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Tracer methodology focuses on the care of patients, not paperwork

Pay less attention to manuals, more to safety goals

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

Although a change in any 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. 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 the surveyor follows the path of a patient throughout the patient's encounter with the home health agency. That might mean 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 are 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 as our home health nurse and the IV nurse made their visits," Hieb explains.

"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," Hieb adds. It was clear from the patient's responses that the home health agency, along with the other services, had done a good job educating the patient and making sure the

correct phone numbers were handy, she notes.

It is still important to keep employee records up to date, she points out. "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," Hieb explains.

Because the new process focuses more on actual patient care rather than paper documents, staff members have more direct contact with surveyors and often are the home health representatives questioned about processes rather than managers.

At the same time, home health employees may be the best prepared to interact with surveyors of all health care-related staff, notes **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. My staff have 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, Falkowski explains. 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 also are focusing on national patient safety goals, Falkowski says. **(See 2005 National Patient Safety Goals, p. 100.)** "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. The surveyors aren't looking for perfection," she says.

"What they do want to see is that your agency has systems in place to promote safety and to protect patients," Falkowski 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?" Hieb says. "That question led into other questions about how we address medication safety or improve communications," she notes.

While some home health agencies may feel let down that the surveyor doesn't spend more 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 explains.

In the home health agency, there were two surveyors who spent about four hours each looking at different patients, Hieb adds.

Don't forget that even though your home health agency is part of a hospital, you still need to have your own emergency management plan

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in place, Falkowski warns. "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. 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," Falkowski explains.

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. Within the plan, she addressed the possibility of receiving large numbers of admissions from the hospital as the hospital prepared to receive victims of an emergency. **(For information on ordering a hazard analysis tool, see contact information, at right.)**

"We looked at how we would handle these admissions with and without power," she adds. **(For information on operating without electricity, see *Hospital Home Health*, October 2003, p. 109.)**

Infection control is another area upon which the surveyors focus, Falkowski says. 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," Falkowski explains.

She suggests that any employee who might draw blood be prepared with all of the equipment, including containers, regardless of what patients may be scheduled on that day.

While the survey may be easy for most home health agencies, the periodic performance review (PPR), the midcycle self-review now required by 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. **(For information on the PPR, see *HHH*, July 2003, p. 73.)**

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

"I went through the on-line tool, reading every section to determine which ones applied to us," Brown notes.

For the standards that apply to home care, she either completed the form stating whether the agency met the standard and how, 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, staff discussed the completed information as a group. This is one way to ensure that all of the information is accurate and to identify areas for improvement and develop plans of action, she adds.

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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 Joint Commission on the Accreditation of Healthcare Organizations 2005 National Patient Safety Goals.

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

For example, a part of Goal 2C focuses on improved communications by assessing the timeliness of reporting critical results, she notes.

If a digoxin level on a patient 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." The most difficult part of this requirement is that the Joint Commission has not defined "critical," Popovich says.

Just as the Joint Commission added further clarification to the requirement to identify do-not-use abbreviations after the goal was announced, she explains there are advisory groups working

Joint Commission 2005 National Patient Safety Goals

The following goals 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 right side of home page, then choose home care, and then choose "Applicability Grid."

The new goals or requirements for 2005 are listed in boldface:

Goal: Improve 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.**

Goal: Improve the safety of using medications.
- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride > 0.9%) from patient care areas.
- 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 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 potential risk associated with patient's medication regimen, and take action to address any identified risks.** ■

on definitions of "critical" and "timely."

Because home health nurses deal with patients on an individual basis, the requirement that look-alike, sound-alike medications be identified also should pose no problem, she notes.

"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," Popovich explains. 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. This read-back, along with the awareness of look-alike, sound-alike medications, will increase patient safety," Popovich says.

While other health care organizations may struggle with the new requirement that a complete list of patient medications be documented, home health agencies always have collected this information and in a manner that other health care providers might envy, she adds.

"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," Popovich notes. Because gathering an accurate list of medications is imbedded in the home health nurse's practice, she sees no problem for home health agencies to meet this goal.

