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the monthly update for executives and health care professionals

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IN THIS ISSUE

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As agencies recover, more disaster planning tips, suggestions offered

Communications, gasoline, and patient records key areas to address

(Editor's note: This is one of a periodic series of stories that will follow up on the experiences of home health agencies, associations, and their staff in the Gulf Coast states affected by the hurricanes this year. Tips and suggestions they have as a result of their experience will help all home health agency managers better prepare for their own emergencies.)

The television crews are gone and other news items lead the 6 o'clock news, but the devastation of hurricanes Katrina and Rita are still everyday stories for the people who live and work in the Gulf Coast states affected by the storms.

"It is still extremely important that we continue to let the home health industry know that agencies in this area are still struggling with significant problems," says **Warren Hebert**, RN, CHCE, CAE, executive director of the HomeCare Association of Louisiana in New Iberia. For agencies that had only one location in New Orleans, the amount of damage makes it obvious that some won't reopen, says Hebert. "Other agencies that were located in parts of the city that weren't flooded as severely are able to repair their office locations and are beginning to have employees and patients returning to the area," he adds.

Because Hebert's association staff and volunteers have come into contact with a wide range of agency representatives as they have offered assistance, he says there are a number of lessons learned in this experience that can help all home health agencies better prepare for emergencies.

• Obtaining gasoline must be a priority

"When power is out, gas pumps don't work," points out Hebert. "Even when there are working pumps, gasoline is in short supply and home health nurses often found themselves sitting in long lines to receive a ration of gasoline that did not allow them to make all of their visits," he says. "Making sure your nurses get the gasoline they need is essential because their home visits can keep patients out of already crowded hospitals.

"Home health agencies should look at developing a relationship with

gasoline providers that recognize the home health need for gasoline as a critical community service," Hebert says. "One agency manager in a small town contacted a local gasoline station owner and pointed out that rationing gas to her nurses affected patients in the community. The store owner agreed with the home health manager and said that home health nurses from her agency could, when they showed their identification, get more than the ration allowed for other customers so they could do their jobs," he says. "The owner also agreed to run a tab for the agency's nurses that the home health agency offered to pay."

• Explore alternate forms of communication

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"Communication was critical in the aftermath of the storms but telephone landlines were not working and cell phone coverage was inconsistent," says Hebert. "Some people found that e-mail on a blackberry worked well," he says.

"Even with cell phones, text messages were easier to send than voice calls," says **Stan Sweeney**, RN, executive director of the Oklahoma Association for Home Care in Oklahoma City. Sweeney spent time in Louisiana, volunteering with Hebert's association and visiting agencies that were trying to see patients and resume business. "Text messages and satellite-based communications seemed to work better than traditional phone lines or cell phones," he adds.

One of the reasons that text messaging is often easier than voice phone calls is the fact that text travels on different channels than voice communications, says **Patrick Kimball**, spokesman for Verizon Wireless in Houston. "When a network is overloaded due to damage to cell towers or due to high call volume, text messages will not only travel on different channels than voice calls but because text messages take up less space on the channels, more text messages can be sent over the same network than voice calls," he explains. Another advantage to using text messages in the aftermath of a disaster is that if the system is busy, the message is held in queue and sent when the channel is open, he adds.

"One agency in our area also purchased satellite phones after the storms took out communications systems," says Hebert. Because the agency had not established satellite service prior to the hurricanes, managers of the agency were unable to hook up their phones as open satellite links were designated for use by the military and by Federal Emergency Management Agency personnel in the area, he adds. Satellite phone service for an emergency must be set up prior to the emergency to ensure access, he explains.

• Have backups for your backup plans

"The main recommendation I have brought back to our Oklahoma agencies is to decide how you will continue service following a disaster that destroys one or several of your locations," says Sweeney. Addressing this problem means thinking about what happens if all patient records maintained in the office are lost, as well as all computers, clinical supplies, employee records, and financial information, he points out. If you have other offices, make it possible to operate from that office with as little difficulty as possible by setting up duplicate systems, he suggests.

