Providing the highest quality information for 26 years

HOSPITAL HOME HEALTH

the monthly update for executives and health care professionals

April 2010: Vol. 27, No. 4 Pages 37-48

IN THIS ISSUE

Financial Disclosure:
Editor Sheryl S. Jackson, Managing Editor Karen Young, Associate Publisher Russ Underwood, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media LLC

Don't wait any longer: HH-CAHPS is around the corner

Select vendor and test survey before October 2010

Home health managers got a little breathing room when the Centers for Medicare & Medicaid Services (CMS) announced a delay in the implementation requirements for the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS). Many providers needed the additional time to focus on implementation of OASIS C [Outcome and Assessment Information Set], which was initiated in January 2010. (**See "Addition of process measures means more prep for OASIS C,"** *Hospital Home Health,* **February 2009, p. 13.**)

"OASIS C required so much staff education, revision of software, and preparation for implementation that many home health agencies could only focus on [that]," says **Sue Squibb**, BSN, director of consulting services for The Corridor Group in Overland Park, KS. With OASIS C directly affecting the agencies' reimbursement, it is no surprise that agencies with limited staff and financial resources focused on it first, she adds.

Now, agencies should be into their preparation to collect and report the standardized patient satisfaction data required by CMS, Squibb warns. "Right now, and in the foreseeable future, participation in HH-CAHPS is voluntary, but it is reasonable to assume that patient satisfaction ratings will ultimately be a part of any pay-for-performance

EXECUTIVE SUMMARY

Now that OASIS-C is in place, some home health managers are turning to the next big requirement from the Centers for Medicare & Medicaid Services (CMS), the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS). With test runs due in the third quarter of 2010, agency managers have a lot to accomplish in the next few months.

- Decide if you want to participate in the voluntary program. Non-participants can have their market basket update reduced by 2%.
- Select a vendor that is approved for HH-CAHPS and meets the needs of your agency.
- Educate staff members about the survey and obtain additional customer service training if needed.

model," she adds. Although it is voluntary at this time, agencies with more than 60 Medicare patients per year that do not participate will receive a 2% reduction in their annual market basket updates, she points out. Agencies with fewer than 60 patients during the year can apply for a waiver, she adds.

Home health agencies should be contracted with an approved vendor to survey patients and collect and report the data by June 2010, suggests Squibb. (**See resource box for information on how to find a vendor.**) Each agency should conduct a test run of the survey for at least one month during the third quarter of 2010 and begin to collect data on an ongoing basis in October 2010. "Starting in October 2011, four quarters of data at a time will be publicly reported," she says. The results will be reported on the Home Health Compare web site.

Preparation for HH-CAHPS was a little easier for Aseracare than it may be for other home health agencies. "We have been using an outside vendor for patient satisfaction measurement for several years, and the company is approved by CMS for HH-CAHPS," says **Nancy Ponder**, RN, national director of clinical operations and quality management. In spring 2009, Ponder started looking at the requirements for HH-CAHPS and consulted with the existing vendor to confirm that the company could support Aseracare's needs to meet the requirements. "The vendor is adding questions that are required by CMS to our existing survey, so we will be ready to collect and report the data CMS has specified," she adds.

Small agencies may face some expenses

"Smaller programs that have been using homegrown surveys to measure patients' satisfaction may find the requirements scary, because they perceive use of an outside vendor as expensive," admits Squibb. "If they do their homework and factor the full cost of printing, mailing, and personnel labor … to develop, distribute, and report the data in-house, the use of an outside vendor might not be as expensive as first thought," she says.

Not only will an outside vendor take over some of the time-consuming aspects of patient satisfaction surveys, but also vendors approved for HH-CAHPS are up to date with the changes in CMS requirements. "A good vendor will take the worry out of the process," Ponder says.

Look for a vendor that will add agency-specific questions and develop reports that fit your internal needs, but don't try to do too much at the beginning, suggests Squibb. "Most vendors are suggesting that home health agencies make sure they are meeting CMS requirements first, then adding custom features later," she says. This keeps the preparation process simple, because CMS has a standard questionnaire that must be used, she adds. (**See survey questions on page 39.**)

Work with your vendor to determine how many surveys must be mailed to patients to guarantee the minimum 300 responses per year required by CMS, suggests Squibb. "Most vendors project a 30% return rate for mailed surveys, so agencies

Hospital Home Health® (ISSN# 0884-8998) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Hospital Home Health*®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcmedia.com. World Wide Web: http://www. ahcmedia.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for nurses, managers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues. It is in effect for 24 months from the date of publication.

