads outside of work. The Veterans Health Administration is launching a pilot program at 10 facilities that provides integrated services for employee health and well-being, he says.

Meanwhile, employers must address the aging of the work force, says Silverstein. For example, aging may lead to changes in vision, increased prevalence of arthritis, and greater risk of back injury. "We've got to think about designing workplaces that are age-friendly," he says.

NIOSH suggests programs that are tailored to the workplace, incorporate employee participation, and include assessment of effectiveness. An employee health and wellness program should be developed in the context of a "culture of safety" that encourages worker input, NIOSH says.

Basic health screening is quite cost-effective, including screening for colon cancer, high blood pressure, and high cholesterol, notes Silverstein.

"There's a big gap between what's needed and what employers are actually doing," he says." It's a failure of vision and understanding rather than a failure of will and desire. A lot of employers just don't understand how effective these programs can be for relatively little cost — or how great the cost will be if they ignore it." ■

Unique model provides disease management

New approach includes face-to-face interventions

When the home health nurses at Little Rock, AR-based Baptist Health Home Health Network began observing that many of their patients had poorly managed chronic diseases and were not receiving evidence-based care, the network designed a new approach to delivering care for patients with chronic diseases.

The home-based chronic care model, implemented in 2007, provides disease self-management support to home health patients with diabetes, heart failure, coronary artery disease, chronic pulmonary obstructive disease, and asthma.

The National Association of Home Care & Hospice has given its Excellence in Innovation Award to Baptist Health Home Health Network in recognition of its work in creating a better way to deliver heath care to patients with chronic diseases.

The goal is to reduce health care utilization and the rehospitalization rate by engaging patients in disease management.

The initiative was so successful that the department created 2020 Health Solutions to provide similar services for employees of Baptist Health under an arrangement in which the home health network will share in any health system cost savings, says **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home

Health and 2020 Health Solutions.

"When we started telemonitoring services for our patients, we began noticing that many of our patients with chronic diseases were not receiving evidence-based medicine. What was more concerning to us was that many of these patients also had poor disease self-management ability and knowledge. They were not very engaged in disease management for a variety of reasons," Suter says.

The home health nurses were frustrated because they couldn't engage the patients in efforts to get their conditions under control and sometimes labeled them as noncompliant.

"At that time, our nurses didn't have the competencies they needed to engage the patient, especially those who are non-adherent to the plan of care or the competencies needed to help change behavior," she says.

Recognizing that the Centers for Medicare & Medicaid Services (CMS) and private insurers are moving toward value-based purchasing and that poor disease management affects patients' quality of life and often results in rehospitalization, the home health network made it a strategic objective to provide evidence-based chronic disease management, Suter adds.

The team researched the literature to identify the best practices in medical care as well as the best ways to educate adults and to effect behavioral change.

They looked at CMS demonstration projects that revolved around disease management and researched what the experts in the field were recommending.

"We took all of that and came up with a cohesive model for home health patients," she says.

Four areas of focus

The program has four key focus areas: a high-touch delivery system, theory-based self management, specialist oversight by advanced practice nurses, and technology.

"We found that when we provide all components of the program, rehospitalization drops significantly with the sickest of the patients," Suter says.

Before beginning the program, Baptist Health developed a chronic care course to teach clinicians how to effectively work with patients and change their behavior. The curriculum includes principles of motivational interviewing, methods to improve patient confidence with disease management, and principles of adult learning.

The course also provides information on expert guidelines and best practices for heart failure, diabetes, and chronic obstructive coronary disease care. When clinicians pass the course, they are considered a home-based chronic care specialist (HBCCS), Suter says.

"Most health care professionals don't receive this kind of training as part of their education. We work with the clinicians to help them hone their skills for patient engagement and behavioral change," Suter says.

The purpose of the program is to help people learn to keep their chronic diseases under control by modifying their behavior and adapting healthy habits, says **Paula Evans**, MSN, RN, CCM, CS, clinical practice specialist with Baptist Health 2020 Health Solutions.