One of the ways that the HomeCare Association of Louisiana helped agencies was to open their offices as a business recovery center with staff and computers to enable agencies to continue billing for the patients they were seeing, says Hebert. "Few agencies took advantage of this, but we believed it was important for the association to do something immediately after the storms," he adds. "We have taken our business recovery efforts on the road, traveling to different agencies, asking what type of help they need, and offering advice on steps they need to take," he says.

"This hurricane season definitely points out the need for electronic records," says Hebert. "Agencies that have electronic records, with backups kept at distant locations, are in the best shape in terms of recovery."

•Make sure patients take medical records with them

The number of people evacuated from their homes, both before and after the hurricanes, resulted in a problem that has never happened on this scale, Hebert says. "Patients were relocated to different cities and different states, with no medical information available to the physicians and health care providers that were charged with caring for them," he says. "Part of any home health agency's emergency preparedness plan should be to be sure that patients carry an abbreviated copy of their medical chart with them when they evacuate," he continues. "Many agencies leave a home copy of the medical information and update it as needed each visit. Patients should know to carry this with them," he says. "Diagnosis, medications list, and treatment plans are the minimum amount of information they should have with them.

"Some agencies are evaluating the use of patient armbands, similar to those worn in hospitals, as preparation for other emergencies," Hebert says. The armbands would include patient information, including diagnosis, as well as family contact information and home health agency information, so that the receiving caregiver could get in touch with someone for more information, he says.

Another technological solution would also be the use of flash drives, also known as key drives due to their size and shape, says Hebert. "If the nurse uses a laptop for documentation, she could just update a flash drive that is kept in the patient's home. If patients evacuate, the flash drive is easy to pick up and carry with them," he adds.

While recovery from the hurricanes slowly and steadily moves along, Hebert says that the offers of assistance from people who want to volunteer time and from people who want to contribute to the association's recovery fund, which will provide money to agencies and agency personnel who need assistance, has been awe-inspiring.

"We've learned a lot about our ability to deal with a crisis and about our industry's support of our efforts," he says.

Hebert's association members will share their experiences at the association's annual conference that was moved from a November date due to lack of hotel space as a result of emergency personnel in the area, to Jan. 16-18 at the Hilton in New Orleans. "We planned the topic after the hurricanes," he says. It is appropriately named "Transcending Crisis. Transforming Your Future." ■

SOURCES

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For more information about disaster planning resources developed by the HomeCare Association of Louisiana or about the national conference, go to www.hclanet.org.

Education on 'do-not-use' abbreviation list needed

Physician orders, staff competency compliance issues

(Editor's note: This is the second of a two-part series that looks at accreditation standards that pose compliance problems for home health agencies. Last month, we looked at emergency preparedness and what components are necessary to satisfy a surveyor. This month, we examine do-not-use abbreviation lists, written orders, and competency assessments.)

Meeting the Oakbrook Terrace, IL-based Joint Commission on the Accreditation of

Healthcare Organizations' patient safety goal that calls for a list of abbreviations not to be used because they can be misunderstood or misread, resulting in potential safety risk to a patient, seems like an easy task to achieve. The standard that reflects the appropriate use of abbreviations (IM 3.10) is, however, the second most problematic standard for organizations accredited by the Joint Commission with 16% of home health agencies found non-compliant.

"Everyone has their lists of 'do-not-use' abbreviations but home health agencies are finding themselves non-compliant because they are not providing the staff education needed to implement the do-not-use lists consistently," says **Maryanne L. Popovich**, RN, MPH, executive director of home care accreditation for the Joint Commission.

In addition to educational inservice on the do-not-use abbreviations, staff at Midwest Home Health in Del City, OK, have laminated reference cards that include the abbreviations and serve as a reminder not to use certain ones, says **Sue Gibson**, RN, director of the agency. "When the first core group of abbreviations was published we laminated bright pink index cards that contained the abbreviations, then we updated them when the next group was identified," she says. "The cards are taped to nurses' clipboards so they always have a quick, easy reference tool."

