

HOSPICE Management ADVISOR

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New client satisfaction tool offers better data on improving care

NHPCO provides benchmarking services with new tool

Too many hospice client satisfaction surveys do more to boost hospice staff morale than to generate suggestions for improvements. The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, used such a self-congratulatory survey for years before deciding to revamp the survey with the goal of giving more useful feedback to hospice organizations.

"As consumer evaluation of health care research has evolved, it has become clear to us that the tool wasn't helping us improve quality," says **Stephen Connor**, PhD, vice president of NHPCO.

"It had a leniency bias, so people were not inclined to answer questions in a way that would admit there was a problem," Connor says. "It was a back-patting exercise that made everyone feel good but didn't really help us improve care."

NHPCO asked for help in revising the tool from researcher **Joan Teno**, MD, MS, professor of community health and medicine at Brown Medical School and associate medical director of Home and Hospice Care Rhode Island in Providence.

Teno and co-investigators spent seven years developing a tool for family evaluation of hospice care that could be validated and compared for national benchmarking purposes.

"It's been a lot of work," Teno says. "We shortened the tool, put it into a format to be self-administered, and helped to build a Web site

This month's cover story is the first of a two-part series on client satisfaction in hospice care. The first story in the series delves into a new satisfaction survey that will help hospices spot areas where improvement is needed. In the next issue, we will provide additional client satisfaction tips offered by hospice organizations.

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that NHPCO has further redesigned to allow hospices to send in their satisfaction data and obtain a report with national benchmarks.”

Previously, satisfaction tools used ratings ranked on a scale from “very good” to “very dissatisfied,” Teno says.

“Everybody either said care was excellent or good or they were very satisfied,” she says. “The classic example is when the family member reports that the patient was in moderate pain during the last three days of life and then for the next question would say they were very satisfied with the level of pain control.”

So the new tool asks bereaved family members about specific processes of care that they observe. For example, a question might be, “Did the doctor tell you how to administer the pain medication in a way you can understand?”

This is very different from asking how satisfied a person is with pain control, and it’s more likely to produce useful information, because if a person

doesn’t understand how to administer pain medications, then there likely will not be effective pain control, Teno says.

“We tried to come up with the key important areas to measure end-of-life care in the United States,” Teno says.

The model researchers developed is based on these tenets:

- Patients desire a certain level of pain control and emotional support.
- All health care providers should promote shared decision making.
- Health care workers should treat a dying person with respect and dignity.
- Health care workers should attend to family members’ need to have information about what to do and should provide emotional support both before and after the patient’s death.

After researchers field-tested the satisfaction tool, they addressed various concerns expressed by hospice providers, including a concern that family members might not want to fill out a long survey form, Teno says.

Four domains of information

The tool originally had eight domains, but it was shortened to these four domains:

- informing and communicating about the patient’s care;
- providing information about symptoms;
- providing coordinated care;
- tending to the family’s needs.

The new and revised survey has the same response rate as the previous one (about 50%), but it provides more valuable information to hospice providers, Teno says.

When investigators spoke with hospice providers, they learned that some would let the survey results pile up on a corner of their desks and not fully analyze the results, mostly because they weren’t sure how to do the analysis, Teno says.

“So we gave them an Internet tool that allows them to analyze it and provides them with benchmarks, as well,” she says.

Since January 2004, the tool has been used to collect data that are uploaded to NHPCO each quarter and analyzed for a benchmarking report, Connor says.

“There is an individual hospice report with comparisons on each question and domains for their state and national percentiles and significance,” he says. “Right now we have over 500 hospices using it, and that amount increases every quarter.”

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Editorial Questions

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

Some hospices already have made important program changes based on the feedback they've received from the family satisfaction tool results, Connor says.

For example, the Hospice of St. Mary's in Leonardtown, MD, created a new volunteer position that involves the volunteer meeting with each hospice family and patient to find out how they are doing with the specific areas covered by the satisfaction tool. This proactive measure has resulted in improved satisfaction ratings and results that are better than the benchmark averages, says **Charlene Taylor**, RN, BSN, hospice director. **(See story on Hospice of St. Mary's satisfaction improvements, lower right.)**

"We have discussed the idea of identifying programs that are particularly exemplary and seeing if they wished to share information about how they are doing it," Connor says. "But at this point we're very early in the process."