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, Popovich says. "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."

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," adds Popovich.

Although this area always has been addressed in home care, the Joint Commission's goal with 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," Popovich explains.

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 its web site, she says. "We are continuously evaluating feedback and providing information that will help home health agencies comply."

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Be on guard for avian flu threat, CDC advises

Flu has pandemic potential, high mortality

If infectious disease specialists used a color-coded alert system, the color would be yellow, for elevated. And it's edging up to orange.

While the threat of severe acute respiratory syndrome (SARS) has subsided, public health experts are becoming increasingly concerned about the potential for pandemic influenza coming from a highly pathogenic avian influenza strain in Asia.

Hospitals need to be as vigilant as ever for cases of pneumonia among travelers from Asia, say epidemiologists from the Centers for Disease Control and Prevention (CDC). They should consider avian influenza as a differential diagnosis in patients with severe respiratory illness who have traveled to Asia. **(For more information on precautions, see p. 102.)**

The highly pathogenic influenza strain H5N1 remains widespread in domestic poultry in six Asian countries. China, Vietnam, Thailand, and Indonesia have reported increased outbreaks among poultry. And according to a report in the journal *Nature,* the avian flu strain H5N1 is endemic in domestic ducks in southern China and in wild birds throughout Asia, making it difficult, if not impossible, to contain the disease.[1]

"This has been an unprecedented outbreak of H5N1 among poultry in Asia," says **Tim Uyeki**, MD, medical epidemiologist in CDC's influenza branch.

Even more troubling, this strain is associated with extremely high mortality for people who become infected. Of 34 confirmed human cases, 23 people have died. "That's a case fatality proportion of 68%. All these human cases were hospitalized," says Uyeki, although he adds that more mild cases may have occurred without being identified as avian flu. Most of the hospitalized cases occurred among children and young adults.

In some of the countries, it almost is impossible to control the avian influenza by culling or killing infected poultry because of the prevalence of backyard farms, he explains.

International public health authorities are facing the possibility that this avian influenza strain will remain a long-term threat.

"There has been no conclusive evidence of efficient human-to-human transmission. That's what we worry about. That's what we fear," Uyeki says. "If there is efficient human-to-human transmission of H5N1 viruses, then it will result in a global influenza pandemic.

"If there is a global influenza pandemic, it will dwarf SARS," he adds. "It will make SARS look like it was really a minor problem. If this continued to cause this [68%] mortality, it would be one of the most devastating infections ever to be introduced into the human populations," Uyeki says. "We have no way to know whether a 68% case mortality proportion is going to apply to a larger population or not. We hope not."

Protect health care workers

If avian influenza becomes transmissible among humans, its spread would be rapid and community-based, says CDC medical epidemiologist **L. Clifford McDonald**, MD. Although SARS was most contagious when people were very ill (and often hospitalized), influenza is contagious very early in the illness, he notes. "It's generally understood that if influenza took off as a pandemic, the battle to contain it wouldn't be primarily waged in

CDC issues avian influenza IC recommendations

All patients who present to a health care setting with fever and respiratory symptoms should be managed according to recommendations for respiratory hygiene and cough etiquette and questioned regarding their recent travel history. Patients with a history of travel within 10 days to a country with avian influenza activity and are hospitalized with a severe febrile respiratory illness, or are otherwise under evaluation for avian influenza, should be managed using isolation precautions identical to those recommended for patients with known severe acute respiratory syndrome (SARS). These include:

Standard precautions

- Pay careful attention to hand hygiene before and after all patient contact or contact with items potentially contaminated with respiratory secretions.

Contact precautions

- Use gloves and gown for all patient contact.
- Use dedicated equipment such as stethoscopes, disposable blood pressure cuffs, disposable thermometers, etc.

Eye protection (i.e., goggles or face shields)

- Wear when within 3 feet of the patient.

