

HOSPICE Management ADVISOR

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Telehospice programs improve care coordination, patient satisfaction

VA has telehealth model that's opening nationwide

Experts predict a bigger role for telehealth in the hospice industry as model programs demonstrate high patient/caregiver satisfaction and improved staff efficiency and quality of care.

Hospices and home health agencies increasingly are using a variety of telehealth services, says **William A. Dombi**, JD, vice president for law at the National Association for Home Care and Hospice in Washington, DC.

"The types vary from vital-sign checks to monitors that offer high-resolution pictures of a patient that allow monitoring of everything from wound sites to skin tone," Dombi says.

Hospice agencies are the latest to explore the advantages of telemedicine, experts say.

"I've been involved in doing research in telemedicine since the early 1990s, and one of the areas that has emerged over time as being an important area is hospice and palliative care services," says **Pamela Whitten**, PhD, associate professor at Michigan State University in East Lansing.

"Telemedicine has huge ramifications for hospice and palliative care," Whitten adds.

The Veterans Health Administration (VHA) in Bay Pines, FL, launched a telemedicine care coordination service in 2000 as a way to provide home services while keeping patients connected to the health care system, says **Patricia Ryan**, RN, MS, director of the Veterans Integrated Service Network 8 (VISN-8) and acting associate chief consultant to the VHA Office of Care Coordination in Bay Pines.

VISN-8 recently added hospice and palliative care services to the program, and there are plans to roll out the telehealth program in other states, Ryan says.

"We're not taking over any other of the health care programs we have in the VA system, but this is a complex system," Ryan says. "So what we wanted to do was make sure that those patients who were very sick and clinically complex could participate in their own care at

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home, and if they needed hospice care, we were there for them.”

The Michigan telehospice program was limited to home health for the purposes of research, but it shouldn't be limited to that segment of hospice patients over the long term, Whitten says.

“We decided to determine what type of technology could be brought into the home in a realistic manner, and we decided to use video phones that use analog phone lines,” Whitten says. “We wanted to look at areas where there was a potential challenge in access, and so we provided telehospice services to rural areas and an urban area.”

The rural areas were located in Northeastern Michigan, where severe winter weather sometimes makes it difficult, if not impossible, for home health professionals to visit patients, Whitten explains.

The urban area selected was in parts of Detroit, where one challenge is to provide evening home health services to some low-income patients

because of safety issues, Whitten adds.

The Bay Pines VHA's telemedicine project is divided into 21 programs across the state of Florida and Puerto Rico, and each program serves a different population, Ryan says.

For example, one program at the San Juan, Puerto Rico, VA serves only diabetes patients, and another serves wound care patients. In northern Florida, there is a palliative care program, and another program serves most chronically ill medical patients, Ryan explains.

Program targets clinically complex patients

The hospice/palliative care program has a chaplain who serves as care coordinator. While that was the first formal telehospice program, many of the other programs will also help patients stay at home at the end of their lives, Ryan adds.

“Not everyone in the VA system is enrolled in these programs,” she notes. “We look at those who use the system the most — the most clinically complex patients.”

Dombi, Whitten, and Ryan describe some of the features of telehospice programs and how they may fit in with existing hospice services. Here are their observations and advice regarding starting a telehospice program:

- **Understand the licensing and legal issues.**

While a telehospice program doesn't need a special license, there are circumstances when its use could be in violation of state licensing laws, Dombi says.

For instance, if a physician is licensed in New Jersey and is providing health care services to a New York resident via telemedicine, then this could be a violation of licensing laws because the doctor is not licensed to practice medicine in New York.

It's also important to understand the special liability and malpractice concerns that affect telehealth programs, Dombi says. **(See story on following Medicare Conditions of Participation and reducing risk of telehealth malpractice suits, p. 88.)**

“There are some issues that arise regarding practice acts for nurses,” Dombi points out.

Nurses must comply with state nurse practice acts. States commonly only give nurses limited authority to act without a physician order, and in most states nurses can usually only provide care consistent with a physician's order, Dombi explains.

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Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

So the question arises: "Do they need an order to use telehealth service in the fashion they are using it?" Dombi says.

"We've long recommended having specific physician orders for telehealth, for both liability and licensing issues," he adds. "The liability concern relates to someone who has the responsibility to the patient, and then something goes wrong and leads to injury; if the nurse is acting consistently with the physician's order, then you're at least sharing risk with the physician."

- **Select the telehospice model that works best for your clientele and staff.**

The telehospice study conducted in Michigan found that patients uniformly liked the telehealth service, and many even wanted to use it more frequently, Whitten says.

