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## IN THIS ISSUE

- Improve nursing recruitment with re-entry nurse program . . . . . 100
- Develop nursing assistant assessment tool to make better use of CNA visits and improve caregiver satisfaction. . . . . 101
- Falls reduction project tracks witnessed and unwitnessed falls . . . . . 103
- IT recovery plan should include backing up your backup . . . . . 105
- Clinical pathway lays out three levels of pain and three levels of medication . . . . . 106

## Hospices and hospitals increasingly focus on palliative care programs

*Even a free-standing hospice can make it work*

Palliative care programs are growing in number and prominence at hospitals and hospices across the nation, as increasing numbers of health care providers want to focus on medicine used as much for comfort and quality of life as for diagnoses and cures when dealing with patients who have chronic illnesses for which there are no easy resolutions.

The number of hospital-based palliative care programs nearly doubled between 2000 and 2003 to 1,100, and now about 1,800 physicians have become board-certified to participate in palliative care, says **Amber Jones**, BA, Med, hospice liaison consultant at the Center to Advance Palliative Care (CAPC), based at Mt. Sinai School of Medicine in New York City.

There also has been an increase in the number of nurses specializing in palliative care, she adds.

There are about 200 certified advanced practice nurses now, and soon there will be more, Jones says. "There also are licensed nursing assistants in palliative care, and so we're seeing a huge growth in the number of palliative care-trained professionals," she adds. "We did a survey of hospices 2½ years ago, asking how many were interested in providing palliative care services, and 25% were already offering palliative care services and 90% were in the process of planning it."

For hospices, the move to palliative care is a natural one, says **LaDonna Van Engen**, RN, CHPN, hospice program coordinator of Saint Elizabeth Hospice of Saint Elizabeth Regional Medical Center in Lincoln, NE.

"In order for hospices to survive with Medicare, Medicaid, and insurance, we need to promote and look at palliative care," she says. "It offers people the control they want."

Palliative care is becoming an attractive service for patients with a wide variety of chronic diseases, including congestive heart failure, emphysema, peripheral vascular disease, and end-stage heart disease, experts say.

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The concept is directed toward supportive care for patients who have symptoms that are not well controlled, medication side effects that have led to a poor quality of life, and chronically ill patients who are not terminally ill.

For instance, a person with advanced heart disease might be routinely shuffled into surgery, but the palliative care approach would have a team help the patient look at the quality-of-life risks of such surgery and make a decision that, while not ideal, may be better suited to their needs and situation, Van Engen says.

"Maybe if families knew all of the opportunities and options they might make different choices," she adds.

Van Engen says under the palliative care approach, she would say to the adult child of an 80-year-old patient whose health is failing rapidly, although no one disease qualifies as a hospice referral, "Tell me about your mom. What kind of person is she? Would she want you to do

everything to keep her alive like this, and can she get better?"

"When someone is facing a serious, chronic, or life-limiting illness, they also have a lot of emotional issues, and they need to make decisions about what they want with the rest of their life," says **Cindy Marsh**, executive director of the Hospice of Texarkana (TX) Inc., a free-standing, community-based, nonprofit hospice that provides palliative care services.

"They may need to make advanced directives and those types of things are addressed with the social worker on the team," she says.

Likewise, the social worker will help palliative care patients understand what will happen when they're discharged from the hospital."

## **Palliative care education**

The biggest question hospices have with regard to palliative care isn't whether to provide these services, but how, Jones says.

CAPC answers the how question by providing educational programs that help health care providers build a business plan and gain support for the utilization of palliative care services, she explains.

One program is a two-day intensive seminar that provides a primer on building a palliative care program with lectures, small group sessions, and the goal of providing attendees with an understanding of the elements of the program, Jones says.

CAPC also offers site visits at one of the organization's six palliative care leadership centers, at a cost of \$1,500 to \$1,750 for four people. A health care team may visit a center over a two- to three-day period to gain hands-on experience with people who have been through it, Jones explains.

The team typically brings to the site visit data from the hospice or hospital, which can be used in developing a business and implementation plan, she adds.

As a follow-up, the visiting teams receive a year of technical support from the leadership center.

The Hospice of Texarkana formed a palliative care program after staff received training from CAPC, Marsh reports.

The palliative care initiative is two-pronged: The first and main effort involves a collaboration with CHRISTUS St. Michael Health System in Texarkana, and the other effort will be the opening of an outpatient palliative care clinic at the hospice medical director's clinical setting, she says.