Gibson's agency also audits charts on a monthly basis, with staff members looking for use of banned abbreviations. "We audit the charts at different points of the patient's care, not just prior to filing a claim," she says. "We pick up problems such as a nurse who is using do-not-use abbreviations early in the process so we can make sure the nurse has the reference card and understands the importance of not using certain abbreviations," she says.

In a recent Joint Commission survey, the surveyor found only one do-not-use abbreviation that was used in a medication profile, says Gibson. "The surveyor reviewed a number of charts, so we were pleased that there was only one abbreviation misused," she adds.

A key to successfully implementing a do-not-use abbreviation list is to keep the list manageable, suggests Gibson. "We review the abbreviations carefully and include only those abbreviations that are really applicable to our practice," she says. If your list becomes too long, and includes abbreviations your staff rarely uses anyway, nurses will not use the reference tool because it is too time-consuming and cumbersome, she adds.

SOURCES

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Physician order must be in chart

Another tough standard for home health agencies that resulted in non-compliance in 15% of agencies surveyed is the requirement that care be provided according to a physician's order, points out Popovich. "This standard has always been in the list of top 10 standards that pose compliance problems," she says. "The challenge for home health nurses is managing patients whose conditions may require multiple changes in orders in a short period of time," she explains. "While staff members may get verbal orders for changes in the care plan, the system is not always in place to quickly transmit this information into a written order.

"Home health patients may also be seeing multiple caregivers if they are seeing different nurses or therapists for different visits," Popovich says. "A physician may give a verbal order to one caregiver, but that order may not make it into the chart as a written, signed order prior to the next nurse or therapist's visit," she explains.

Organizations that are using point-of-care laptops or other technology to instantly transmit a change in an order are complying with this standard more easily, says Popovich. But even with technology, it is important to make sure that someone is reviewing charts on a regular basis to ensure that orders are written and placed in the chart in a timely manner, she adds.

Case managers are the reason that Gibson's agency doesn't have a problem meeting this standard. "Each case manager carries a case load of 20 to 25 patients but she only sees four patients each day," explains Gibson. "The remainder of the case manager's time is spent coordinating care that is

given by LPNs, other RNs, or therapists that are seeing the patients," she says. "If medications are changed or if the physician orders a different therapy, the caregiver that receives the verbal order must call and update the case manager on the day the order is changed. This ensures that the case manager can get the order written and signed, and update the medical record to reflect the change before another caregiver visits the patient," she points out.

The case management system works well for several reasons, says Gibson. "The case manager is able to coordinate the larger group of patients because she isn't the only nurse visiting the patient and she does have time during her day to oversee the documentation issues," she says. The system is also beneficial for the other staff members seeing the patient because once they have notified the case manager of the change in orders, they do not have to spend time making sure that the written orders are placed in the record, she explains. "This is a very efficient use of staff and time, and we see that it does keep the patient's plan of care updated more effectively," she adds.

One other standard for which 11% of home health agencies were found non-compliant was HR.3.10, a requirement that the agency assesses a staff member's competence to perform his or her job, points out Popovich. "Agencies across the board struggle with this standard," she says. "Everyone has a program to assess competence developed but it is not always implemented according to the plan developed by the agency."

In many cases, the agency has developed such a cumbersome plan that it is too difficult to implement, Popovich points out. "I always recommend that home health managers take a close look at their competency assessment plan and make sure that they are including only what is really necessary to assess an employee's competence," she says. If you require too much that supervisors or employees don't believe is necessary or appropriate to the job, the assessment won't be performed correctly and the documentation won't be completed, she says.