One of the chief findings resulting from the tool's development and use is that patients are often referred to hospice when it's too late to provide optimal end-of-life care, Teno says.

"From my standpoint, what's frustrating is how late hospices get people referred to them, so that it's difficult to do anything except acute symptom management," she says. "Hospices don't get the opportunity to provide emotional support to family members."

Teno and colleagues published results of their research in the January 2004 issue of the *Journal of the American Medical Association*. The study found that more than two-thirds of Americans die in an institution. Of the people who died at home, 38.2% did not receive nursing services, while 49.3% had home hospice services.¹

The study, which interviewed family members or other people who were knowledgeable about the deceased person's end-of-life care, found that many people who are dying in institutions have unmet needs for symptom amelioration, emotional support, and physician communication.

"We used the survey results from people who died at home with hospice as benchmarks," Teno says. "Some of the consistent findings in the study are that there are opportunities to improve care across all sectors of the health care system, even hospice."

However, hospice uniformly had a lower rate of reported concerns and higher overall satisfaction, Teno adds.

"Another big picture is the emerging rate at which nursing homes are now being the last place

of care for older frail persons and the significant concerns that bereaved family members have with that last place of care," Teno says. "Nursing homes had some of the higher rates of concerns and some lower satisfaction."

These findings are a reflection of how the United States finances its health care system, Teno says. Nursing homes are not adequately financed and staffed to provide end-of-life care, which has led to staff shortages and high rates of turnover in those facilities. This means hospice has an important role to play in providing help, especially given that increasing numbers of people are going into nursing homes, she adds.

National statistics indicate that about one in four people dies in a nursing home, up from fewer than one in five in the late 1980s, Teno says.

"Health care providers don't do a good job of effectively communicating with patients and families about the possibility that the patient is dying," Teno says. "I think hospices need to partner with nursing homes or hospitals and really try to figure out how to create systems that facilitate communication and earlier referral."

Reference

1. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA* 2004; 291:88-93. ■

Special Report: Making the Satisfaction Grade

Measure satisfaction when you can still improve it

One volunteer position might make the difference

Hospice families repeatedly report needing more education to help their dying loved one, according to the new satisfaction survey the Hospice of St. Mary's in Leonardtown, MD, began using in January 2004.

So the small hospice, which has 16 employees, created a new volunteer position that involves the volunteer meeting with each hospice family to ask them about their needs and concerns during the hospice stay, says **Charlene Taylor**, RN, BSN, hospice director.

"Our volunteer loves her role because she can be a little bit of help to every family," Taylor says.

“She talks with the family and comes back with excellent suggestions.”

As a result, the hospice’s family satisfaction levels have improved and now are higher than benchmark averages in all indicators, Taylor says.

The hospice’s new survey, which is distributed by the National Hospice and Palliative Care Organization of Alexandria, VA, polls family members after their loved one has died about their specific needs and concerns during hospice care. The new survey has been shown to produce more useful information than a typical survey that only asks for ratings from “very good” to “very dissatisfied.”

Meeting with families during hospice care

However, the information arrives well after the episode of hospice care has ended, so Hospice of St. Mary’s took the process a step further and now has the volunteer meet with hospice families during care to ask them some of the same types of questions as those on the survey. This way, there still is time to make improvements for that particular family, Taylor explains.

“She goes out about one or two weeks after a patient is admitted and sits with the family to find out if there’s anything else we need to do to raise their level of confidence and emotional support, Taylor says. “She comes back with answers, and we sit together as an interdisciplinary team and address the cases where families feel they need more help.”

The volunteer was trained to ask questions that are more specific, such as:

- **Is there anything else the hospice could be doing?**
- **Do you have a financial concern that is not being addressed?**
- **Do you feel comfortable that you have all the tools you need to care for your loved one?**
- **Are you receiving the emotional support you need?**

“In about one-third of the cases, something comes up where the family member will say, ‘I’ve been worrying about how to pay for the funeral,’ or ‘I’m worried because I have a family member coming to visit who hasn’t seen our family in 10 years, and I don’t know how to talk to them,’” Taylor says.