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### **Editorial Questions**

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"We had been working with CHRISTUS for some time in providing hospice services, and we had gained their trust in both our clinical operations and in how we conduct business with our patients there in the facility," Marsh says.

The hospice's mission was helped by CHRISTUS leaders who wanted to implement palliative care services in all of the health system's facilities, she notes.

"What made this effort extremely successful is the fact that CHRISTUS contracts from us a nurse liaison who is working with case management on a daily basis to identify patients who might benefit from a palliative care consult," Marsh says.

The Hospice of Texarkana program also involves a social worker and doctorate-level pharmacy consultants, she says.

### ***The palliative approach***

Palliative care contacts with patients and families involve at least two disciplines with the goal of making it a team meeting, Marsh says.

"I think one of the real strengths of a palliative care program can be continuing the interdisciplinary approach that is so successful in hospice," she says.

For hospices that already are part of a hospital system, palliative care is a natural fit both clinically and economically.

For example, Saint Elizabeth provides some of the same comfort and support for patients and families referred to palliative care services as those referred to hospice, although the palliative care patients do not have to have a diagnosis of fewer than six months to live.

"We provide comfort care on things besides healing," says Van Engen.

Palliative care patients must meet Medicare guidelines for home care services, but they receive home care with the additional comfort and support that palliative care offer, she says.

"Medicare doesn't recognize palliative care in the home at this point," Van Engen adds.

Hospices that have home care services or are affiliated with health systems with home care services train home care staff to provide a palliative approach to their care, she explains.

"The staff don't just provide wound care, but focus on end-of-life issues, family support, and that sort of thing," Van Engen says. "With the palliative approach, the home health aide may say, 'I'm going to give them a bath, but if they insist on not getting up today, I won't push that hard.'"

The benefit to the hospital system is that referring chronically ill patients referred to palliative care services helps to reduce rehospitalizations and saves health care dollars, both Van Engen and Marsh note.

Palliative care staff provide focused education and care for patients who have multiple symptoms and medical problems that typically result in frequent rehospitalizations, Marsh says.

"One of the things we found most helpful in aiding the hospital is identifying patients who are returning to the hospital because their symptoms are not controlled, or the support in the home is not adequate to maintain them," she says.

In discussing palliative care services with hospital administrators, the hospice used the hospital's own readmission data to highlight the cases where patients were not able to stay home for at least 30 days, Marsh adds.

It's also better medical practice because it provides a more holistic approach to making certain patients receive the appropriate level of care, Van Engen says.

"We have someone sit down with the patient and identify what the goals are and make the best decision they can," she says. "Sometimes that means the patient will say, 'No, I don't want to have that test.'"

A registered nurse serves as a liaison member of the palliative care team, and the hospital's social workers and pastoral care staff also are on the team. A hospice pharmacist is on the team, and a hospitalist physician is the palliative care medical director, Van Engen says.

"The hospitalists have been instrumental in referring patients to the service," she reports. "We thought we'd be most requested in oncology, but we have seen patients in every unit of the hospital."

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In the palliative care model used by Hospice of Texarkana, the palliative care team is made available to the attending physician for treating patients when their pain, nausea, anxiety, or other symptoms are out of control, and the hospice is reimbursed by the hospital through a palliative care contract, Marsh says.

"Although we never want to be seen as a barrier to care, what we do provide is an opportunity to have a big picture conversation," Marsh says. "If the hospital is seeing you as being a good steward with a plan of care even when in their setting and when it's their financial risk, then you have a lot of trust and credibility in place when you introduce this idea to them." ■

## Hospice program improves RN recruitment, retention

*Re-entry RNs are untapped source*

Hospices have had to deal with the periodic nursing shortages for decades, but California arguably has one of the most challenging problems, so a Sunnydale, CA, hospice has developed a nursing retention and recruitment program that tackles the problem with innovative solution.

"The pool in California of nurses is shrinking a little faster than nationally," says **Jane McLeod**, BSN, MA, a professional staff recruiter with Pathways Home Health and Hospice of Sunnydale, CA.

Starting Jan. 1, 2005, California requires all hospitals to have a ratio of one RN to five patients, and this has caused hospitals to rapidly staff up with RNs, she explains.

"This leaves community health providers with a huge challenge," McLeod says. "So we looked at some of our options, and we saw that the pool of nurses that hospitals weren't actively recruiting were re-entry nurses."