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

Editor: Sheryl S. Jackson, (770) 521-0990, (sherylsjackson@bellsouth.net)
Associate Publisher: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor: Karen Young, (404) 262-5423, (karen.young@ahcmedia.com).
Production Editor: Ami Sutaria.

AHC Media LLC

Editorial Questions

For questions or comments, call Karen Young at (404) 262-5423.

need to decide if they want to send more than needed to ensure the proper number of responses," she says. Smaller agencies may choose to send surveys to 100% of patients, she adds.

When selecting a vendor, make sure the company has specific home health experience and ask to talk with current home health clients to make sure the company meets deadlines, suggests Squibb. "I recommend that an agency get three proposals to compare before selecting a final vendor," she says. When looking at survey costs, keep in mind that mailed surveys are the most cost-effective, she adds.

Don't forget to let all of your staff members know about the survey and its importance to the agency, suggests Squibb. "Let staff members see the survey, learn how it will be distributed, and talk about customer service," she says. (**See staff education tips, page 40.**)

Even with the preparation and financial investment in preparing for and meeting HH-CAHPS requirements, this is a program that is good for home health, says Squibb. "It will provide a national database that enables home health agencies to compare their patient satisfaction results with others, and vendors will be able to provide best practice information," she says.

If a home health manager finds that the cost of participating in HH-CAHPS is greater than the 2% reduction in the agency's market basket update, there is always the option to decide not to participate and to accept the reduction, points out Squibb. "I don't recommend that an agency that makes this decision become comfortable opting out," she says. "I have no reason to believe that at some point in the future it will be mandatory for any home health agency that accepts Medicare patients."

RESOURCE & SOURCES

• For information about the Home Health Care Consumer Assessment of Healthcare Providers and Systems requirements, go to https://homehealthcahps.org. The site contains the list of approved vendors, the survey questionnaire, updates on the program, and other valuable tools for home health agencies to use in implementation.

For more information about HH-CAHPS, contact:
• **Nancy Ponder**, RN, National Director of Clinical Operations and Quality Management, Aseracare, 30 Perimeter Park Drive, Atlanta, GA 30341. E-mail: nancy.ponder@aseracare.com.
• **Sue Squibb**, BSN, Director of Consulting Services, The Corridor Group, 6405 Metcalf St., Suite 108, Overland Park, Kansas 66202. Telephone: (415) 452-4383. E-mail: ssquibb@corridor group.com. ■

Communication and education key to survey

Patients rate care, assistance, and responsiveness

The standardized questionnaire required for the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) contains 34 questions that resemble questions most home health agencies use on their own patient satisfaction surveys.

There is a group of questions to collect demographic data, but the key questions focus on overall patient care, communication, and specific questions about different aspects of care or patient education.

Questions on the survey include:

• When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?

• When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?

• When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?

• In the last two months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?

• In the last two months of care, did you and a home health provider from this agency talk about pain?

• In the last two months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines?

• In the last two months of care, did home health providers from this agency talk with you about the side effects of these medicines?

• In the last two months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?

• In the last two months of care, how often did home health providers from this agency explain things in a way that was easy to understand?

• In the last two months of care, how often did home health providers from this agency treat you

with courtesy and respect?

• In the last two months of care, when you contacted this agency's office did you get the help or advice you needed? ■

Keep customer service top of mind

Ensure staff members know what patients will rate

Preparing your staff for implementation of the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) patient survey program requires a different approach than preparation for OASIS-C, says **Sue Squibb**, BSN, director of consulting services for The Corridor Group in Overland Park, KS. "Success with OASIS-C reflects how well your staff members document and answer questions on the OASIS form," she says. "Success with HH-CAHPS depends on how well your staff members act."

Don't just tell staff members that patients will receive a satisfaction survey; let them see the questionnaire, suggests **Nancy Ponder**, RN, national director of clinical operations and quality management for Aseracare. "Our staff members see the patient satisfaction survey, so they understand what questions patients will be asked about their care," she says.