"Some providers loved it from day one, and some providers resisted it," Whitten says. "The challenge was not with the patients accepting telehealth and liking it; the challenge was with the providers."

This project used video phones and video monitors plugged into existing telephone lines. All patients would have to do is push a button for a video connection, making it a very simple process, Whitten explains.

The hospice staff would conduct home visits via the video phones in the same way they would conduct a visit in person, with each visit tailored to the particular patient, Whitten says.

"Some might need a pain assessment and to talk about issues with pain, and others might need counseling of some type," Whitten adds. "Sometimes the providers would just call in to check on their comfort and check on bed sores or wounds."

At other times, hospice providers might provide support services to family members or caregivers.

Care coordinators direct telehealth services

The VA telehealth program provides a nurse practitioner and chaplain for palliative care services, but also provides easy access to physicians, an interdisciplinary team, and anyone else who is needed, Ryan says.

The first step is to assign the patient a care coordinator who selects the technology that will be used to provide the telehealth services, Ryan says.

Typically, the technology is a 365-day messaging unit, about twice the size of a caller ID box, that is connected to the patient's telephone. Each morning the unit will beep until the patient responds to 10 to 15 questions that require four simple button

presses to answer. Based on these answers, the care coordinator labels each person as "green" for okay and "yellow" if the patient needs to be watched, Ryan says.

The patient's answers to the questions are sent to a computer, where the care coordinator can evaluate all the patients' results to determine who needs to be called that day, Ryan explains.

System tailors education to patient

The system then automatically delivers education to the patient based on how the patient answered questions, Ryan says.

"Instead of giving patients a three-inch notebook with information, you give them education based on their answers and on their behaviors," Ryan notes.

For patients who are unable to use that technology, a video phone also is available, Ryan adds.

Either way, patients are monitored by the technology, but they always have someone they can call in case of an emergency or if they have additional questions.

- **Provide initial home visits, emergency care, and follow-up support.**

It typically takes one home visit to set up the messaging device if patients need assistance, Ryan says of the VA's telehealth system.

"Everyone who receives a telemonitor will receive a home visit, but there are some patients you wouldn't visit at home at all," Ryan says. "We screen everyone to see if they need a home visit, and for the palliative care population, we make at least one or two visits to their home."

For palliative care patients, the care coordinator will establish routine communication with the caregiver to assess the caregiver's burden, Ryan notes.

"A lot is done by the phone, but as more of a scheduled activity to relieve the caregiver's stress," Ryan says. "Also, for palliative care patients, we'll arrange for respite care if it's needed, because a lot of time there's access to a lot more community services."

The program provides some patients with added support through the use of a video phone that the patient can use to speak with another family member who is too ill to visit the patient, Ryan adds.

The chaplain will keep in touch with the patient and family by telephone and may schedule regular appointments for spiritual counseling. The chaplain, like other care coordinators, also serves

as a conduit to the primary care physician and other providers, so if a patient needs access to some service, the chaplain will arrange it for the patient, Ryan says.

Patients who need help outside of scheduled calls and visits can call a 24-hour nurse during off-hours, Ryan says.

So far, the system has helped reduce unnecessary emergency room visits and hospitalizations, Ryan notes.

Hospice nurses, physicians, and other clinicians know that the care coordinator is keeping a close eye on the patient, so if the care coordinator calls to request that someone see the patient, the visit is scheduled immediately, Ryan says.

Sometimes, hospice patients in the Michigan program will call in for assistance via the video phones, but usually their telehospice visits are scheduled, Whitten says.

There have been occasions when the telehospice service has saved a nurse hours of commuting time when an emergency has occurred, Whitten notes.

For example, one patient's caregiver in northern Michigan called to say the patient was having some abdominal discomfort, and the caregiver didn't know what the problem was. The nurse asked the caregiver to move the video phone camera down the patient's body so she could look at the patient, and she discovered a kink in the Foley catheter. Once the caregiver unkinked it, following the nurse's instructions, the patient's discomfort eased, Whitten recalls.

"That would have been a 60-mile visit out and back in the middle of the night for the nurse," Whitten says. ■

Legal issues are critical for telehospice programs

Liability and Medicare rules are chief concerns

The legal issues that apply to telehospice chiefly relate to the legal issues that already affect health care, including licensure, Medicare's Conditions of Participation (COPs), accreditation, and malpractice laws, with some added details, an expert says.

For example, because most hospices are certified Medicare providers, the COPs confer a range of responsibilities upon them, including

communication with interdisciplinary team members and documentation of critical actions for patients, says **William A. Dombi, JD**, vice president for law at the National Association for Home Care and Hospice in Washington, DC.