"Our goal is to get our clients to make a commitment to take the smallest positive step. So many of them have lost confidence in their ability to stay healthy. If they can experience a small success, we can build on that. We use motivational interviewing to determine what they are willing to work on and to get to the crux of what might prevent them from being successful," she says.

In the home health program, the nurses work with patients who have been hospitalized because of exacerbation of their chronic disease as well as those who need home health services for other reasons.

"Patients are so overwhelmed when they are in the hospital that they often don't understand their discharge instructions or what they should do. They don't know what symptoms indicate that they should call a physician. They are a very sick population and require a good bit of support," Evans says.

Some patients are not referred for chronic disease management, but when the nurses go into the home, they realize that the patient also has a chronic disease that he or she is having trouble managing.

For instance, the nurse or physical therapist may be visiting the patient after a hip replacement and learns that the patient has diabetes and a blood sugar level that is out of control.

"We are seeing more and more patients with two or more chronic diseases. Due to overcrowded emergency rooms, a shortage of beds, and reimbursement constraints, hospitals are under pressure to discharge patients as soon as they possibly can. Since patients are in the hospital only a short period of time, they don't have enough time to absorb all the education on self-management that

they receive," Suter says.

Patients in the 2020 Health Solutions program are referred by the self-insured health care system, which identifies patients who are not managing their chronic diseases well.

The nurses in the home health program make several home visits in the early weeks of the program to comprehensively assess the patient for their needs, to learn about the barriers in the home, and to develop rapport with the patient. In the 2020 employee program, the nurses may meet with their clients in the workplace instead.

"Studies have shown that it takes face-to-face encounters to develop a trusting relationship with an individual. Provider services over the telephone don't work as well," Suter says.

After the relationship is established, the patient is supported by telephone calls from the home-based chronic care specialist nurse and the telehealth nurse.

The nurses use laptops with air cards to access current patient information, enter new assessment information, and to document the patient encounters while they are in the patients' homes or at the worksite.

"We have a lot of point-of-care assessment tools built into the software," Suter says.

For instance, if the nurse administers an assessment for depression, the computer system scores it instantly, and the nurse can talk to the patient's physician about the need for medication or referral to a counselor, right on the spot, if appropriate.

Because the nurses document during the patient encounter and don't have to rely on notes or memory, the documentation is much more complete than it would be if they didn't have the laptops, Suter points out.

About 160 patients use telehealth monitors, which measure typical vital signs such as blood pressure, pulse rate, weight, and pulse oximetry, along with disease-specific information. The devices can be programmed to ask patients questions about symptoms every day. The patients transmit the data over the telephone on a daily basis to a computer database at the home health network, which is monitored and acted upon by telehealth nurses.

"The telehealth nurses are very experienced. They review the data seven days a week, and if they don't look right, they intervene before the patient ends up in the emergency department. Depending on the situation, they may call the patient, send out the home health nurse if needed, or call the physician for orders," she says.

The telehealth nurse also helps provide positive reinforcement for the patients. For instance, if a patient's blood pressure drops to the recommended level, the nurse will call and praise him or her for a job well done.

"This helps the patients understand what variables are important, and it reinforces self-management," she says.

Based on results from the CMS demonstration project, the agency hired advanced practice nurses in key fields, including pulmonary medicine, heart failure, and diabetes.

They oversee the care being provided by the nurse generalist, make sure evidence-based guidelines are being delivered, and intervene with physicians on the nurses' behalf when they report that patients are not receiving recommended care.