Also, make sure staff members understand the potential future importance of good patient satisfaction results on the agency's bottom line, says Ponder. "Pay-for-performance for home health is coming, and patient satisfaction scores will be an important part of an agency's performance ratings," she says. "Our educational sessions include discussions of how patient satisfaction results affect everyone in the agency."

If necessary, provide customer service training to staff members, suggests Squibb. Remember that questions on the survey do not just apply to nurses, she says. Not only are there questions about therapists and aides, but there are also questions about the home health agency office personnel and their ability to provide advice and answer questions, she adds.

In order for a home health agency to maintain good patient satisfaction ratings, the commitment to patient satisfaction must be part of the corporate culture, points out Ponder. "Aseracare's commitment to patient satisfaction is an integral part of the organization's philosophy, not just an activity to meet a regulatory requirement," she explains. "We live and breathe customer service."

One way Aseracare keeps customer service top-of-mind for all staff members is to start each meeting or conference call with a service excellence story, says Ponder.

Recently, a story surfaced that described a nurse who arrived at the patient's home to find it blocked by snow. Rather than turn around because she couldn't get up the driveway to the house, the nurse shoveled the snow off the driveway and went inside to make the visit. Because the person who normally fixed the patient's meals couldn't make it to the house that day, the nurse also fixed the patient something to eat.

"Stories like this are important to share," says Ponder. "If we didn't share them, no one would understand how often our employees go the extra mile for our patients. It is also a wonderful way to recognize those employees for their efforts." ■

Advance directives not in place for many

Study shows need for public education

About 66% of respondents to a Maryland telephone survey do not have advance medical directives, according to a new report by researchers from the Johns Hopkins Bloomberg School of Public Health's Department of Health Policy and Management.

Younger adults and African-Americans were less likely than older adults and whites to report having an advance directive, which includes the living will and health care power of attorney. The results will be published in an upcoming issue of *Health Policy*.

While 34% of all respondents had an advance directive, 61% indicated they have preferences about medical care in the event they are unable to make such decisions. The primary reasons reported for not having an advance directive include being unfamiliar with them, feeling too healthy to need one, or, for the younger adults, being too young to need one. Forty percent of adults surveyed reported that they would like to

obtain information on advance medical directives from a physician; however, only 12% of the respondents with advance directives reported obtaining it from their doctor.

"These results support a need for legislative and regulatory changes to increase the number of people with advance directives," said **Dan Morhaim**, MD, one of the study authors and an adjunct professor with the Bloomberg School's Department of Health Policy and Management and member of the Maryland House of Delegates. "Advance medical directives cost nothing to complete and are readily available from many sources. We need to make sure that people know where to get them and why it's important to complete them."

Research has shown the benefits of advance directives include improved quality at the end-of-life, fewer burdens on family and health care providers, and a reduced need for life-sustaining treatment. Lead study author **Keshia Pollack**, PhD, MPH, an assistant professor with the Department of Health Policy and Management and the Centers for Injury Research and Policy and Health Disparities Solutions, added, "These findings suggest a disconnect between what people want in the event they are unable to make medical decisions for themselves and their actions to ensure their preferences are actually carried out."

Pollack and colleagues administered a population-based cross-sectional telephone survey to 1,195 adult Maryland residents. In addition to being asked whether they have an advance directive, respondents were asked where they had received information on them and where they would like to receive such information. "While these results are specific to Maryland, they are relevant to other areas of the country with the factors that lead to or hinder completion of advance directives," said Pollack. ■

Target those at risk for cardiometabolic syndrome

Aim to get members on the path to healthier lifestyles

As part of its focus on prevention as a successful strategy to improve the quality and lower the cost of health care, Independence Blue Cross has launched a program targeting members who are at risk for cardiometabolic syndrome, a condition that may increase a person's chance of developing heart disease and diabetes.

The cardiometabolic risk management program is part of Independence Blue Cross' Connections Health Management Program.

"Chronic conditions, such as heart disease and diabetes, are very costly, not only to those who have them, but to all of us. These diseases may be preventable and are treatable. We strive to help our members get on the path to healthier lifestyles now, in the hopes that they will lessen their chances of developing, or worsening, serious and costly health conditions," says **Esther Nash**, MD, senior medical director for Independence Blue Cross.

The American Heart Association estimates that more than 50 million Americans have cardiometabolic syndrome.