Airborne precautions

- Place the patient in an airborne isolation room. Such rooms should have monitored negative air pressure in relation to corridor, with six to 12 air changes per hour, and exhaust air directly outside or have recirculated air filtered by a high-efficiency particulate air (HEPA) filter. If an airborne isolation room is unavailable, contact the health care facility engineer to assist or use portable HEPA filters (see *Environmental Infection Control Guidelines*) to augment the number of air changes per hour.
- Use a fit-tested respirator, at least as protective as a National Institute of Occupational Safety and Health (NIOSH)-approved N-95 filtering face-piece (i.e., disposable) respirator, when entering the room.

For additional information regarding these and other health care isolation precautions, see the *Guidelines for Isolation Precautions in Hospitals.* Those precautions should be continued for 14 days after onset of symptoms or until either an alternative diagnosis is established or diagnostic test results indicate that the patient is not infected with influenza A virus.

Patients managed as outpatients or hospitalized patients discharged before 14 days with suspected avian influenza should be isolated in the home setting on the basis of principles outlined for the home isolation of SARS patients (go to www.cdc.gov/ncidod/sars/guidance/i/pdf/i.pdf).

(Editor's note: More information about avian influenza is available at www.cdc.gov/flu/avian.) ■

the hospital, like SARS was," he says.

The protection of health care workers will be crucial both to avoid nosocomial spread and to maintain a healthy work force that can care for infected patients. Even in last year's influenza season, a relatively moderate one, about a third of hospitals reported staff shortages due to influenza.

The public health concern is heightened by past experience with avian influenza. Pandemics in 1957 and 1968 occurred when other avian strains re-assorted and began infecting humans, who had no immunity. Avian flu caused about 70,000 U.S. deaths in 1957-58 and 34,000 U.S. deaths in 1968-69.

In 1997, public health authorities averted the spread of H5N1 avian influenza by killing a million chickens in Hong Kong; 18 human cases were linked to the strain. In a retrospective study, researchers found evidence of person-to-person transmission of avian influenza to health care workers caring for the hospitalized patients.[2]

Immunization efforts are crucial

These findings give greater weight to the efforts to immunize health care workers against the known, circulating influenza strains. (A vaccine for H5N1 avian influenza is under development.) One nightmare scenario would be for a health care worker to become infected with both avian influenza and a human strain, allowing the virus to re-assort and become more easily transmissible, McDonald says.

Even without dual infections, "each human infection [with avian influenza] is an opportunity for the flu to adapt further," he notes. "If there is an avian flu-infected patient, we want to make sure health care workers are vaccinated against the human virus."

Hospitals should focus on preparedness for pandemic influenza — and awareness of this avian influenza threat, McDonald says. "We need to use what we learned from SARS and rechannel [the efforts] to what is now the present threat, the major threat. It's going to stay with us."

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LegalEase

Understanding Laws, Rules, Regulations

CMS proposes extending patient choice regs

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

As many providers already know, the Balanced Budget Act of 1997 (BBA) requires hospitals to share with each patient as part of the discharge planning process a list of available home health agencies (HHAs) that:

- are Medicare-certified;
- serve the geographic area in which the patient resides;
- request to be listed by the hospital as available.

In addition, the BBA prohibits hospitals from limiting or steering patients to any specific HHA or qualified provider that may provide post-hospital home health services.

In proposed rules published May 18, 2004, the Centers for Medicare & Medicaid Services (CMS) proposes to incorporate these provisions of the BBA into Conditions of Participation (COPs) applicable to hospitals and to extend these requirements to skilled nursing facilities (SNFs).

If these COPs are finalized, it likely is indicative of the trend of extending the BBA's patient choice requirements to all providers, including home medical equipment companies and hospices.

1. Hospitals must include in the discharge plans a list of HHAs or SNFs available to patients. Facilities on the list must participate in the Medicare program and serve the geographic area, as defined by the HHA, in which the patient resides, or in the case of SNFs, in the geographic area requested by the patient. HHAs must request to be listed by hospitals as available.
2. Lists must be presented only to patients for whom home health care or post-hospital extended care services are indicated and appropriate, as determined by discharge planning evaluations.
3. Hospitals must document in patients' medical records that the list was presented to patients or to individuals acting on patients' behalf.