Hospice families typically don’t share these types of concerns with hospice staff, but since the volunteer is there solely for the purpose of listening to their worries, they will speak freely, Taylor notes.

“It makes a difference when one person goes out to meet with them and that’s all that person is there for,” Taylor says.

The hospice team will address the family’s needs by sending out a chaplain if the need is spiritual, or sending out a social worker if there are financial concerns, Taylor adds.

As a result of this fast response to client concerns, the hospice’s satisfaction scores are high, with the hospice receiving 100% on the indicator of hospice caregiver confidence about care that’s being delivered. That item has a benchmark of 95%, Taylor says.

The benchmark for pain control and symptom management is 74.49%, and the hospice’s score was 87.5% for the last quarter, Taylor says.

With the previous survey, the hospice had achieved improvement in some areas, but the new survey tool has more extensive questions and information that’s more readily useful for quality improvement, Taylor says.

“I see a decrease in the amount of people who want to answer all of those questions, but what I’m getting back is a much more valuable tool,” Taylor says. ■

How a small hospice boosted its fundraising

Raising \$160,000 in one day

Fundraising is the lifeblood of Fox Valley Hospice in Geneva, IL, because the hospice is a free service hospice that does not contract with Medicare.

However, it’s difficult to pay for the costs of providing hospice services when your one big fundraiser nets only \$25,000 a year. That was the quandary Fox Valley faced five years ago, says **Nancy Vance**, development director for the hospice. Vance also is an alderman with the City of Batavia.

“We had a garden party luncheon fashion show that needed some work to make it our signature fundraiser,” Vance says. “We did smaller fundraisers that netted smaller amounts of money, and I wanted to concentrate on one and make it as good as we could make it.”

This past May, that revitalized garden party

brought the hospice more than \$160,000 in net proceeds, a sum that covers more than one-fifth of the hospice's annual \$750,000 budget, Vance says.

"We raise the rest of the money through foundations and gifts and planned giving through endowments, bequests, wills, gifts, and trusts," she adds.

Fox Valley has a staff of 14, most of whom work part time, including a full-time nurse, three part-time nurses, three social workers, two administrators, and a bereavement coordinator, Vance says.

In addition to direct contributions to the hospice, the organization receives about \$300,000 in products and services that are donated to the annual garden party fundraiser, she says.

These donations include thousands of items to fill 20 large baskets that are raffled off, as well as 100 themed packages featured in a silent auction.

Making the charity top-10 list

"We wanted to reach a large prospective donor base, and there are only so many dinners, luncheons, and golf tournaments that they'll attend," Vance says. "The idea was to get this event on their top-10 list."

The strategy has worked. Six thousand invitations are mailed, and only the first 850 to respond are sold \$40 tickets to the luncheon. Even the hospice's board members compete for the first-come, first-served seats.

If you want to spruce up your fundraiser the way Fox Valley did, follow these steps:

- **Put the event on everyone's short list of must-do charity fundraisers.**

"We have gone the extra mile to make the event stand out above the rest of them," Vance says. "We took an ordinary luncheon and made it into a magical event."

First, Fox Valley staff found an ideal luncheon location at the Q Center in St. Charles, IL. A former executive training facility, the Q Center is large enough to feature a luncheon and fashion show for 850 people, Vance says.

The event easily could pull in twice as much money if it were held in a bigger location or put on twice a year, but doing so would make the event lose some of the ambience that has made it so successful, Vance notes.

"I work with the volunteer steering committee, and they'd frown on having to do this twice

a year," Vance says. "We thought about making it a nighttime event, but the people who come to this are usually moms who want to support our efforts."

Since the hospice serves many young women who are dying of breast cancer, the women who attend the garden party often are family members, neighbors, and friends of the attendees, Vance adds.

And that's part of the fundraiser's mystique: It serves a cause that the garden party attendees can relate to on a personal level, Vance says.

"We invite an individual who has benefited from the hospice to share their experience with the attendees," Vance says.

Typically, a pianist and a local stringed instrument band perform during the luncheon, and these performances also are donations to the hospice.

The other factor that makes this an A-list fundraiser for the area is that its silent auction and raffle feature top-quality prizes, Vance says. (See story on prize donations, p. 102.)

"I wanted our theme baskets to be the most incredible they've ever seen," Vance says. "The baskets are so large now that people need a truck to get them home."