"Are hospices prepared to continue to comply with those rules and regulations in the age of new health technologies?" Dombi says. "A monitoring system may give 24/7 data. What kind of access to that information do team members have?"

For instance, the hospice may need to assign someone to review and digest the data, or at least have someone monitor the telehealth findings for the interdisciplinary team, Dombi explains.

"It's not a new responsibility, but an old responsibility applied in a new context," Dombi says. "How has the hospice adapted to that new context in terms of communication?"

An example of how the COPs should be revisited to make certain they are correctly applied is by having at least one employee review all telehealth data. That procedure should be audited periodically to ensure that the reviewer is doing a comprehensive assessment of the information, Dombi says.

Hospices that have accreditation through the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, will have to go through an assessment to ensure that they are complying with the commission's telehealth standards, Dombi says.

"Go through your system with the new telehealth and ask the question, 'Am I still doing the right thing to comply with either the Conditions of Participation or the standards of accreditation?'" Dombi says. "The old ways may be adequate, but until you analyze them, you're not sure they are."

Malpractice is the area of greatest legal concern, and there are a number of actions a hospice should take to prevent problems in this area, Dombi says. These steps include the following:

1. Reassess staff competency.

"A very competent nurse may not be a very competent nurse when it comes to utilizing telehealth services," Dombi says. "A competency evaluation of the nurse and staff generally is essential, and you must have well-trained staff using telehealth services."

For example, if the telehospice service includes the use of a video camera, some nurses may not know how to visually assess a patient who is seen through one of these devices. There will be a need to check the staff's telehospice technology competency, Dombi says.

2. Educate patients and families.

“Telehealth is a two-way health care service, and not every patient and family member is able to use the services properly,” Dombi says.

Just as an agency needs to make certain staff are fully trained in the technology, they will need to assess patients and caregivers for competency in using the equipment, Dombi adds.

“It’s difficult teaching patients to use telehealth services rather than teaching them to take oral medications,” Dombi says.

3. Have a disaster preparedness plan.

The hospice’s existing disaster preparedness plan may not be adequate for dealing with telehospice patients, Dombi notes. For instance, an electrical problem could be a bigger safety issue for patients who are depending on telehealth monitoring equipment, Dombi says.

The hospice should have a plan for managing telehealth patients who are affected by fire, flood, hurricane, or other disasters.

4. Evaluate competency of equipment.

There are liability concerns relating to the competency and operation of equipment, which needs to be calibrated properly, Dombi says.

“Hospices will rely on the equipment supplier, but ultimately the responsibility falls on the hospice,” Dombi says. “What systems are in place to make sure vendors are properly maintaining equipment, and what kind of system is in place for when the equipment is out of function?”

The main idea is that when using telehealth services, the home health agency is responsible for receiving the equipment’s information, making it a part of the overall care planning for the patient, and making certain the equipment is operating properly and the staff are educated in its use, Dombi says.

For instance, if a patient goes into cardiac arrest that was caused by a condition to which the hospice could have responded, then the hospice could be held liable, even if the condition had nothing to do with the terminal illness, Dombi says.

“The hospice could have responded to it and failed to do so because they failed to properly monitor data,” Dombi explains. “So there is a causal relationship between the injury and the hospice’s lack of fulfillment of its duties, and that’s what creates liability.”

Although liability risks are not high, hospice staff need to be aware that when they use new technology, they should have a more modernized view of risks and management of risks, Dombi says. ■

Hospice ethics committee can smooth a rocky process

Florida committee provides model

A hospice ethics committee can often provide additional emotional support to patients and family members during a time when making decisions is extremely difficult.

For instance, one of the more difficult ethical cases handled by Hospice and HomeCare by the Sea of Boca Raton, FL, involved a patient for whom the legal issue was in less dispute than the emotional issue. Yet, if the hospice’s ethics committee hadn’t met with the patient’s family, the situation might not have been resolved well.

The case presented to the hospice’s ethics committee involved a man with cancer of the stomach who had attempted suicide and ended up in an acute care hospital, explains **Joyce A. Richard**, RN, co-chairwoman of the hospice’s ethics committee.

The man was put on a ventilator and sent to a nursing facility. The issue presented to the ethics committee was that the patient wanted to eat, and his physician had ordered a test to see if he could swallow without choking, Richard says.

‘Just don’t feed him — let him die’

However, the patient’s wife disagreed with the physician’s order, saying that the patient, who now had a brain injury, had an advance directive stating that he should not be fed, Richard adds.