4. Hospitals, as part of the discharge planning process, must inform patients or patients' families of their freedom to choose among participating Medicare providers of HHA and post-hospital extended care services and must, when possible, respect patients' and families' preferences when they are expressed. Hospitals must not exclude qualified providers that are available to patients.
5. Discharge plans must identify any HHA or SNF to which patients are referred in which hospitals have a disclosable financial interest, as specified by the secretary of Health and Human Services, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

Although commentary to the proposed regulations does not carry the force of law, it provides a window on the point of view of regulators and enforcers that providers are well advised to consider the following recommendations:

- Hospitals would not be required to duplicate lists in patients' medical records. Hospitals would have the flexibility to determine exactly how and where required information would be documented in patients' medical records.
- Hospitals would have the flexibility to implement the requirement to present lists in a manner that is most efficient and least burdensome. Commentary to the proposed COPs indicates hospitals simply could print lists from the Home Health Compare or Nursing Home Compare sites on the CMS web site (www.medicare.gov) or develop and maintain their own lists. When patients require home health services, the CMS web site list could be printed based on the geographic area in which patients reside. When patients require SNF services, hospitals can provide a list of facilities in the geographic area requested by patients.
- When hospitals develop their own lists, they will have the flexibility to design the format of the lists. The lists, however, cannot be used as either a recommendation or endorsement by hospitals of the quality of care of any particular providers. Hospitals will not be required to include agencies and SNFs on lists that do not meet all of the criteria described above.
- Lists provided by hospitals must be legible and current; they should be updated at least annually.
- CMS further suggests that hospitals share lists with patients or individuals acting on their behalf at least once during the discharge planning process. But CMS points out that lists may need to be presented more than once during the discharge planning process to meet patients' needs for additional information or as patients' needs change.
- No specific form or manner in which hospitals must disclose financial interests will be required. Hospitals simply could highlight or otherwise identify those entities in which a financial interest exists directly on lists of HHAs and SNFs. Hospitals also could choose to maintain separate lists of those entities in which they have any financial interests.
- Lists provided to patients enrolled in managed care organizations (MCOs) should include available and accessible HHAs and SNFs in a network of the patient's MCO. Hospitals also will have the option, in the course of discussing discharge planning with patients, to determine whether beneficiaries have agreed to excluded services or benefits or coverage limitations through enrollment in MCOs. If this is the case, hospitals may inform patients of the potential consequences of going outside the plan for services.
- Compliance with the proposed COPs would be monitored as part of the hospital survey and certification process. Anyone aware of instances in which patients are inappropriately influenced or steered toward a particular agency or SNF in a way that violates the regulations could file a complaint with the state survey agency. State surveyors would then investigate and follow up with the complainant.

Stay tuned for more new developments in the continuing story of patients' right to freedom of choice of providers.

[More information about this topic is available in How to Form Alliances Without Violating the Law. *Send a check for $55 (includes shipping and handling) to the address below.*

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Are you missing serious illness in older patients?

Improve assessment of geriatric patients

An elderly woman presents with a chief complaint of constipation, with few symptoms of acute abdomen. Would you suspect appendicitis in this patient?

You may find a misleadingly benign physical assessment in older patients, despite the presence of a potentially lethal illness, warns **Karen Hayes**, ARNP, PhD, assistant professor at the School of Nursing at Wichita (KS) State University.

"Some nurses may feel uncomfortable assessing older adults because of all the challenges and comorbidities that characterize the elderly patient," she notes.

You'll need to be able to recognize an altered and often nonspecific presentation of disease in elderly patients, Hayes explains. "By using a heightened index of suspicion with astute assessment skills, the nurse may avoid inappropriate triage or missing a serious illness," she adds.

Another challenge is that it is difficult to distinguish the effects of normal aging from serious illness, Hayes emphasizes. "The combined effects of genetics, lifelong health habits, medical problems, environment, and sociocultural influences make elderly patients quite different from one another," she says.