Get the right volunteers for the job

- **Find volunteers who are willing and able to put in the time that's needed.**

For a fundraising event as big as the garden party, an organization needs a professional fundraiser who would create a theme, a time line, job descriptions, an event plan, and a budget, as well as recruit volunteers, Vance says.

"You need to make sure all volunteers understand and agree with the game plan," Vance explains. "I recruited 40 steering committee volunteers, and it's critical to make sure the volunteers you recruit are the right persons for the job."

Steering committee members report to Vance, who makes certain the fundraising activities do not take over her job.

"The development director still has to solicit bequests and planned giving and write grants," Vance notes.

Vance finds out what kind of work interests each volunteer the most and steers each person toward that type of work.

"When recruiting volunteers, we take the ones who do the best," she says.

The volunteer committee is in charge of soliciting donations for the baskets, and there are a chairperson and five helpers for each of the theme baskets. The chairperson is responsible for recruiting friends to help him or her solicit donations, Vance says.

Picking a 'mission moment'

One way that Vance makes certain the volunteers are enthusiastic about the fundraiser is through regular meetings that begin with a "mission moment." "I connect volunteers with a story that happened recently," she explains. "For example, on Friday, we had a gentleman come into our office, and you could tell by his face that he was devastated. He said, 'My wife has been diagnosed with Stage 4 cancer, and I have three daughters — how do I tell them their mother is dying?' Those are the kinds of things I need to tell volunteers to make sure they know why we're doing this: It's for this gentleman who needs hope and who is devastated and doesn't know how he's going to do it with his daughters," Vance says.

Vance typically recruits volunteers in September, after the event's theme basket chair and co-chair have been recruited. The 2004 garden party featured Jean Hastert, wife of Speaker of the House Dennis Hastert, as the honorary chairwoman.

The next step is to recruit the event's underwriters and sponsors and then begin meeting with volunteers in September, Vance says.

"We get the volunteers revved up and fill in the spots they don't have, and they have until March to get people they have recruited to help fill those baskets," Vance says. "Then we have a team of creative people who put the items in baskets and make them beautiful."

Then there are volunteers to sell raffle tickets and assist with the many other details that go into putting on the event.

- **Increase fundraising potential without losing what makes the event special.**

The event typically sells out within 10 days and often has 200 people on a waiting list, Vance says.

While the hospice and volunteers do not want to expand the event by selling more tickets, they have decided to increase the ticket price from \$40 to \$50 per person.

Another way to expand the event's fundraising potential is through a silent auction. At present, the silent auction begins at 10 a.m. on the day of

the event. The 850 attendees are permitted to enter and view the baskets, and the bidding starts at that time. The bidding period lasts until 12:30 p.m., when the lunch begins, Vance explains.

"We are considering putting the silent auction on a web site, so people can bid on it on the web," Vance says. "We'd have to be hooked up live so we'd know what was going on." ■

Donated goods, services key to effective fundraising

Top-quality items bring in the most money

Fox Valley Hospice in Geneva, IL, receives more than \$300,000 in donated goods and services each year for its annual garden party fundraising event. The key to obtaining this level of support is to build on previous years' successes and remind vendors about the important work that the hospice provides for the community, says **Nancy Vance**, development director for the hospice.

The silent auction items and the 20 theme baskets that are raffled off represent huge donations from local businesses, which are eager to participate with the project, now in its fifth year, Vance says.

"We say to businesses, 'If you donate to us, you'll have 850 women in that room who shop,'" Vance says. "Businesses know we're a free hospice and we're dependent on those funds, and that helps us."

Silent auction items have ranged from exotic vacations to golf packages to jewelry, and even an original Renoir sketch one year, Vance says.

Each chairperson has a list of what was donated over the past three years, and she is able to return to the businesses and remind them of past contributions and ask for something different for the current garden party, Vance says.

The theme baskets have been built around such topics as "American Girl," "Fore the Golfer," "Girls Night Out," "Toyz for Boyz," "College Bound," and "Family Fun." Raffle tickets sell for \$5 each, 10 tickets for \$40, or 30 tickets for \$100. Since these tickets can be purchased by all of the people invited to the garden party, even if they are unable to attend, there typically are thousands of tickets sold each year, Vance says.