"Cardiometabolic syndrome is not necessarily a disease or a condition but a constellation of risk factors that put people at risk for developing heart disease and Type 2 diabetes," says **Kimberly Siejak**, manager of population health and wellness for the Philadelphia-based health plan.

Risk factors that increase a person's overall chance of developing heart disease and diabetes include tobacco use, high body mass index, obesity, hypertension, high cholesterol, high levels of triglycerides, and elevated blood sugar levels, she adds.

"This program is different from a lot of disease management and health coaching programs, because our goal is to prevent members from developing a disease. The program identifies people who may not have received a diagnosis of the disease, but they are heading that way because of their lifestyle habits," she says.

The program provides education that is designed to help members avoid developing heart disease and diabetes.

The program identifies members at risk through medical and pharmacy claims data, as well as the results of the health plan's health risk assessment.

The health plan uses a series of proprietary algorithms to stratify members and to identify those who are at highest risk.

For instance, to identify members with hypertension who are at risk, the health plan uses a combination of factors, including hospital and emergency department visits, and whether the

member has filled his or her prescriptions.

The purpose of the program is to educate members about the symptoms of heart disease and diabetes and the behavior and lifestyle changes that may help prevent the diseases, Siejak says.

The program is staffed by health coaches, who have an average of 10 to 15 years of clinical experience and are trained to help people manage their chronic conditions and assess readiness to change.

Low-risk members receive automated outreach calls that give them the option of contacting a health coach and enrolling in the program.

High-risk members receive telephone calls from health coaches who describe the program and invite them to participate.

The health coaches assess the members' readiness to change and work with them to develop strategies to modify their lifestyle.

Since many of the people who are at risk for developing metabolic syndrome lead sedentary lives, the coaches work with them to increase their physical activity.

They coach members to adopt healthy eating habits and to reduce their intake of fat.

"Once members engage with the health coach, they are invited to participate in behavioral change programs, depending on their type of risk. We have a program for tobacco cessation and an intensive weight management program," Siejak says.

The coaches help the members make lifestyle changes that can lower their risk. For instance, they may work with people with hypertension on cutting down on the salt in their diets and educate them on which foods to avoid.

Members who are working with the health coaches receive tool kits of exercises they need to complete between the health coach sessions.

For instance, in one exercise that is part of the smoking cessation program, the member keeps a log of triggers for smoking and in another is asked to tally the number of times he or she has tried to quit smoking in the past.

"The health coaches make follow-up calls and discuss the exercises with the member. This coordinated learning experience that combines what they are doing with the tool kit and the session with the health coach enables members to get a better handle on what motivates them to smoke and work with the coach to come up with a plan to change their behavior," she says. ■

Tailoring DM to patient improves outcomes

Study shows reduced hospitalizations, ED visits

People with chronic conditions who received telephonic disease management coaching based on their level of health activation had fewer visits to the hospital and emergency department than people coached in the usual way, a study has shown.

The study, conducted by **Judith Hibbard**, PhD, and her colleagues at the University of Oregon, compared the behavior of individuals receiving standard telephonic disease management coaching with that of those who received more tailored coaching based on their "activation level." The study was funded by the Health Industry Forum at Brandeis University.

Hibbard is a professor of health policy in the department of planning, public policy, and management at the University of Oregon and a clinical professor in the department of public health and preventative medicine at Oregon Health and Sciences University.

A patient's activation level is determined based on his or her responses to the Patient Activation Measure (PAM), a tool developed by Hibbard and her colleagues, which measures a person's knowledge, skills, and confidence in playing a role in his or her own health care.

Participants in the study who received the tailored coaching showed a 33% decline in hospital admissions compared to the control group, resulting in an average savings of $145 per person per month.

The group receiving the tailored intervention also had a 22% decline in emergency department visits compared with the control group, for an average savings of $11 per person per month. Among participants in the control group, hospital admissions remained flat for patients in the control group. Emergency department visits for the control group increased by 20%.

The group that received tailored coaching experienced significant improvements in diastolic blood pressure and LDL cholesterol levels compared to the control group and increased their adherence to recommended immunization and drug regimens.

The study was conducted at two call centers staffed by RN health coaches.

The call centers were selected based on the simi-

larity of the nurse coaches' tenure and years of experience.