To dramatically improve assessment of geriatric patients, do the following:

- **Do not allow ageism to bias your assessment.**

Functional disability or confusion is not a consequence of aging, Hayes underscores.

"A history of inability to perform activities of daily living should be carefully assessed," she continues.

A sudden decrease in functional ability can be an early sign of a serious illness, Hayes says. "For example, an exacerbation of congestive heart failure may interfere with an elderly person's ability to bathe and dress independently," she notes.

- **Consider abnormal lab values.**

"Due to the aging process, normal bodily functions are just not as efficient as they used to be," says **Kelly A. Karpik**, BSN, RN, RRT, clinical manager for the ED at Rhode Island Hospital in Providence. "Renal and hepatic systems are examples of organs that are affected with age."

You need to be aware of abnormal lab values for kidney and liver function in elderly patients, as these will affect the amount of drug to be administered, she explains.

For this reason, it is important to know which drugs are metabolized by the kidneys and which are metabolized by the liver, Karpik adds. "Elderly patients will have different doses of medications, determined by the kidney and liver's ability to metabolize the drugs."

For example, if kidney function is impaired in an elderly patient, creatinine clearance may be reduced, she says. "If this is so, then half-life will be prolonged, and an adjustment in dose is necessary." Karpik gives the example of the antibiotic levofloxacin, which is used to treat community-acquired pneumonia, bronchitis, and urinary tract infections. The usual dose used to treat pneumonia is 500 mg for seven to 14 days; but while an elderly patient with reduced creatinine clearance would be given the same initial dose of 500 mg, subsequent doses would be only 250 mg per day, based on a creatinine clearance of 20 mL to 49 mL/min, she notes.

- **Assess liver and kidney function.**

In many elderly patients, there is a diminished ability to metabolize medications due to aging body systems, she says. "If you couple that with impaired renal and/or hepatic function due to pathology, then you can surely achieve therapeutic medication effect with a lower dose of almost all medications."

For instance, an adult male patient might receive a 2 mg dose of lorazepam for anxiety, whereas an elderly male patient might have the same effect achieved with only 0.5 mg, Karpik notes.

- **Avoid being influenced by the patient's interpretation of his or her own symptoms.**

COMING IN FUTURE MONTHS

- Are your branches official, according to CMS?
- Chronic care improvement: What does it mean to you?
- Coding changes that can affect your payment
- The ties between nutrition and CHF
- Tips for handling the aggressive patient

If an elderly man tells you he has "the flu," ask what specific symptoms he is experiencing. "Pneumonia may be the hidden problem," says Hayes.

"Often, the problem is much more serious than the elderly patient is willing to admit," she notes.

- **Take a thorough medication history.**

If an elderly patient reports confusion, dizziness, falls, or fluid and electrolyte imbalances, remember that the most commonly prescribed drugs for older patients can cause these symptoms, Hayes advises. These drugs include cardiovascular agents, antihypertensives, analgesics, sedatives, and laxatives.

In addition, drug interactions are increased in the elderly because of the multiple medications they use at home, she says. "An accurate medication history . . . is critical."

The safest method to prevent errors is to always question whether the drug is needed, to check that it is the smallest possible dose, and ensure there are no drug allergies or interactions with other medications, Hayes explains. "Often, older adults have many allergies," she notes.

- **Remember the patient's age and unrelated conditions may affect the rate of absorption.**

Drugs given intramuscularly, subcutaneously, orally, or rectally are not absorbed as efficiently as drugs that are inhaled, applied topically, or given intravenously, Hayes notes.

In addition, conditions such as diabetes mellitus and hypokalemia can increase the absorption of drugs, whereas pain and mucosal edema will slow absorption, she says.

"The extended biological half-life of drugs in older adults increases the risk of adverse reactions," Hayes adds.

[For more information on assessment of geriatric patients, contact:

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NEWS BRIEFS

WV plan helps elderly stay in their homes

A West Virginia plan to help elderly and disabled individuals 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 people in certain public housing facilities with the opportunity to receive adult residential care services and allow them to "age in place" rather than be moved to a skilled nursing facility as their conditions deteriorate.