The Q Center in St. Charles, IL, where the event is held, donates its space to the hospice for the event, and the facility's staff donate their time, Vance says.

"Many employees are volunteers for us, and we have corporate people who come down to serve lunch and help to orchestrate the logistics," Vance says. "We only pay for the cost of the lunch, which is \$16.50 per lunch."

Keeping expenses low

Thanks to the many donated items and services, the event's expenses are only 16% of the proceeds, Vance says.

Other donated items include the printing of the programs and invitations, geranium plants for 90 tables, chocolate party favors that are shaped like flowers, small bottles of wine for the tables, and themed gift bags — such as beach-themed bags that include flip-flop sandals — that attendees can take home with them, Vance says.

Also, the models for the fashion show are all volunteers. For instance, the fashion show for the May 2004 event featured child models who were part of the hospice's bereaved program, meaning they had lost a parent, Vance says.

The adult models also are from the bereavement program, or they are hospice volunteers, Vance adds.

"We chose not to hire a production company because they're costly, and most importantly, because we want the community to connect with the family members and friends who are models for us," Vance says.

The hospice also obtains free media exposure by sending press releases to the very receptive local newspaper, which publishes items about the event several times a week in the weeks preceding the garden party, Vance says.

When it's time to thank volunteers, Vance sends a letter to the newspaper's editor in which she thanks the community for its support and thanks volunteers by name. ■

Tracer methodology focuses on care, not paper

Pay less attention to manuals, more to safety goals

Mid-cycle self-assessments, tracer methodology, and less emphasis on examination of policy books are all signs that the new survey process implemented by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations is truly different from the survey process of the past.

Although any change in a process to which people have become accustomed is uncomfortable, home health managers who have undergone surveys in 2004 report positive reactions to the new process.

"I like [the survey process] better this year than in previous years," says **Laura Hieb**, RN, MBA, administrator of Bellin Home Health in Green Bay, WI. "Surveyors used to focus on policy manuals and documents without any pattern or real objective," she says. "Now, everything the surveyor asks to see is based upon the patient who is being followed," she explains.

The use of a tracer methodology for a survey means that the surveyor "follows" the path of a patient throughout the patient's encounter with

the home health agency. This might mean that the surveyor starts with the patient's records from the hospital, then follows the patient through referral, admission, care, and discharge. As the surveyor follows the patient's record, he or she talks with employees who were responsible for different aspects of the patient's encounter.

One of the Bellin Home Health patients who was "traced" was a patient who received services from the home health agency, the durable medical equipment company, and IV services. "The surveyor rode to the patient's home with the driver delivering the IV product, then stayed with the patient a good part of the day while our home health nurse and the IV nurse made their visits," says Hieb. "Throughout the surveyor's stay, she asked nurses how they handle different situations that might arise with a patient's care. She also talked with the patient, asking questions about who should be called for assistance with equipment or medications," she explains. It was clear from the patient's responses that the home health agency, along with the other services, had done a good job of educating the patient and making sure the correct phone numbers were handy, she adds.

It is still important to keep employee records up to date, points out Hieb. "Although the surveyor didn't look through all of our personnel records, she did ask to see the files of four or five employees

who were involved in the traced patients' care," she explains.

Because the new process focuses more on actual patient care than on paper documents, staff members have more direct contact with surveyors and are questioned more often than managers. Of all health care-related staff, home health employees may be the best prepared to interact with surveyors, points out **Judy Falkowski, RN, BSN**, director of Bay Area Hospital Home Health Care in North Bend, OR.

"Home health staff members are accustomed to unannounced visits from state surveyors all the time," Falkowski says. "My staff has learned that the best way to show off the quality of care we offer is to do so while riding with a surveyor on a visit," she adds.

Questions that surveyors ask are prompted by what they see in the documentation or by what the staff member or patient says is being done, points out Falkowski. For example, when medications for a diabetic patient are discussed, the surveyor asks what education is provided and whether other services are consulted for advice and information, she explains.

Patient safety is high priority

Surveyors are also focusing on National Patient Safety Goals, says Falkowski. (See **2005 National Patient Safety Goals, p. 106.**) "They want to see that staff members, physicians, and clients understand safety and know what to do if an alarm on a pump goes off, for example," she explains. "The surveyors aren't looking for perfection; what they do want to see is that your agency has systems in place to promote safety and to protect patients," she adds.