The patient, despite limited his cognitive skills, was able to walk and talk, says **Paul Pfadenhauer**, MDiv/MPS, team chaplain and ethics committee co-chairman.

“The wife kept saying, ‘This man was once a Shakespearean actor and was so vital, and just don’t feed him — let him die,’” Pfadenhauer recalls.

The physician and hospice were on firm legal ground in permitting the man to be tested for his ability to eat solid foods, but the ethics committee saw in this case an opportunity to help ease the pain endured by the man’s wife, who was having difficulty adjusting to the changes in her husband’s condition.

“We said, ‘Your husband’s world has shrunk, but within the smallness he now lives in he can still find things he enjoys, and if eating is one of

them, let him do it," Richard says.

"Paul told her, 'He may not be the man you remembered, but he is a human being, and he has a right to eat,'" Richard says. "The committee achieved so much because the wife relaxed her anticipatory grief."

The wife arrived at the committee meeting with a hostile attitude, but she left with a friendly attitude, Richard says.

"We thought it was one of the most beneficial outcomes because the wife was content now with the new world her husband was in and accepted him for what he was at the present," Pfadenhauer says.

In other cases, the ethics committee is asked to clarify the issues at stake when there are disputes between family members and clinicians about a patient's treatment.

For instance, one of the biggest issues the committee faces involves nutrition and hydration, Richard says.

Advance directive not reviewed till too late

In one such case, an Alzheimer's patient was provided nutrition and hydration through tubes. The patient had been taken to the emergency room after a fall, and the attending clinician asked a family member for permission to insert a feeding tube into the patient. The family member gave permission, Richard recalls.

Some time later, the family reviewed the patient's documents and found an advance directive in which the patient had said she would never want to be fed that way, and the family requested that the tubes be removed, Richard says.

"The attending physician was not comfortable with discontinuing, so we were called in to do a case review," Richard says.

The family was adamant that the patient's wishes be honored, but the physician was against removing the tube, so the family changed physicians and asked that the patient be transferred to the hospice's care center and have the tube removed, Richard says.

The ethics committee discussed the various options, including providing support for having the tube removed, which would provide the benefit of respecting the patient's autonomy but could create burdens in the form of side effects, such as pneumonia and skin breakdown, Richard explains.

"The benefit to the patient would be that she would not be so overloaded with fluids and

would be more comfortable and would die sooner," Richard says. "The benefit to the family is that they'd know Grandma's wishes were honored, and the burden was that they'd know she would die."

The physician's burden was that removal of the tube was against his beliefs, and the benefit was that he'd no longer be responsible for the patient's care, Richard adds.

The second option would be to maintain the status quo, which would only offer benefits to the physician. The burden of that option would be that the patient would continue to deteriorate, Richard says.

A third option would be to have the patient remain in the nursing facility and remove the tube while she was there. But this option was not supported by the physician, and the nursing home wanted the patient transferred to the hospice care center, Richard says.

Ultimately, the hospice decided to bring the patient into the care center under the care of a different physician, as the family had requested, Pfadenhauer says.

"The family has the right to change attending physicians," Pfadenhauer says. "Our concern would be that the person has the right to die, but we wouldn't impose that if the family didn't want the tube removed."

Ultimately, these cases are decided by family members and physicians, in accordance with laws and the patient's wishes, but the ethics committee gives all sides a chance to speak their minds and will make recommendations, Richard says.

Guidelines for your own ethics committee

Richard and Pfadenhauer offer these guidelines for establishing an ethics committee:

- **Select diverse community and professional members.**

"It's extremely important to have diverse members, including volunteers, policy-makers, and community members," Richard says. "It's important to not have all medical folks and not all hospice folks."

When the hospice first established its ethics committee, managers spoke with employees in each department and wanted to have each discipline represented on the panel, Richard says.

"Through attrition we've had some changes, but we do have a good representation in diversity, disciplines, and departments within our organization as well as outside it," Richard says.

"We have, for instance, a lot of patients in nursing home facilities, so we have on our committee a chaplain from one of the facilities."

There are 25 ethics committee members, which may seem like a large group, but a group this size has the advantage of flexibility, Richard notes.

"The beauty of having that many people trained is that if you have a case review, you have at least five trained people available," Richard explains.

The hospice finds potential committee members through recommendations of existing members and local organizations. Members include a Boca Raton police officer, a retired Veterans Administration medical director, and an attorney, Richard says.

- **Train committee members.**

The training program includes a videotape, audio tapes, and handouts, Richard says.