The nurse coaches were trained on coaching skills and how to administer the PAM tool.

At one of the centers, the researchers trained the coaches on how to use the tool to tailor their coaching to each individual. The nurses at the other center, who worked with the control group, were just told to administer the PAM tool at least twice during the six months of the study period.

The team analyzed the gains in the PAM score, adherence to the treatment plan, clinical indicators such as LDL cholesterol and blood pressure, and utilization.

"The results showed that coaching to the patient's activation level was more effective in every measured considered, whether it was clinical indicators, clinical outcomes, cost, or utilization," says **Mary Jane Osmick**, MD, vice president and medical director for LifeMasters Supported SelfCare Inc., an Irvine, CA-based provider of health improvement and condition management programs and services, which operates the call centers.

The Patient Activation Measure includes a series of questions that focus on the role the person plays in his or her own health care. Patients answer the questions on a scale that ranges from "strongly disagree" to "strongly agree."

One question asks if the patients know what medication they are on and how to take them. Another asks if they know how to take care of themselves when they get sick.

"Each question focuses on a specific area where people fall down or are very good at being an advocate for themselves," Osmick says.

Based on responses to the questions, each person is assigned an "activation score" ranging from one to 100, with most people falling in the 35 to 85 range, Hibbard says.

"Research suggests that people pass through four different levels of activation on their way to becoming effective self-managers," Hibbard says.

Patients on Level 1 tend to be overwhelmed and unprepared to play an active role in their own health. Patients on Level 2 lack the knowledge and confidence for self-management. Patients begin to take action on Level 3 but may not have the confidence or skill to support their behaviors. At Level 4, patients have adopted behaviors to support their health but may not be able to maintain them in the face of life stressors, she says.

Patients with low activation feel overwhelmed by the task of managing their health.

"They don't have good problem-solving skills; they have experienced failure and are discouraged. They aren't focusing on their health, because it is a difficult topic for them," Hibbard says.

Individuals whose score indicates that they are highly activated are more likely to have health screenings, immunization, and other preventive care and to exhibit healthful behaviors such as maintaining a healthy diet, exercising, monitoring their condition, adhering to treatment, and seeking information about their condition and their health, Hibbard adds.

"People fall at different points ranging from low activation to high activation. If disease managers understand where people are and support them in understanding their barriers and issues, they can help them become more activated and, in doing so, learn to take better care of themselves," Hibbard says.

Clinicians are trained to educate people about their health conditions, give them directions, and expect them to follow them, Osmick says.

"In disease management, we sometimes unwittingly ask people to do more than they are capable of doing. That doesn't work. It often turns people off and drives them more deeply into becoming less activated in their own health care. When we talk to someone at Level 1 about goals and action plans, monitoring blood pressure and blood sugar, it can be overwhelming," she says.

Patients on Level 1 of the activation scale feel they can make no impact on their own health, and asking them to monitor their blood pressure or weigh themselves may be a waste of time. Instead, the nurses help them understand how what they experience can be related to their health. Coaches work with them specifically to support them achieving a higher level of activiation, Osmick adds.

"We use this tool to help us throttle back and find out where someone is, then carry them forward by working with them to increase their knowledge, skills, and confidence," she says.

For instance, during the study, the nurse coaches worked with patients at Level 1 to build self-awareness and understanding of their behavior patterns. They worked to build a foundation to enable the patients to go on to the next challenge.

When patients were on Level 2, the nurses worked with them on making small changes in their behaviors, such as eating smaller portions, taking the stairs instead of the elevator, and read-

ing food labels at the grocery store.

The nurse coaches took small steps and worked on one issue at a time, rather than overwhelming the patient with a whole list of goals, Hibbard says.

"The coaches work on one thing that the patient wants to do and focus on building confidence by taking small steps. Instead of asking them to go the gym five days a week, the coaches ask them to take smaller steps, like walking to the corner and back. As they experience success, the patients start to feel more confident, and that builds motivation to start managing their own health," she says.

The coaches work with the patients who are low on the activation scale to build a foundation to go on to the next challenge.

LifeMasters has adapted the tool as part of its disease management model and uses the tool for every client who willing and capable of answering the questions, Osmick says.

"Using this tool is like taking a patient's vital signs. It helps us begin to identify the person's needs and to coach to the level that will be most effective. When we know the participant's level of activation, we can specifically coach to that level and avoid overwhelming the program participants," she says.