In one of the open forums held by the surveyors with representatives from all departments of the hospital, surveyors did not ask people to describe how they were meeting the goals. Instead, they asked, "What do you know about the National Patient Safety Goals?"

"That question led into other questions about how we address medication safety or improve communications," Hieb says.

While some home health agencies may feel let down that the surveyors don't spend as much time in home health as they did when surveys were conducted separately, Hieb says the survey of her durable medical equipment company was the most extensive she's ever seen. "One of our surveyors happened to be a respiratory therapist,

so our logs for equipment checks were reviewed, and he went on visits with the respiratory therapist," she says. In the home health agency, there were two surveyors who spent about four hours each looking at different patients, she adds.

Don't forget that, even when your home health agency is part of a hospital, you still need to have your own emergency management plan in place, warns Falkowski. "I am used to no recommendations or conditions in my surveys, so I was surprised to be hit with a recommendation related to E.C. 410, the standard that states that the organization must have an emergency management plan," she says. "My plan that I relied upon was basically the hospital's plan, with a few modifications for home health," she says. "The surveyor pointed out that because home health differs from the hospital, it should have its own unique plan that does tie into the hospital's plan," she explains.

Hazard analysis tool pinpoints risk

By using a hazard analysis tool, Falkowski was able to identify the most likely emergencies that her agency would face and develop a plan to address them. (See **editor's note on p. 105 for information about how to obtain a hazard analysis tool from the American Society of Healthcare Engineering.**) Within her plan, Falkowski addressed the possibility of receiving large numbers of admissions from the hospital as the hospital prepared to receive victims of an emergency. "We looked at how we would handle these admissions with and without power," she adds.

Infection control is another area upon which the surveyors focus, says Falkowski. On one of the patient visits, the surveyor asked the home health nurse if she had protective equipment for drawing blood. Although the nurse did have the equipment, she did not have a hard container in which to transport used sharps, she says. "The nurse was not scheduled to draw any blood that day, so she did not have the container," she explains. Falkowski suggests that any employee who might draw blood be prepared with all of the equipment, including containers, regardless of which patients may be scheduled on that day.

While the survey itself may be easy for most home health agencies, the periodic performance review (PPR) — the mid-cycle self-review now required by the Joint Commission — presents more of a challenge, says **Jodi Brown, RN, BSN**, director and administrator of Alcovy Home Care

in Covington, GA. "It is very time-consuming, especially for a small agency," she says.

"We have received feedback that home health agencies find the PPR difficult," admits **Maryanne L. Popovich**, RN, MPH, executive director of the Joint Commission's home care accreditation program. Although the review is time-consuming, many organizations find it helpful as they target areas for improvement prior to the Joint Commission's survey.

"I went through the online tool, reading every section to determine which ones applied to us," says Brown. For the standards that apply to home care, she either completed the form stating whether the agency met the standard and how it did so, or she pulled out sections for her nurses to complete if they were better qualified to complete the form. "My nurses weren't excited about the extra work, but it was the only way to complete it," she says.

Although the work to complete the self-assessment was split up, Brown says the staff discussed the completed information as a group. She says this is one way to ensure that all of the information is accurate and to identify areas for improvement and develop plans of action.

[Editor's note: To obtain a copy of the Hazard Vulnerability Analysis from the American Society of Healthcare Engineering (ASHE), current ASHE members can go to www.hospitalconnect.com/ashe/pdfs/secure/2001FebTechDoc.pdf. To request a hard copy of the document, go to www.ahaonlinestore.com and request document number 055920. The cost of a hard copy for ASHE members is \$25, and the cost for non-members is \$35.] ■

JCAHO's new safety goals routine for most HHAs

Medications, falls, timely reports top list of goals

Medication safety, improved communications, and reduction of falls are among the new additions to the 2005 National Patient Safety Goals of the Joint Commission on Accreditation of Healthcare Organizations.

The majority of the safety goals, including the new ones, should not be a problem for home health care because they represent standard operating procedure for most agencies already,

says **Maryanne L. Popovich**, RN, MPH, executive director of the Joint Commission home care accreditation program.