"When we started the committee, we had a professor of philosophy and ethics at the local university guide us in principles, and we tape-recorded him," Richard explains. "So new members receive handouts with our principles, and we have a discussion about what we've been doing."

The ethics committee reviews its orientation modules and procedures on a regular basis.

"Another thing we do is have off-site inspirational events where we rent out a retreat center and take the committee out for an afternoon of inspirational activities," Pfadenhauer says. "Or we take the committee on a working picnic, so we build a bond of fellowship."

- **Establish criteria for reviews.**

Each month the committee meets for 2.5 hours to keep abreast of current issues and to practice holding a case review session, Richard says.

"Very often during the meetings, even if we don't have a live case that month, we'll do a retrospective case from the book of cases, and this keeps everyone sharp and on their toes so the process is not forgotten," Pfadenhauer says.

When a patient, family member, physician, chaplain, nurse, team worker, or someone else requests a case review, the committee will hold a meeting within 72 hours of the request, Richard says.

"Any staff member truly is invited to make a recommendation for this consult, and they have a special form to fill out," Pfadenhauer says.

The consult form asks for the patient's name, medical history, what issue is prompting the request for a review, and who is making the

request, Pfadenhauer says.

Issues are often resolved before they come to the ethics committee. For instance, there might be a mini-ethical consult held at the patient's bedside, Pfadenhauer adds.

"Sometimes people come to us and say, 'We need your input,'" Richard says. "Sometimes we'll get questions that don't require a full case review, but we do some of what we call in-the-hall conferences."

Prior to a case review, Richard will gather details on the case, including the patient's history, the medical issues, the social and psychological dynamics of the family circle, and the problem.

Family invited to attend committee meetings

Then the committee meets with the patient, family, and clinical staff, if any or all choose to attend the case review.

"When we started the committee, we weren't comfortable with having the family there while we spoke about these issues," Richard says. "We soon learned that we are there for them, and of course they're going to have to be in the session."

Thus, the family will attend and will be told by the committee that the ethics committee is not there to judge them or the situation, but to listen in respect, as well as to respect each other and their confidentiality, Richard says.

"From there we discuss options, consider benefits and burdens, and the family has a chance to give some input, but they don't have a vote," Pfadenhauer says. "We have to meet the family and take a pulse of the situation and hear what the family has to say."

- **Keep discussions focused to ensure sessions are manageable.**

"I have to keep a tight rein on the group sometimes, and sometimes they resist that," Richard says. "We try to aim at an hour or 1.5 hours for the process, but we've had patients who have dragged it on a bit."

The meetings have been held at the hospice facility, but usually the ethics committee meets with the patient in the patient care center, nursing home, or the patient's home, Pfadenhauer says.

"We ask the patient if they are comfortable with being put into a wheelchair, and we'll use the chapel, which is a non-threatening place," Pfadenhauer says.

Each option presented for the situation at hand includes a discussion of potential benefits

and burdens for each person involved in the case, and committee members vote according to the standard ethical principles of autonomy, professional integrity, justice, and non-maleficence, Pfadenhauer says.

After the issue has been fully discussed, the committee votes for one of the options that have been discussed, stating their vote aloud along with their reasons for that vote, Richard says.

Then the committee chair will say that the majority of ethics committee members have recommended this option for these reasons, and a smaller group recommends another option for these other reasons, Richard explains.

Typically, the patient and family are so appreciative that the ethics committee members have spent time discussing their situation that they leave satisfied with the recommendations, Richard and Pfadenhauer say.

“The beauty of the process is that the family has been present throughout the dialogue and has understood and heard the issues discussed, and they can discuss with the doctor what to do with the recommendations,” Pfadenhauer says.

[Editor’s note: The ethics committee of Hospice and HomeCare by the Sea in Boca Raton, FL, has assisted other hospices with establishing an ethics committee, including providing training sessions. For more information, call the hospice at (561) 395-5031.] ■

Try these foolproof tips to be ready for JCAHO

Preparation efforts must change dramatically

If you still are doing last-minute ramp-up preparation for surveys by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, you’re going to have big problems with the Shared Visions — New Pathways process, warns **Lynne Adams**, CPHQ, director of quality at Upper Chesapeake Medical Center in Bel Air, MD.

“Our preparation process is ongoing throughout the year,” she says. “Our constant-preparation mode paid off with a very positive survey report.”

There is no doubt that your preparation efforts will need to change dramatically, adds **Jacquelyn Lewis**, RN, MBA, CPHQ, former director of

compliance and risk management at Augusta (ME) Mental Health Institute.