"This West Virginia waiver furthers our goal of helping people live independently in their homes and communities, rather than entering institutions," says **Mark B. McClellan**, MD, PhD, CMS administrator.

Individuals served under this waiver will receive a package of adult residential care services including personal care, homemaker, chore, attendant care, companion, 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.

This waiver program will be pilot-tested in four cities in West Virginia: Moundsville, Williamson, Wheeling, and Huntington. ▼

List of resources aids HIPAA compliance

One of the most comprehensive lists of documents that provide guidance to Health Insurance Portability and Accountability Act (HIPAA) compliance can be found in a white paper produced by the Health Care Security Workgroup, a combination of public and private organizations that have worked together to provide guidance to health care organizations in privacy and security issues.

The document includes links to a wide range of presentations, tools, and publications that outline specific steps and challenges to meeting HIPAA

rules, including how to perform a risk analysis and how to assess security compliance.

The document can be found at www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/2004-02-09NUWWP.pdf ▼

Homebound definition test chooses three states

Missouri, Colorado, and Massachusetts are the three states in which a demonstration project designed to test a more liberal homebound definition will occur.

Scheduled to begin in October, the demonstration that was authorized by the 2003 Medicare Prescription Drug, Improvement & Modernization Act may involve up to 15,000 severely disabled patients who would be exempt from Medicare's current restrictions related to the "length, frequency, and purpose of absences from home." The two-year test will determine if the more liberal definition of homebound will cause an "unreasonable increase" in Medicare expenses. ▼

Providers receive award for palliative care

Ten health care organizations were honored on July 26th at the American Hospital Association (AHA) and Health Forum's annual Leadership Summit in San Diego 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 **Dick Davidson**, AHA president.

"They provide excellent models any community can adapt," he added.

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, American Medical Association, National Hospice and Palliative Care Organization, and American Association of Homes and Services for the Aging.

A press release on the awards will be available soon at www.aha.org under "What's New." ▼

Audio conference gets your agency ready for flu

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. Ten percent to 20% of the population will get the flu. Some 36,000 people will die, and 114,000 will be hospitalized.

Most of those who die will be older than 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 with 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 on Tuesday, Sept. 28, 2004, from 2:30 to 3:30 p.m., EST, 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, go to 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**. ■

CE *questions*

This concludes the CE semester. A CE evaluation form has been included with this issue. **Please fill out and return in the envelope provided.**

21. What is one way to ensure your home health agency's emergency plan will meet the Joint Commission's standard on emergency management plans, according to Judy Falkowski, director of Bay Area Hospital Home Health Care?
    A. Use the hospital's plan as your own.
    B. Ask physicians to sign off on the plan.
    C. Address the needs of current home health patients.
    D. Develop unique plan for home health that ties in with hospital plan.

22. What initially will be the most difficult part of meeting requirements for the national patient safety goal that calls for home health organizations to have a process to ensure timely communication of critical test results, according to Maryanne L. Popovich, executive director of JCAHO's home care accreditation program?
    A. reaching physicians' offices
    B. documenting the communication
    C. defining "timely" and "critical"
    D. educating staff members

23. According to Elizabeth Hogue, Esq., if CMS's proposal to extend the provisions of the BBA into Conditions of Participation requirements to skilled nursing facilities is finalized, it will be indicative of:
    A. a trend of extending the BBA patient choice requirements to all providers, including home medical equipment companies and hospices
    B. CMS exerting additional control over medical facilities
    C. additional measures to support patient rights
    D. the intent to steer patients to preselected HHAs

24. According to the CDC, if a patient presents with fever and respiratory symptoms and a recent history of travel to Asia, what level of protection should health care workers use?
    A. standard precautions because the threat of SARS has diminished
    B. standard and contact precautions, including the use of gowns and gloves
    C. standard, contact and airborne precautions, including the use of goggles and respirators, because of the threat of avian influenza
    D. the level of precaution depends on the severity of the respiratory symptoms

Answer Key: 21. D; 22. C; 23. A; 24. C

CE objectives

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

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