Hospitals weren't recruiting these nurses because it took re-entry nurses longer to regain full competency and productivity, and they weren't a good match for hospitals' new graduate programs, she says.

"Many of them had been away from the bedside too long and were not competent in their skills anymore," McLeod notes. "The acuity of a patient in the hospital is so much higher than it was five years ago."

However, these same re-entry nurses had qualities that were ideal for the hospice environment because they brought to the role a necessary maturity, independence, adaptability, and problem-solving ability, as well as the ability to handle stress and crises, she says.

"We identified that this type of nurse might be well suited for end-of-life care, and so we had to go out and figure out where you could find those nurses," McLeod says.

Hospice nurses need to think on their feet and understand the symptoms they observe in patients, which is why new nursing graduates do not do as well in the environment as do re-entry nurses when they're trained, she says.

The next step was to find out the state's requirements, which in the case of California meant that RNs had to have one year of nursing experience within the last three years in order to qualify for hospice licensure, McLeod says.

"So we had to apply for a waiver from the state in order to hire re-entry nurses, and we had to construct a program," McLeod says. "I worked with the state licensing board to see what they would accept as a training program and supervision program."

Hospice managers applied for waivers for each nurse who didn't make hospice nursing requirements, says **Jane Hoffman**, BA, BSN, MS, staff education coordinator for Pathways Home Health and Hospice.

McLeod also contacted the state's board of registered nursing to make certain there weren't additional requirements for re-entry nurses.

As a result, the hospice's re-entry nurses complete a re-entry program and then go through preceptor training, she says.

Technically, the state of California doesn't require re-entry nurses with BSN degrees to apply for the waiver, but Pathways Home Health and Hospice decided to require re-entry nurses with BSN degrees to go through the re-entry program if they had been away from nursing work for more than three years, McLeod adds.

"We made a decision to invest in these nurses because they're a valuable resource," she says.

The training program has also helped with nursing retention. The hospice has hired eight re-entry nurses within the past 1½ years, and seven of the nurses still are with the hospice, McLeod says.

Here's how the re-entry program works:

### **1. Find re-entry nursing prospects.**

The hospice has recruited re-entry nurses who

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have been out of the field for up to 15 years, and most are women older than 40, McLeod says.

"Most women with young families are looking for per-diem work," she notes. "They cannot commit to the hospice schedule because of their family responsibilities."

The re-entry nursing recruits typically are parents and sometimes grandparents who have raised their families and now want to return to nursing, but think that hospice nursing is what they'd really like to do, McLeod says.

### 2. Screen and interview re-entry nurses.

Hospice managers have designed a set of interview questions to assess the job candidate's personal qualities and to filter out the nurses who may not be a good fit with hospice, McLeod says.

"We require all candidates to spend one day with a hospice nurse before we even interview them," she says. "It gives them an opportunity to see if this might be a good fit for them."

Hiring preceptors also helps evaluate the potential employees during the tag-along day, observing how the nurses behave in the hospice home and to see if they've asked appropriate questions, McLeod adds.

Job candidates who pass the first screening test are then interviewed by hospice managers.

### 3. Train re-entry nurses.

Re-entry nurses take a nursing training program of 90-plus hours, meeting three days a week for four weeks at a continuing education facility, McLeod reports.

"They go through physical assessment, medical management, IVs, wound care, nutrition, and a very broad curriculum," she says.

The re-entry nurse's orientation at the hospice then is longer than the standard orientation program, and it includes quarterly meetings with preceptors over the course of a year, Hoffmann says.

"Re-entry nurses make no independent visits for the first month and are asked to observe and put their observations in writing," Hoffmann adds.

"One thing we found out is these nurses, even though they've been through refresher courses, need extra clinical experience," Hoffmann says. "So we have them all spend some time with one of our nurses from the home health section to review clinical areas, such as wound care, phlebotomy, IV education, and pain and symptom management."

The additional training is individualized, she says.

"If I have a nurse who doesn't do urinary catheters, we can send the nurse out with a home health nurse to review and practice," Hoffmann notes.

"Sometimes the re-entry nurse will make joint visits with physicians so the doctors can review their physical assessment and give them a more thorough one-on-one mini-refresher program," McLeod says.

"What we're finding from the nurses we've hired is if they have a strong medical or surgical background, then they have some of the core clinical skills that it's hard to teach people," McLeod explains. "They understand critical thinking and are good problem-solvers, so we give them a lot of practical experience."