“With unannounced surveys coming, I just can’t emphasize enough that you have to be ready every day,” she says. “We need to get away from the mindset that ‘This is our Joint Commission year.’”

Continual preparation paid off with increased staff buy-in at Harford Memorial Hospital in Havre de Grace, MD, according to **Jane Gordon**, RHIT, director of quality. “The team members don’t feel like we’ve only worked to put on a show for the JCAHO,” she explains. “They feel that we truly care about meeting the standards for the well-being of our patients.”

Here are preparation tips from the three organizations, which were all surveyed in early 2004:

- **A Joint Commission team meets continually between surveys.**

The team consists of department heads, with each team member responsible for a specific chapter of the standards. Any new standards or revisions are reviewed, and reports are given on any issues that need to be resolved. “We keep an issues-tracking list that is reviewed at each meeting, and the item stays on the list until there is resolution,” Adams explains.

- **Quarterly mock surveys are done.**

Having mock surveyors make regular appearances on all units allows staff to develop a level of comfort with being interviewed and helps them comprehend the intent of the standards, she says.

Each Joint Commission team member is assigned a unit, with patients randomly selected for tracing. Tracers were conducted on about 10 patients the month before the survey.

“It proved to be a great tool for us,” Adams notes. “It really helped the staff prepare and be comfortable with the process.”

For example, the mock surveys revealed a lack of knowledge of how to obtain an interpreter for non-English-speaking or deaf patients, Gordon reports. “The mock surveyors spent a lot of time on the units and talked with any team members they came in contact with about how to access this service for our patients,” she says.

- **E-mail and snail mail updates are sent to staff on a weekly basis.**

Each communication covers a different hot topic, such as unapproved abbreviations, core measures, read-back of verbal orders, and critical values, Lewis adds.

- **A Joint Commission preparation festival is held.**

Three months before Upper Chesapeake Medical Center was surveyed, a Joint Commission Festival was held, with food, information booths on specific topics, contests, and prizes. The event was held for 24 hours so all staff could attend.

"It was a lot of work for the Joint Commission team, but it was such a big hit with the staff that it was well worth it," Adams explains. "It was a way to emphasize the new standards and make it fun at the same time."

- **Make sure all staff are comfortable talking with surveyors.**

Be honest: There probably are certain staff members whom you would prefer not to be questioned at length by surveyors. However, even the poorest communicators can improve dramatically with a little practice, Lewis says.

She recommends walking around the units and giving staff pop quizzes, such as asking a housekeeper, "What do you do about infection control?"

"The people you are afraid of putting out front may not present themselves well, but most of the time, it's only because they get tongue-tied," Lewis adds.

The goal is to reduce the intimidation factor by getting staff used to answering on-the-spot questions. "Lots of times, staff are afraid of people because of their title or status as a Joint Commission surveyor, and their mind just goes blank," she says.

If staff are confused by JCAHO-speak, rephrase the question with an emphasis on clinical practice, such as asking, "How do you handle a person who is out of control?" instead of asking about the restraint policy.

"They often know much more than they realize. These are the things that they deal with every day," Lewis points out.

Although surveyors generally are using a lot less jargon these days when interviewing staff, terms such as "core measures" or "verbal read-backs" occasionally may be used. "So it's still a good idea to get staff used to the terminology," she says. "It also makes them less afraid of the Joint Commission because we speak the same language now."

- **Accept the fact that things won't be perfect.**

Since surveyors will be arriving unannounced as of 2006, you must accept that everything won't be flawless. "You will *always* be in the middle of something; you will *always* be implementing a new program," Lewis notes.

Surveyors will understand this and will want

to hear why you chose to make certain changes and how far you've gotten, she explains.

- **Do chart reviews on a continual basis.**

A full-time chart-review nurse checks for key pieces of documentation on an ongoing basis, which was a big help during the survey, Lewis says.

At Augusta Mental Health Institute, the required pieces of documentation include a universal assessment within 24 hours, a complete treatment plan within three days, and an assessment of the initial care plan after 10 days.

"By continually getting all of the pieces in place during the chart reviews, all of that documentation was already there during the tracers," she says. "Having the patient charts polished all the time was invaluable to us."

- **Play games.**

Lewis says that by playing games such as Family Feud and Jeopardy with Joint Commission themes at staff, department, and administrative council meetings, staff learned much more than they expected.

"We had a stuffed JCAHO bear, and whoever won the contest that week got to have the bear on the unit," she says.

- **Post "JCAHO jewels."**

Lewis posts these nuggets of JCAHO-themed information throughout the facility for staff to see.