Tweaking current processes

For example, in Goal 2C, which focuses on improved communications by assessing the timeliness of reporting critical results, Popovich points out that if a patient's digoxin level is outside a normal range, the nurse automatically contacts the physician. "While new processes won't have to be developed, current processes may be evaluated and tweaked," she points out. The most difficult part of this requirement is that the Joint Commission has not defined "critical," she says. Just as the Joint Commission added further clarification to the requirement to identify do-not-use abbreviations after the goal was announced, Popovich says there are advisory groups working on definitions of "critical" and "timely."

Because home health nurses deal with patients on an individual basis, the requirement to identify look-alike, sound-alike medications should also pose no problem, says Popovich. "The agency does have to develop a list of look-alike, sound-alike medications that patients may use, but it is unlikely that the nurse will find two of these medications in the individual patient's home," she points out. The benefit of developing this list will be increased awareness among home health staff, she adds. "Remember, too, that phone and verbal orders must continue to be read back to the originator to verify orders and medications," she adds. "This read-back, along with the awareness of look-alike, sound-alike medications, will increase patient safety," she says.

While other health care organizations may struggle with the new requirement that a complete list of patient medications be documented, home health has always collected this information — and has done so in a manner that other health care providers might envy, says Popovich. "Other providers have to rely upon the patient providing the information. Our nurses can simply ask to see everything, then copy the information off the prescription bottles, herbal containers, or over-the-counter packages," she points out. Because gathering an accurate list of medications is embedded in the home health nurse's practice, Popovich says home health agencies should have no problem meeting this goal.

(Continued on page 107)

2005 National Patient Safety Goals

The following patient safety goals of the Joint Commission on Accreditation of Healthcare Organizations, in Oakbrook Terrace, IL, were developed for home health care but may not apply to all areas of home health, says **Maryanne L. Popovich**, RN, MPH, executive director of the Joint Commission home care accreditation program. To verify which goals apply to your agency, durable medical equipment division, or infusion service, go to www.jcaho.org, click on "2005 National Patient Safety Goals" under "Headline News" on the right side of the page, then choose "Home Care," and then choose "Applicability Grid."

The new goals or requirements for 2005 are listed below in boldface.

Goal: Improve the accuracy of patient identification.

- Use at least two patient identifiers whenever administering medications or blood products, taking blood **samples and other specimens for clinical testing, or providing any other treatments or procedures.**

- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure, and site, using active — not passive — communication techniques.

Goal: Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result read back the complete order or test result.

- Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.

- **Measure, assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver of critical test results and values.**

- Standardize and limit the number of drug concentrations used by the organization.

- **Identify, and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.**

Goal: Improve the safety of using medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, and sodium chloride >0.9%) from patient care areas.

Goal: Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and patient-controlled analgesia intravenous infusion pumps used by the organization.

Goal: Reduce the risk of health care-associated infections.

- Comply with current Centers for Disease Control and Prevention hand hygiene guidelines.

- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal: **Accurately and completely reconcile medications across the continuum of care.**

- **Have a process for obtaining and documenting a complete list of the patient's current medications upon the patient's entry to the organization and with the involvement of the patient.**

- **A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner, or level of care within or outside the organization.**

Goal: Reduce the risk of patient harm resulting from falls.

- **Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.**

The challenge for home health with the medication list will be educating the patient to keep an up-to-date list with him or her in case of a visit to the physician or the hospital, says Popovich. "Other organizations will rely upon the patient to provide the information, and home health can help by making sure our patients and their caregivers know to keep the list with them," she adds.

Another patient safety goal that will provide a challenge for hospitals is the goal to reduce the risk of patient falls. "Home health is already the only health care program that automatically assesses the patient's environment for risk of falls as a normal part of the initial assessment," points out Popovich. Although this area has always been addressed in home care, the Joint Commission's goal for patient safety has been to highlight the areas of greatest risk to patient safety, she says. "All of our advisory committee members agreed that although reduction of the risk of falls is addressed throughout home health, it is still a serious enough risk to patients to be highlighted in the national safety goals," she adds.