While hospice managers expect the re-entry nurses to become fully productive and competent members of the hospice team, they don't expect them to learn everything as quickly as other newly hired nurses, Hoffmann says.

"Part of their big adjustment is just coming back to work and being back in the work force," Hoffmann explains. "That's a challenge to them."

So re-entry nurses are assigned preceptors who case manage the re-entry nurse as the nurse makes patient visits for three to six months, Hoffmann says.

"The preceptor who is an RN, is teacher, trainer, and manager, and we put a lot of resources into training preceptors to train new nurses how to be hospice nurses," McLeod says. ■

## Tool decides who would benefit from CNA visits

*Client satisfaction improves with its use*

Hospice families often need assistance with personal care for their dying loved one, but it's sometimes difficult for hospice staff to determine

which patients truly need the help and which would be just as well off without it.

"Is it the staff determining that the patient and family have this need, or is it a need that the patient and family have identified," says **Lorna Hearn, RN, BSN, MS**, vice president and chief operating officer for Delaware Hospice in Wilmington.

"Many times we have found in retrospect that our staff offer personal care services to every patient and family because every patient is seriously ill," she says. "Then the certified nursing assistant [CNA] arrives in the home to find that personal care has already been accomplished."

Providing CNA care to almost every patient is difficult in light of financial and staffing constraints, Hearn notes.

"So, we said we needed to get a handle on this," she says.

### ***CNA education***

As a result of a quality improvement process that involved making CNA visits more efficient, the hospice developed an assessment tool, new policies, and training program. The result was that the hospice's costs decreased by 20%, while caregiver satisfaction increased, Hearn says.

"We actually decreased by only a small percentage the number of visits per week per patient," she says.

The big change was that nursing assistants may visit patients for less than the two-hour visit, which was standard before, and their visits are supplemented with volunteer visits, Hearn says.

This way nursing assistants can go into a home where the assessment determined a need, provide the necessary services, and leave to make the next visit. Then, in cases where CNAs previously would also provide some respite care for families, staying with patients while a caregiver ran an errand, now these sorts of visits are scheduled in advance with hospice volunteers, Hearn explains.

Here's how the new program works:

#### **1. Develop a CNA assessment tool.**

Delaware Hospice's home health aide assessment tool provides evaluative scoring in three major areas:

- **Patient's actual condition:** This includes the patient's ability to assist with care and transfer out of bed and bear weight, and the patient's comprehension and cooperation and orientation to reality.

- **Activities of daily living (ADLs):** "We go

through the standard list of ADLs, and they're scored depending on how many ADLs they need assistance with," Hearn reports.

- **Caregiver's abilities:** "Is the caregiver able and willing to provide care?" she says. "The caregiver may be able, but not willing, or the caregiver might be working full time or is an adult son caring for his mother, and he's really uncomfortable with personal care."

At admission, nurses evaluate the patient and family, using the assessment tool, and they will use the tool again whenever there's a changing need with the patient, Hearn says.

#### **2. Decide assessment scoring.**

The hospice's assessment tool provides scoring in this way:

- **For CNA visits twice a week:** The patient is dependent on at least two ADLs and has a score of two in the patient's condition. The higher the number means the patient is worse off physically.

- **For CNA visits three times a week:** The patient would need to have a score of three or higher, and the patient would need to be dependent on at least three ADLs or have moderate disease progression, having some occasional confusion or agitation, and either having no willing or able caregiver or having a need for ostomy care, catheter care, or nonsterile dressing change.

- **For CNA visits five times a week:** Four of the following conditions must be present: the patient is dependent in four out of five ADLs, the patient's condition is a four or five score; the patient has rapid disease progression, is actively dying, or is comatose; the patient is bed-bound; there is no willing or able caregiver; and the patient has ostomy, catheter care, or nonsterile dressing change needs.

- **For CNA visits seven times a week:** All of the following would be true: the patient is dependent in all ADLs; the patient's condition is a six to eight score; the patient is bed-bound; there is no able caregiver, or the caregiver is exhausted; the patient is dying or comatose; the patient has multiple symptoms not in control, and the patient has either ostomy or catheter care or needs nonsterile dressing changes.

- **For two CNA visits per day, five days per week:** Three of the following four conditions must be met: the patient is dependent in all ADLs; the patient is bed-bound; there is no able caregiver; there are excessive symptoms, such as diarrhea, vomiting, bleeding, heavy drainage; or there's another crisis going on in the home.