"I have them plastered all over the hospital — in hallways, on bulletin boards, in staff locker rooms," she says. For example, one sign says, "Our patients are identified with two forms of identification: A current color photograph posted in the medication room and their birth date." ■

JCAHO raises infection bar for long-term care facilities

Standards similar to hospitals must be adopted

While much attention has been paid to new hospital infection control standards for 2005, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, also is adopting similar standards in long-term care facilities.

A pre-publication edition of the new standards for long-term care, which will be effective Jan. 1,

2005, lists the following key provisions:

Prevention of health care-associated infections (HAIs) represents one of the major safety initiatives that a long-term care organization can undertake.

The Centers for Disease Control and Prevention estimates that each year approximately 2 million patients admitted to acute care hospitals in the United States acquire infections that are not related to the condition for which they were hospitalized.

Residents of long-term care facilities often are transferred to and from hospital settings, making infection prevention and control a priority.

Older adults may not present with the typical signs and symptoms of infection, making identification of these residents with infections more challenging.

The design and scope of the long-term care organization's infection prevention and control program are based on the risks that the organization faces for the transmission of infectious disease.

Therefore, the organization assesses its risk and designs the infection control program based on this assessment. Once the organization has designed its program, the program must be monitored to ensure that the infection prevention and control activities are implemented.

The goal of an effective program is to reduce the risk of acquisition and transmission of HAIs.

Long-term care organizations must do the following to achieve this goal:

1. The organization incorporates its infection program as a major component of its safety and performance improvement programs.
2. The organization performs an ongoing assessment to identify its risks for the acquisition and transmission of infectious agents.
3. The organization uses an epidemiological approach that consists of surveillance, data collecting, and trend identification.
4. The organization effectively implements infection prevention and control processes.
5. The organization educates and collaborates with leaders across the organization to effectively participate in the design and implementation of the IC program.
6. The organization integrates its efforts with health care and community leaders to the extent practicable, recognizing that infection prevention and control is a communitywide effort.
7. The organization plans for responding to infections that potentially may overwhelm its resources. ■

New JCAHO survey process targets medication errors

Examining the six steps of the medication process

In light of so many providers having difficulty meeting the standard of care for medication administration, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is taking action.

One of its 2004 national patient safety goals is to improve the safety of using high-alert medications. In addition, updated medication standards from the Joint Commission focus more on medication processes as a system than on individual standards, says **Michael Jarema**, associate project director of the Division of Standards and Survey Methods at the Joint Commission.

For all surveys that take three days or longer, surveyors will walk through the six steps of medication process:

1. Selection and procurement: This is the process by which the organization decides which medications to have available and the process by which it obtains medications, including what to do if there is a shortage of a medication.

2. Storage: The provider addresses issues of medications that sound alike and look alike, as mentioned in the National Patient Safety Goals, including control of medications.

3. Ordering and transcribing: This step of the process includes consideration of computerized physician order entry, verbal orders, and written orders. It covers approved abbreviations, use of generics, indications for use, precautions, and 13 orders that require special attention, including an incomplete or illegible order.

4. Preparing and dispensing: This area covers preparation, issuance, and accountability for doses of a prescribed medication by a pharmacist or other authorized individual. It includes review of medication orders for appropriateness, safe preparation, labeling, dispensing practices, and medication recalls.

5. Administering: The standards addressing this part of the process cover giving a prescribed dose of a medication to a patient and describes safe administration processes such as verifying the medication, dose, route, time, and patient.

6. Monitoring: The standards addressing this process within an organization's medication management system focus on the responsibility

for monitoring effects of medications and the organization's response to actual or potential adverse drug events and medication errors.

The surveyors might pinpoint a specific medication and "walk it through" the organization, Jarema says. They may ask, "How would you determine how you're going to use this drug in your facility? What are storage issues? How do you train staff?" For new medications, they might ask, "Does this medication require anything unique?" Surveyors might pull a patient's chart and ask about any medications the patient is taking that are considered to be a high risk, such as warfarin. They might ask staff, "How is the medication approved for use in your organization? How did you decide to use it? How frequently do you review the medication you're using? How do you know providers are competent to use them?" If surveyors see a drug is administered in a specific area, such as pre-op, they may go to that area and talk to staff about storage and other safety issues, he explains.

Also, the Joint Commission requires facilities to have a regulation that provides a process for a nurse to contact a physician when an order isn't legible or is the wrong dose, adds **F. Dean Griffen**, MD, FACS, surgeon at the Highland Clinic at Shreveport, LA. ■

Medicare's definition of 'homebound' tested

Three states in demonstration project

Medicare officials recently announced the three states where Medicare will conduct a demonstration project involving a new definition of "homebound" that would allow Medicare beneficiaries receiving home health benefits to leave their homes more frequently and for longer periods without risking the loss of benefits.