As home health agencies raise questions about patient safety goals and how to meet the requirements, the Joint Commission will post updated information and responses to frequently asked questions on the Joint Commission web site, says Popovich. "We are continuously evaluating feedback and providing information that will help home health agencies comply," she says. ■

News From the End of Life

Audio conference prepares you for influenza season

Brace yourself: Flu season is right around the corner. Are you prepared? If an influenza pandemic hits, the entire U.S. population could be at risk.

The annual impact of influenza on the United States is staggering: Some 10%-20% of the population will get the flu. About 36,000 people will die. And 114,000 will be hospitalized. Most of those who die will be over 65, but children 2 years old and younger will be as likely to be hospitalized

as the elderly.

Thomson American Health Consultants is offering an audio conference that will present the information necessary to help you diagnose and treat patients with flu symptoms and, as important, prepare for an influenza pandemic.

Get Ready For Influenza Season: What You Need to Know About the Threat, Diagnosis and Treatment, which will be held Tuesday, Sept. 28, 2004, 2:30 - 3:30 p.m. EDT, will be presented by **Benjamin Schwartz, MD**, and **Frederick Hayden, MD**.

Schwartz, who is with the National Vaccine Program Office and is spearheading the development of the National Pandemic Influenza Preparedness and Response Plan, will discuss the potential impact of an influenza pandemic.

Hayden, a professor of internal medicine and pathology at the University of Virginia School of Medicine in Charlottesville, will discuss current methods of diagnosis and the latest information on treatment with antivirals.

This program will serve as an invaluable resource for your entire staff. Your fee of \$249 includes presentation materials, additional reading, and free continuing education.

For more information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

When registering, please reference code **T04118-61332**. ▼

Awards given for palliative and end-of-life care

Ten health care organizations were honored at the American Hospital Association (AHA) and Health Forum's annual Leadership Summit in San Diego on July 26 for their innovative palliative and end-of-life care programs.

Receiving the 2004 Circle of Life Award are Hope Hospice and Palliative Care of Fort Myers, FL; St. Mary's Healthcare System for Children of Bayside, NY; and University of Texas M.D. Anderson Cancer Center of Houston. The three winners, chosen from nearly 70 nominees, each will receive a \$25,000 prize. Seven other organizations also will receive Citations of Honor.

"These programs share overriding themes of compassion and dedication and find new ways

to expand the reach of palliative and hospice services," said AHA President **Dick Davidson**. "They provide excellent models any community can adapt." Awarded annually since 2000, the Circle of Life Awards are supported by a grant from the Robert Wood Johnson Foundation and are sponsored by the AHA, the American Medical Association, the National Hospice and Palliative Care Organization, and the American Association of Homes and Services for the Aging. ▼

CMS purposely slower to pay noncompliant claims

On July 6, 2004, the Centers for Medicare & Medicaid Services (CMS) began to treat electronic claims that were not in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards as paper claims.

"The great majority of electronic claims we are receiving meet the required HIPAA standards, but, for those still not in compliance, there is going to be a delay in getting their money," says **Mark B. McClellan**, MD, PhD, administrator of CMS. "We are hoping this will motivate more filers to get into compliance soon," he adds.

Under a modification to its HIPAA contingency plan announced in February, noncompliant electronic claims will still be accepted by CMS, but their payment will take 13 additional days, which is the same payment time frame as that for paper claims.

Currently, 90% of all electronic claims comply with HIPAA standards, says McClellan. "A two-week delay is an important further incentive to get to 100%," he says. ▼

WV plan helps elderly stay in their homes

A West Virginia plan to help elderly and disabled people remain in the community and out of institutions has been approved by the Centers for Medicare & Medicaid Services (CMS).

Approval of this home-and-community-based waiver program will provide elderly and disabled

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people in certain public housing facilities with adult residential care services and allow them to "age in place" rather than be moved to a skilled nursing facility as their conditions deteriorate.

The experiment will apply to 150 people in each year of the waiver's initial three-year term. The plan targets people who otherwise would require care in a nursing facility. People served under the waiver will receive a package of adult residential care services that include personal care, homemaking, chores, attendant care, companion services, medication oversight, therapeutic social and recreational programming, transportation, and periodic nursing evaluations. These are all services that would be provided in a licensed community care facility. The program will be pilot-tested in four areas in West Virginia: Huntington, Moundsville, Williamson, and Wheeling. ■

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