• **For there to be two CNAs assigned to each visit:** There must be three of the following conditions: the patient is dependent in all ADLs; the patient weighs more than 250 pounds; there are staff safety issues; the patient is bed-bound; and there is no able caregiver.

**3. Have CNAs teach caregivers how to provide care.**

“As a part of this whole initiative, we had our CNAs teach caregivers more about how to provide the care,” Hearn says. “We built into the tool the ability to determine whether caregivers needed some education.”

Hospice nurses taught CNAs what to teach family caregivers, and so some of the CNA’s visit time is spent providing this education, she explains.

“My goal was that we would reduce our cost and use the resources we had available without affecting the quality of care negatively,” Hearn says. “So the goal was that caregiver satisfaction would stay the same, but in fact what happened is it improved.”

Previously, CNAs never had the responsibility to teach caregivers, but as part of the project there was a training module about ADLs added to the CNA training, she notes.

“We teach them how to teach others to give a bath, how to transfer a patient out of bed into a wheelchair or commode, how to change bed linens with the patient in it, and some of the other specific tasks required to provide personal care,” Hearn says. “We take it for granted that everyone knows how to do these tasks, but for many people they’ve never had to bathe anyone except small children, and this is a whole different set of skills.”

She says the CNA education probably has contributed to the increase in caregiver satisfaction. For example, one question included in the caregiver survey asks, “How confident did you feel about doing what you needed to do in taking care of the patient?” she explains.

“And the percentage who answered ‘very confident’ rose from 72% to 74%,” Hearn says. “So we felt confident that the initiatives we had put in place were continuing to help us provide quality services.”

CNAs also report being happier with their jobs and feeling more valued as a member of the hospice team now that they have the added responsibility of education and since they make more efficient visits, she says.

“CNAs tell us that even though they are doing more visits a day, they feel much happier because

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they feel useful,” Hearn says. “Instead of going to a patient’s home where the bath already has been given, they’re going into a home where they’re truly needed and have an opportunity to do some teaching.”

**4. Improve use of volunteers.**

The hospice has changed the way volunteers are used and how CNA services are presented to patients and caregivers, Hearn says.

“We say, ‘We’ll have the CNA do personal care and stay long enough to do so, and if there is time you need to be relieved, we’ll have volunteer services help you with that,’” she says.

This way respite care is removed from CNA services and becomes part of the hospice volunteer support that’s provided, Hearn explains.

“Our use of patient/family volunteer services has increased as a result of the project,” she says. “Part of the challenge is making good use of those resources as well.” ■

## Benchmark study identifies frequency, causes of falls

*Medication changes, pain cause more falls*

Although home health agencies have focused upon falls in the home for many years, their importance was brought into the spotlight when the Joint Commission on Accreditation of Healthcare Organizations included that category in the 2005 National Safety Patient Goals.

With an average fall rate of 5.1% for a total of 7,622 patients assessed during the first year of the Patient Fall Reduction Benchmarking Project and an average of 8.1% of patients who fell requiring emergent care for hip fracture, the importance of reducing falls in home care is apparent, says **Janice Roush**, project coordinator for the Missouri Alliance for Home Care in Jefferson City, one of the participants in the study.

**Mary Calys, MSPT, rehabilitation supervisor**

for North Kansas City (MO) Hospital Home Health, agrees with that assessment.

"Home health agencies have always tracked patient falls and collected a lot of data, but we never had any benchmarks to which we could compare our own agency." To address that need, the Missouri Alliance for Home Care put together a group of agency representatives who began meeting in June 2003, to identify existing research related to falls in the home and to identify pertinent risk factors, she says.

"There are now 29 agencies that participate in our falls reduction project," Roush notes. The agencies, which represent 10 states, collect and submit data on patient falls quarterly, Calys says.

The data are compiled into an overall report for all agencies, and also are split into reports that show agencies how they rank according to type of agency such as freestanding or hospital-based, Roush explains. The cost for participation in the project is \$300 per year and includes data collection forms, questionnaires, and telephone support.

As with any benchmark study, it was critical to make sure the data were collected in the same manner in all agencies, Calys continues. "We spent time defining falls, defining witnessed and unwitnessed falls, and making sure our forms were clear and easy to understand," she says.