The demonstration in Missouri, Colorado, and Massachusetts will mark an important step in identifying strategies to promote greater freedom and independence for people with disabilities who require daily assistance. As part of the three-state demonstration, which was authorized by the Medicare modernization legislation enacted last year, Medicare will use a more liberalized definition of homebound to facilitate greater

mobility for those receiving home-based services.

"This demonstration will give those with chronically disabling conditions a chance to live full lives and contribute to their communities while still receiving services in their homes," said **Tommy G. Thompson**, secretary of the Department of Health and Human Services (HHS).

Current rules used to determine who qualifies for Medicare payment for services at home require that any time away from home must be "infrequent or of short duration." Congress and the Centers for Medicare & Medicaid Services (CMS) have refined this definition in recent years by clarifying that leaving home for adult day care or religious services is allowed. The demonstration project removes a limitation based on actual time spent away from home, eliminating the concern among many homebound people that they will lose their home-based care if they attempt to take advantage of activities outside the home.

Participants must meet needs-based criteria

"This evaluation of a less restrictive definition of homebound for Medicare coverage is an important step toward achieving our goal of greater freedom and independence for people with disabilities," said **Mark B. McClellan**, MD, PhD, administrator of CMS, the agency that oversees Medicare. "By eliminating current restrictions, this group of persons who require substantial daily assistance will have access to more normal lives in their own communities."

Up to 15,000 beneficiaries will be eligible to enroll in the two-year demonstration, which will begin in the fall of 2004. To qualify for the demonstration, Medicare beneficiaries must have a permanent, severe disability that is not expected to improve. In addition, the individual must meet each of the following needs-based criteria:

- **Needs permanent help with three of five activities of daily living (ADLs), such as bathing, dressing, eating, toileting, and transferring.**
- **Needs permanent skilled nursing care, and daily attendant visits to monitor, treat, or provide ADL assistance.**
- **Requires assistance to leave home.**
- **Is not working outside the home.**

The goal of the demonstration is to determine the cost impact of the changed definition for patients with chronic illnesses, a population that otherwise may be at risk for costly institutional care. As part of the process of addressing this question, CMS plans to host an Open Door Forum

on June 25 specifically to solicit input from interested groups to discuss the major features of the demonstration.

"As we move forward on implementing this important demonstration program, we will work with home health professionals and advocates for disabled beneficiaries to make sure we do so effectively," McClellan said. "We need to find the best, least costly ways to provide more freedom for beneficiaries with severe disabilities."

HHS has played a critical role in advancing the New Freedom Initiative since its launch on Feb. 1, 2001. To date, about 60,000 people with disabilities now have Medicaid health coverage through the Ticket to Work and Work Incentive Improvement Act Medicaid Buy-in Program. HHS also has approved waivers for nine states that give about 22,000 individuals with disabilities the option to direct their own health care.

In addition, the HHS fiscal year 2005 budget plan would authorize more than \$2.2 billion in new spending over the next five years to build on and expand the New Freedom Initiative to promote greater independence for Americans of all ages with a disability or long-term illness. ■

Study finds fewer people dying in hospitals

Research from the past two decades shows that fewer Americans are dying in hospitals, and more are dying at home and in nursing homes.

When researchers from the National Institutes of Health looked at more than 35 million death certificates issued during the years 1980-1998, they discovered that the proportion of patients dying as hospital inpatients dropped from 54% to 41%. During the same period, the proportion of deaths both at home and in nursing homes increased. Home deaths rose from 17% in 1980 to 22% in 1998, and nursing home deaths rose from 16% to 22% during that period.

The researchers found that the shift applied to both men and women, and the largest shift occurred for patients dying from cancer. The proportion of cancer patients who died in hospitals dropped from 70% to 37%.

One of the most significant shifts related to race. In 1980, statistics showed that 54% of both blacks and whites died in hospitals. By 1998,

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researchers say, 48% of blacks were still dying in hospitals, while only 40% of white patients died there. Deaths among females showed the greatest racial divergence, with half of black women dying in hospitals and only 39% of white women dying there.

The researchers, writing in the May/June issue of the journal *Health Affairs*, said they could not say for certain why the racial disparity existed, with possible reasons including a preference among blacks for hospital death, an unwillingness among blacks to sign advance directives, or the fact that blacks have more limited access to hospice and home health agencies. ■

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