LifeMasters' overarching goal is to improve the activation among the population it serves, Osmick says.

"We know this leads to lower cost, higher adherence, improved clinical measures, and better outcomes. It is heartening to see the progress we made when we used the PAM tool. Effective coaching is about helping people develop the information, skills, and motivation to do the right thing for their health. That is a challenge we must respond to," she says.

(For more information on the PAM tool, see www.insigniahealth.com.). ■

Research provides clues to adherence strategies

Study looks at its impact

HIV clinicians often work with patients who have such an overwhelming number of barriers to optimal treatment adherence that it's difficult to know where an adherence intervention should begin.

There are issues of homelessness, substance use, mental illness, stigma, drug side effects, etc. Primary care physicians will see the chief problem as being one particular barrier, while specialists and case managers might think a different problem should be targeted.

Now at least one researcher who approaches treatment adherence from the perspective of a nurse believes the best possible intervention will incorporate a variety of disciplines and approaches in one package.

"I remember having a few conversations with the medical director, saying, 'What you need in a program like this is a theoretical approach that different disciplines can agree on and to approach care from this perspective,'" says **Donald Gardenier**, DNP, FNP-BC, a nurse practitioner, assistant professor, and clinical program director in the division of general internal medicine at Mount Sinai School of Medicine in New York, NY.

"That's not an unusual approach for a nurse; but the medical director being a physician was intrigued and unfamiliar with this," Gardenier recalls. "So, I dove into this a little bit further and came up with a social support theory as a way to contextualize care in this setting."

Gardenier's work has led to research into an adherence intervention approach for HIV-infected patients who qualify for enhanced services based on one or more threats to optimal adherence or health outcomes in terms of their HIV disease.

"These can be multiple medical problems, decreased social support based on family systems, homelessness, incarceration, and almost all of them have at least one psychiatric diagnosis and substance use issues — either currently or in the past," Gardenier says.

The patients attend an AIDS day health care (ADHC) program to which they are referred by providers based on their need for psychiatric services.

"The services are based on the statistical or evidence-driven needs of people with HIV, including housing services and nutrition services," Gardenier says. "These are in addition to being basically a psychiatric day treatment program with onsite primary care."

Gardenier first studied the ADHC's population, comparing patients' participation and reported

adherence and measured social support.[1]

"I used the Social Provisions Scale [Cutrona & Russell, 1987], which was uniquely suited to this population," Gardenier says. "So, it seemed to me in looking at it as a nurse that different disciplines could look at different aspects of social support and design different interventions around them."

It's not as useful to ask clients if they have social support, because clients might list having a spouse, although their mate is not socially supportive, or they might not think to mention the social support they receive from peers in the day program, he explains.

"Some studies say it doesn't matter where you get social support so long as you're getting it," Gardenier adds.

In the Social Provisions Scale, social support is measured with 24 items, divided between six subscales, including: reliable alliance, attachment, guidance, nurturance, social integration, and reassurance of worth.

Reliable alliance and guidance are the types of support an HIV patient might receive from the medical professionals who help him or her, Gardenier says.

The more emotional support provisions involve attachment, nurturance, social integration, and reassurance of worth, he adds.

"Attachment is the closeness and intimacy that fosters a sense of security," Gardenier says. "Social integration is a sense of belonging to a group with similar interests and concerns."

HIV patients who experience reassurance of worth are given recognition of their abilities and competence, and nurturance is the feeling that one is needed by others, he adds.

When Gardenier measured social support among the ADHC population, he found that the highest social support scores were among the instrumental provisions of reliable alliance and guidance.

"This was not a surprise, because people are in this intensive program receiving guidance," he says. "And among the emotional provisions, the highest scores were in social integration, which is belonging in a group and also was not a surprise."

The HIV clients reported the lowest social support in the area of nurturance, suggesting they did not feel needed, he says.

"If you think about how someone experiences life during and after substance use, I think it's fairly common in the pathology of substance use to find that people who otherwise rely on you learn not to," Gardenier says. "So, even when you go through a recovery period, you lack this social support."

HIV patients struggle with the feelings that they're unneeded, but this also is a social support that a comprehensive HIV/AIDS program can foster, he notes.