*(For more information, contact says **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home Health and 2020 Health Solutions, e-mail: Paula.suter@baptist-health.org.)* ■

NEWS BRIEFS

Study shows telehealth improves access

17,000 VA patients' data analyzed

The Veterans' Administration (VA) was able to reduce the number of bed days of care by 25%

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and reduce the number of hospital admissions by 19% with a national home telehealth program implemented in 2003.[1]

The program, Care Coordination/Home Telehealth (CCHT) increased enrollment from 2,000 patients in 2003 to 31,570 patients in 2007. Analysis of the data obtained for quality and performance purposes was performed for more than 17,000 patients as part of a study to evaluate the program's effectiveness. The data also show that for some patients, the cost of telehealth services in their homes averaged $1,600 a year — much lower than in-home clinician care costs.

In addition to reducing hospitalizations and lengths of stay, the program showed a mean patient satisfaction score rating of 86%.

CCHT was developed to better coordinate care and manage care of patients with chronic conditions. "The study showed that home telehealth makes health care more effective, because it improves patients' access to care and is easy to use," said Secretary of Veterans Affairs **Dr. James B. Peake**. "A real plus is that this approach to care can be sustained, because it's so cost-effective and more veteran-centric. Patients in rural areas are increasingly finding that telehealth improves their access to health care and promotes their ongoing relationship with our health care system."

VA's Under Secretary for Health, **Dr. Michael J. Kussman**, said the key to the program's success is VA's computerized patient record system. "Data obtained from the home such as blood pressure and blood glucose, along with other patient information in the electronic system, allows our health care teams to anticipate and prevent avoidable problems," he said.

VA health care officials emphasize that home telehealth does not necessarily replace nursing home care or traditional care but can help veterans understand and manage chronic conditions such as diabetes, hypertension and chronic heart failure. Patients' partnerships with the medical team can delay the need for institutional care and maintain independence for an extended time.

Reference

1. Darkins A, Ryan P, Kobb R, et al. "Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions." *Telemedicine and e-Health* December 2008, 14(10): 1118-1126. ■

CNE *questions*

9. What should a key purpose of an ethics committee be, according to Sigrid Fry-Revere PhD, JD, medical ethicist and president of the Center for Ethical Solutions in Lovettsville, VA?
   A. Satisfy state regulatory requirements.
   B. Provide peer-to-peer support for staff facing ethical issues.
   C.Create a formal method for dealing with problems after they arise.
   D.Provide a forum for complaints about other staff members.

10. What is an emerging issue for home health ethics committee, according to Leslie Kuhnel, MPA, clinical ethics officer for Alegent Health in Omaha, NE?
   A. dog bites
   B. intimidating family members
   C. non-compliant patients
   D. emergency preparedness and surge capacity

11. What forum has Winona Health found to be an effective way to communicate the purpose of ethics services, according to Mary Miller-Hyland, RN, BBA, NHA, administrator of Winona Health's Senior Services in Winona, MN?
   A. new employee orientation
   B. day-long, required seminars for employees
   C. community health education programs
   D. schools

12. By what percentage was the Veteran's Administration able to reduce hospitalizations after implementing a telehealth program for patients with chronic conditions, according to a study published in *Telemedicine and e-Health*?
   A. 19%
   B. 23%
   C. 27%
   D. 31%

Answer Key: 9. B; 10. D; 11. C; 12. A.

No new patient safety goals for 2010

Joint Commission conducting extensive review

There will be no new National Patient Safety Goals (NPSGs) established in 2009 for implementation in 2010 as The Joint Commission performs an extensive review of the current goals and the process to develop goals.

NPSGs have evolved over time, becoming more specific and detailed in some cases, and therefore, require more time and resources to implement. The field is struggling to meet some of the current NPSGs, according to The Joint Commission.

The review will include a baselines survey, a review of potential changes by the Patient Safety Advisory Group and the Standards and Survey Procedures Committee, and final approval by the Board of Commissioners. The process will incorporate feedback from health care organizations. The goal is to clarify language, ensure that NPSGs are program-specific, delete NPSGs that are redundant or non-essential in specific programs, and consolidate similar NPSGs. Revisions to the NPSGs will be effective in 2010. ■

CNE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■