Defining a fall as "an unintended change in position that results in coming to rest on the ground or lower level" was essential to ensure accurate collection of data, Calys explains.

"A patient might tell a nurse that he or she had a near miss, but didn't fall," she says. The near miss might mean that the patient fell but landed on a bed or a chair, Calys adds.

"Even if the patient didn't land on the floor, it is a fall because the patient would have landed on the floor if the bed wasn't there," she points out.

### **Track unwitnessed falls**

Another difference in the data collection for this project is that witnessed and unwitnessed falls are counted, Roush explains.

"We discovered that agencies were documenting falls witnessed by nurses or other home care staff members such as physical therapists, but not documenting falls that the patient or the family caregiver might mention," she says.

"Excluding the unwitnessed falls from the data does not give an accurate picture of falls risks because the majority of falls are not witnessed by

the health care provider," Roush notes.

Nurses and therapists ask patients and their family members if they have fallen since the last visit, Calys points out. The falls reported to the nurse are listed as unwitnessed and included in the overall report, she says.

"The average percentage of unwitnessed falls for 2004, the first year of collected data, was 92%." This demonstrates the importance of documenting all falls, including unwitnessed falls, Calys adds.

Patient and family education is important to make sure falls are reported to nurses, she says. While patients may be reluctant to report falls because they are afraid that a fall means that they cannot stay in their home, a nurse can reassure patients that a fall doesn't mean admission to a nursing home, Calys notes.

"We explain that we want to know about all falls so that we can take steps to keep the patient in the home. We also emphasize the fact that patients who have fallen once are at increased risk to fall again," she says.

It is important that patients and their families understand the risk factors for falls, Calys says.

"We also make sure our employees know the risk factors so that they will be able to identify them when they are in the home," she adds.

They don't educate home care nurses only, but also make sure all therapists and aides attend educational sessions related to falls, Calys notes. "Any agency employee in the home is responsible for identifying risk factors."

Participants in the benchmarking project have started looking at trends associated with falls to see what programs agencies can put into place to reduce the risk, Roush says.

"We have added questions to our reporting form that ask nurses to document patient medications at the time of the fall," she adds.

The questions ask how many medications the patient is taking, how many pain medications are taken, and if there was a change in any medication prior to the fall.

They've learned that a change in medication is an important risk factor for a fall, Calys explains. "Not only are the number and type of medications taken by the patient important, but if there is a change in the dose or if an additional medication is added, it can affect the patient's balance for up to two weeks," she says.

Nurses at North Kansas City Hospital Home Health now call a patient on the day of a doctor visit to ask if there were any medication changes,

Calys says.

"If there is, the nurse will explain that the patient's body may need a week or so to adjust to the new medication so the patient will be at higher risk to fall," she explains.

"The nurse will advise the patient or the family caregiver to be more aware of the risk." If there is any indication that the patient is unsure of the proper way to take the medication, or seems to be experiencing side effects, the nurse will schedule a visit, Calys adds.

Her agency also is looking at options to pain medications. "The popular way to treat pain is to pop a pill," she admits. "Unfortunately, when an elderly patient is on four or more medications and at least one is a narcotic for pain, you have a higher risk for dizziness, balance problems, and confusion."

They are investigating other pain treatments such as ultrasound, electrical stimulation, and massage, she adds. Review of the data collected for the falls prevention project did provide one surprise, Calys notes.

"As a physical therapist, I always focus on a thorough assessment of the patient's environment to remove any potential causes of falls," she says. "The data from the agencies show that environmental factors are a very low risk factor for falls."

One reason for the low risk may be the years of focus on the environmental factors and education of patients and families by home care nurses and therapists, Calys explains.

"I believe these data show that we've done a good job addressing one risk factor for falls," she adds. "Now we need to identify and focus attention on other factors." ■

## Don't forget IT factors in disaster planning

*Address loss of power, server, communications*

Your disaster plan is complete. You know who is responsible for every aspect of contacting patients, contacting employees, arranging transportation, documenting evacuation plans, providing medications and supplies during the emergency, and keeping track of patient records. You are ready for weather-related emergencies, power outages, and transportation difficulties.

What about your information technology (IT) systems? Have you made all the plans you should?

The IT system disaster plan is one of the most difficult to develop and implement because it involves so many different departments with so many different needs, admits **Rajesh Shetye**, MS, MBA, executive vice president of information services for VNA Healthcare Partners of Ohio in Cleveland.