"We had one man in the program that really had his life together, and he came to the day program every day for years, participating in all the groups," Gardenier recalls. "He had a key spot in social integration in the place, and you had to ask what he was doing there, because he had his life together."

The answer was that the man showed up each day because he felt needed, and so his attendance fostered the experience of nurturance, he adds.

"Once I saw the limitations of what I could do in correlating social support and adherence in using this instrument, there was more than enough material to use and apply toward the design of an intervention," Gardenier says.

There's considerable potential for such an adherence intervention, he notes.

"I can see how a case manager would look at this and see how to teach services to clients, who could then provide services for each other," Gardenier explains. "For example, a peer could lead an HIV group, and then you'd re-measure adherence and see how that has changed with the peer."

REFERENCE

1. Gardenier D, Andrews CM, Thomas DC, et al. Social support and adherence: differences among clients in an AIDS Day Health Care program. *J Assoc Nurses* AIDS Care. 2009; E-publication. ■

Lack of adherence in heart failure therapy

Educate and monitor to improve results

When research suggests changes in standard medical practice, the public health community expects physicians and hospitals to adopt the new way and help improve patient outcomes.

But occasionally, as one study recently found, the medical community is very slow in adopting

new treatment recommendations.

A good example of this is what has happened with hospitalized heart failure patients who are eligible for aldosterone antagonist therapy, according to a large database study, published in the Journal of the American Medical Association late last year.[1]

The study found more than 12,000 patients who were eligible for this therapy, which research has shown would have improved their health outcomes. But only about one-third of these patients had received the therapy, which was recommended in several national guidelines.1

The research was limited by what physicians had documented with regard to contraindications, says **Nancy M. Albert**, PhD, CCNS, CCRN, NE-BC, FAHA, FCCM, director of nursing research and innovation in the Nursing Institute, and a clinical nurse specialist at the Kaufman Center for Heart Failure in Cleveland.

"Maybe a patient had a contraindication, and the doctor knew it but didn't document it," Albert says. "If they didn't document a contraindication with therapy, we would assume the patient was eligible to receive therapy."

The analysis began in January 2005, and continued through December 2007, and there was a steady trend from baseline of improvement in the guideline-recommended use of aldosterone antagonist therapy from 28%, when the study began, to 34% when it ended, Albert says.

"The American Heart Association and American Cardiology Association gave their stamp of approval for using aldosterone in patients in 2005," Albert says.

So investigators expected to see increased use of aldosterone antagonist therapy after the guidelines were updated. But they were surprised it was only a small increase, she adds.

This lackluster response to changing to using aldosterone antagonist therapy might have been due partly to a small discrepancy in how the guidelines were worded in 2005, Albert says.

"The guidelines should have said the treatment was recommended, but instead said it was reasonable to use an aldosterone antagonist, and that doesn't have as strong a connotation," she explains.

Although a correction was published in 2006, it's possible that many physicians didn't see the correction, she adds.

Also, none of the national performance measures for hospitalized heart failure patients include aldosterone antagonist therapy as a core measure yet, Albert notes.

"It could be that hospitals were so focused on doing what they had to do based on The Joint Commission's performance measures and other expectations that they didn't take the next step of doing what was right based on the guidelines," she says.

Another factor is that one aldosterone antagonist is a generic drug that has been available as a potassium-sparing diuretic for years, Albert says.

"When we use it as an aldosterone antagonist, it's at a different dosage and it's for a different reason," she says. "Because the drug has been available for many years, there has been no drug company marketing of the drug, so maybe lack of use is that it's out of sight and out of mind."

Some physicians might have been reluctant to prescribe aldosterone antagonist therapy because of the drug's side effect profile, Albert says.

If the patient is already on some other therapies that are used to treat heart failure (such as an ACE inhibitor or angiotensin receptor blocker), they might have a higher risk of increased serum potassium and creatinine levels, she explains.

"So, maybe some health care providers were focusing on providing ACE-1 or ARB therapies, and maybe they had intended to start aldosterone antagonist therapy after the patient went home," Albert says.

The database did not yield information about therapies initiated after discharge, she adds.

The point is that while there are numerous reasons why providers might not have followed the national guidelines, the fact is that for most patients deemed eligible for the treatment, the guidelines should have been followed, leading to improved patient outcomes over time, Albert says.