"Because it involves all departments, it is important that the support for creation of a disaster recovery plan for IT systems comes from top administrators," he says. "The key to a successful IT recovery plan is to pull resources from all areas of the home care agency, not just the IT staff," he adds.

Your IT recovery plan should be detailed and consider all aspects of potential disasters, including who will be available to implement the plan," Shetye explains.

"This means spelling everything out clearly and making no assumptions." Once the plan is written, don't forget to test it, he adds.

### ***What problems could your agency face?***

There is no such thing as a standard disaster plan that can apply to all agencies, Shetye says. "In Cleveland, the threat of damage from hurricanes or tornadoes is not realistic, but we can face power outages in the winter," he explains. "Prioritize the most likely threats and develop your plan to address them."

Include potential disasters such as your building becoming unavailable due to fire or weather damage, a single phone line available rather than multiple lines, damage from fire or water, or a telephone switch that is not working due to cable problems, suggests Shetye.

In addition to her location in a hurricane-prone area, **Debbie Sweade**, office manager for Omni Home Health in Homosassa Springs, FL, points out that most of Florida also is in a flood zone.

"Our plan not only covers protection of the data, but also protection of the hardware," she explains. Whenever there is a possibility of a storm that might cause flooding, they disconnect and move all hard drives onto high shelves, adds Sweade.

"We have had times when we've gone through this exercise every day for several days in a row," she adds. "While it is time-consuming to put everything up and then take it down and reconnect the

next morning, it is better to be safe than sorry and lose all of your equipment.”

### **Know who uses your system**

Once you’ve identified the most likely problems you’ll encounter, develop a plan to address them, Shetye recommends.

“If you lose a server during a power outage, you will need to recover the information on that server,” he says. “Make sure you have an inventory of what users are on that server, what information is stored on the server, and what impact the loss of that server for a period of time will have on the agency.”

Obviously, servers that contain patient information are critical, and your plan for restoring that information should address the problem as soon as possible, Shetye adds.

For power outages, you might consider adding generators that will keep servers running, he suggests. If you are concerned about servers that quit working, find out which components are most likely to fail and take steps to have those components in-house or know how to get them quickly, Shetye notes.

“Make sure you make backups on a regular basis and consider storing critical information in two different places simultaneously,” he adds.

Also, make sure you back up information from laptops and desktop computers frequently, Shetye continues.

“If a nurse uses a laptop during the day, he or she should transmit that information to the server at least once each day. If the patient load is heavier on some days, the information should be sent twice during the day,” he recommends.

To reduce the chance that you will lose all of your telephone lines at once, you might look at using different lines from different carriers that enter the building at different locations, says Shetye.

“This is easy for a larger agency, or an agency located in a larger city with a variety of different carriers,” he says. “Smaller agencies or agencies in more rural areas may not have this option.”

Another option also might be setting up Internet connectivity, Shetye suggests.

“This allows your users to access your server through any Internet service provider from a remote location,” he points out.

Omni Home Health opted to use a company that is located away from their location to house and maintain their servers, Sweade explains.

“The company is responsible for testing recovery plans and backing up our information on a daily basis to ensure that we don’t lose information,” she says.

“We do require our nurses to transmit information at least once each day so that the most information that can be lost due to a disaster is one day,” Sweade adds.

### **Consider laptop’s potential uses**

While his agency doesn’t use wireless transmissions for communications or information transmission, Shetye does say that option is a viable one to consider.

“A laptop transmitting through a high-speed cell phone is just as effective as using a land line to transmit information,” he says.

Agency managers need to evaluate wireless coverage in their markets to ensure that nurses will get a signal in all areas they visit before committing to wireless, Shetye suggests.

Don’t forget some paper backup, recommends Sweade. “We do keep paper backups of patient information, but we store it at a different location,” she says.

A paper backup of the schedule, list of patients, and contact information for patients and employees should be printed once each week, notes Shetye.

“If your system is only down for two to three days, paper backups can help you make sure you don’t miss visits or contacts with patients,” he adds. ■

## **Pain management project includes pathway for care**

*Pain expert describes how it works*

A quality improvement team that focused on ways clinicians could better manage patients’ pain developed a one-page clinical pathway that clearly shows what needs to be done.

“Our job now is to promulgate that pathway throughout our hospital and to share it with anyone who wants to use it,” says **Frank Forte, MD**, director of medical oncology/hematology and director of palliative medicine at Staten Island (NY) University Hospital.

One side of the pathway includes written

guidelines, including general principles.

One of the general principles is for clinicians to be familiar with the analgesic ladder, which is part of the World Health Organization's (WHO's) recommendations for palliative care.<sup>1</sup>

### **The analgesic ladder**

The idea behind the analgesic ladder is there are three levels of pain and three types of medications and ways for treating it, including assessing the pain, using a drug appropriately, and not managing it continuously, Forte explains.

The guidelines also address what should be done with initial opioid treatment, reassessment, adequate pain control, and partial intolerance.

"For some reason, when someone goes into the hospital, they're immediately put on IVs, and it makes no sense," he says. "So one of our comments is to use IVs only when necessary and to use the appropriate dose for breakthrough pain."

The pathway has two main categories of opioid-naïve and nonopioid-naïve. Under the opioid-naïve flowchart section, there are two choices to be made, depending on whether a patient is able to take medication by mouth. Only if the patient is not able to do so, does the algorithm direct the clinician to the box for choosing an opioid that would be given intravenously.

"We looked at those who could take medication orally, and then the algorithm says if they can take it orally, they should choose an opioid, such as morphine and have a breakthrough dose," Forte notes. "The breakthrough dose is provided at 10% to 15% of the total daily dose."

The next major step in the algorithm is to reassess the patient in 18 to 24 hours, unless the patient's pain requires an assessment before then, he says. "If the patient's pain is controlled, we keep the patient on dose and consider changing to a long-acting medication, and if the pain is not controlled, then we go over the cycle again," Forte adds.

For nonopioid naïve patients, the only

difference is that the dose might be different, so the clinician works with a bigger dose at baseline and makes adjustments as needed, he notes.

"For example, we took care of a lady several months ago who was on a methadone maintenance program, so we had to start her on much bigger doses than someone who wasn't on opioids before," Forte says.

"Physicians, in general, are very hesitant about making changes in opioids because of a fear of side effects and addiction, but addiction in patients with chronic pain due to ultimately progressive terminal diseases is not a great problem," he says. "They're also afraid of respiratory depression, but if you watch someone closely, that's a very unusual occurrence."

"Finally, when the patient has reached the algorithm step where the pain is controlled, then it's time to switch to a long-lasting medication and have the patient stay on that dose as long as is needed," Forte adds.

### **Reference**

1. The World Health Organization. Palliative Care: Symptom management and end-of-life care. World Health Organization's interim guidelines for first-level facility health workers. December 2003; pp. 1-52. Web site: [www.who.org](http://www.who.org). ■

## **Home health/day-care demo project announced**

Up to 15,000 Medicare beneficiaries will be able to receive adult day-care services while receiving home health services as part of a demonstration project announced by the Centers for Medicare & Medicaid Services (CMS).

"This demonstration will permit Medicare to assess whether providing medical adult day-care services through the home care benefit will improve patient outcomes and provide respite for beneficiaries' caregivers," says **Mark B.**

### **COMING IN FUTURE MONTHS**

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**McClelland, MD, PhD**, CMS administrator.

Medicare-certified home health agencies, or corporate entities that include one or more such agencies, are eligible to be selected as demonstration sites.

The demonstration is limited to no more than five sites and associated adult day-care facilities that provide services in states that license or certify medical adult day-care facilities.

Participating home health agencies will be paid 95% of the home health prospective payment rate for services provided to beneficiaries participating in the demonstration.

### **3-year project starts in 2006**

Up to 15,000 beneficiaries at any one time will be eligible to enroll in the three-year demonstration, which is scheduled to begin in February 2006.

Currently, Medicare beneficiaries who attend medical adult day-care facilities pay out of pocket for those services, or they are reimbursed through a third-party payer other than Medicare.

Under this demonstration, Medicare beneficiaries will be eligible to receive medical adult day services as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries' home.

Since these adult day-care services will be provided in coordination with the home health benefit, beneficiaries will not have any associated out-of-pocket costs for these additional services while enrolled in the demonstration.

The deadline for submitting an application to

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participate as a demonstration site is Sept. 20, 2005.

For more information about the demonstration and to access the application form, go to [www.cms.hhs.gov](http://www.cms.hhs.gov). Under "topics" on the left navigational bar, choose "demonstrations." Under "Open Solicitations," click on "Demonstration Project for Medical Adult Day Care Services." ■

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