Since this is an area that has fallen through the cracks, it would be a worthwhile quality improvement project for discharge planners to raise awareness about the treatment and include information

COMING IN FUTURE MONTHS

- Managing employee stress
- Effective QI studies
- Results of national benchmarks
- Meeting needs of multicultural groups

about aldosterone antagonists in discharge planning paperwork for patients who meet criteria for use, he notes.

"Hospitals could monitor the use of the therapy in patients with systolic heart failure," Albert says. "If you have a registry or database, then you could keep track of your own data, and over time you should see the frequency of aldosterone antagonist use increase in patients who meet recommended criteria for receiving it."

REFERENCE

1. Albert NM, Yancy CW, Liang L, et al. Use of aldosterone antagonists in heart failure. *JAMA*. 2009;302(15):1658-1665. ■

NEWS BRIEFS

AONE outlines health reform preferences

Increasing home visits by nurses and establishing a demonstration program for home-based primary care teams are two of the nursing-related provisions in the final health care reform bill that members of the American Organization of Nurse Executives (AONE) urged lawmakers to keep. Other provisions supported by AONE members include:

- expanding the nursing workforce;
- promoting public health and disease prevention;
- reducing rehospitalizations;
- increasing care coordination;
- improving access to nurse midwives and nurse-managed clinics;
- expanding a proposed Medicare Graduate Nursing Education demonstration programs for advanced practice nurses. ■

Study: Hospital patients lack meds knowledge

A new study published in the *Journal of Hospital Medicine* highlights the problem of hospital patients being unaware of their own medi-

CNE QUESTIONS

1. Why have many agencies waited to begin preparation for the Home Health Care Consumer Assessment of Healthcare Providers and Systems requirements to report patient satisfaction data, according to **Sue Squibb**, BSN, director of consulting services for The Corridor Group?
A. It does not impact their reimbursement.
B. Most agencies cannot afford to implement it.
C. There is no benefit to participating.
D. They were focusing on OASIS C preparation.

2. What is the return rate on patient satisfaction surveys experienced by most vendors, according to **Sue Squibb**, BSN, director of consulting services for The Corridor Group?
A. 15%
B. 30%
C. 45%
D. 50%

3. What is the best way to maintain high patient satisfaction ratings, according to **Nancy Ponder**, RN, national director of clinical operations and quality management for Aseracare?
A. Offer bonuses to employees who receive positive mentions.
B. Present satisfaction survey results to new employees at orientation.
C. Use a high-quality survey vendor.
D. Make customer service part of the corporate culture.

4. How many respondents to a telephone survey do not have advance directives?
A. 35%
B. 53%
C. 66%
D. 72%

Answer Key: 1. D; 2, B; 3. D; 4. C.

cations.[1]

Investigators found that 44% of patients thought they were receiving a medication that they had not been prescribed. And only 4% of patients were able to remember the names of all of their prescribed medications.[1]

This education deficit poses a safety risk for hospital patients since patients who know their medications might be able to prevent the wrong medication from being administered.

There were 50 study participants, ages 21 to 89, and all said they knew all of their outpatient medications. They spoke English and were from the community around the University of Colorado Hospital.[1]

Patients who lived in nursing homes or had a history of dementia did not meet the study's criteria.[1]

REFERENCE

1. Cumbler E, Wald H, Kutner J. Lack of patient knowledge regarding hospital medications. *J Hosp Med*. 2009;10.1002/jhm.566. ■

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 the **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Dear Hospital Home Health subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Hospital Home Health, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours — the best possible patient care.

The objectives of Hospital Home Health are to:

- identify the clinical, ethical, legal or social issues particular to home health care;
- describe how the clinical, ethical, legal, or social issues particular to home health care affect nurses, patients, and the home care industry in general.
- integrate practical solutions to the problems faced by home health professionals into daily practices

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester, you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is nurses, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life-care, pain management, multicultural issues, elder care, and similar issues.

Those participants who earn nursing contact hours through this activity will note that the number of contact hours is decreasing to 15 annually. This change is due to the mandatory implementation of a 60-minute contact hour as dictated by the American Nurses Credentialing Center. Previously, a 50-minute contact hour was used. AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5560. You also can email us at: customerservice @ahcmedia.com. On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,

Cynthia Molnar
Director of Continuing Education
AHC Media LLC