The Joint Commission doesn't specify what components make up a satisfactory competency assessment so the surveyors have to evaluate the home health agency based upon the program described by the agency, she says. "Keep your competency assessment program simple, straight forward, and directly tied to the job, and this standard won't be difficult to meet." ■

LegalEase

Understanding Laws, Rules, Regulations

Should you have your own malpractice insurance?

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

Licensed practitioners of all types who are employees of health care providers are often covered by malpractice insurance that is paid for by their employers. Employees who are covered by their employers, however, wonder whether they should also purchase their own malpractice insurance.

Below are some of the pros and cons of purchasing your own malpractice insurance coverage.

You should purchase and maintain your own malpractice insurance coverage because:

1.) When claims are filed in which you may be involved, your employer's insurance company will assign legal counsel to defend the claims. Legal counsel assigned by your employer's insurance company clearly represents your employer, not necessarily you. In fact, if legal counsel determines that the actions you took are outside the scope of your employment, your employer's insurance company may decide that there is no coverage for the claims filed against you. Under these circumstances, the only insurance you have may be the coverage you purchase yourself.

2.) In some instances, multiple claims may be filed against the same provider, including you. These multiple claims may exceed the limits of liability of your employer's insurance policies. Once again, the only coverage you may have may be the coverage you purchase and maintain yourself.

3.) Almost all practitioners have assets that should be protected, even though most practitioners are not accustomed to thinking of themselves as "deep pockets." These assets often include wages from employment, a home, automobiles, savings, stocks and bonds, etc. The only way to help ensure protection of these assets is to purchase and maintain your own insurance pol-

icy.

4.) Malpractice insurance is relatively inexpensive for most types of practitioners, except for some advanced practitioners, such as nurse midwives. It is readily available through professional associations at a reasonable cost.

5.) If you purchase your own malpractice insurance and a claim is filed against you, your insurer will assign legal counsel. Unlike counsel assigned by your employer's insurance company, legal counsel assigned by your insurer owes allegiance only to you. You will have legal counsel who is solidly in your corner and who can, if necessary, counter arguments made by your employer's insurer that your employer's policy should not cover you.

6.) It is untrue that if you have your own malpractice coverage you are more likely to be sued. In most instances, patients and their families have no way of obtaining information about whether or not you have malpractice insurance before they file lawsuits. Even after lawsuits are filed, rules governing discovery may prohibit attorneys for patients and their families from getting information about whether you have malpractice insurance and, if so, the amount of coverage, etc.

You should not purchase and maintain your own malpractice insurance coverage because:

1.) Employers, especially large institutions and organizations, may not want their employees to have their own malpractice insurance. It may be time-consuming for everyone involved if your insurer assigns legal counsel in addition to counsel from your employer's insurer. The attorneys may disagree about your liability or it may be difficult for them to communicate effectively and to get "on the same page" regarding your best interests.

The bottom line, however, is that purchasing and maintaining your own malpractice insurance will provide peace of mind at a relatively low cost. As indicated above, the potential benefits far outweigh possible difficulties of having your own coverage. Having your own malpractice insurance in our litigious society may now constitute an important aspect of professional practice.

[To obtain more information about professional liability in a book entitled Legal Liability*, send a check for $30.00 that includes shipping and handling made out to Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Phone: (301) 421-0143. Fax (301) 421-1699. E-mail: ehogue5 @comcast.net.]* ■

Home environment better atmosphere for learning

Observation aids in overcoming learning barriers

Education is the backbone of home health care, says **Eileen McFadden**, BSN, MN, manager of educational services at VNA Home Health Care Services in Spokane, WA. It is through education that the patient's goals and outcomes are met.

"It is the purpose of home health care to instruct and assist the patients in gaining the knowledge and skills to allow them to remain in their own homes and return to their prior health status," says McFadden.

The purpose of home health care is rehabilitation, says **Jeanne M. Martinez**, RN, MPH, CHPN, former quality and education specialist at Northwestern Memorial Home Health Care in Chicago, who now is a quality specialist with palliative care and home hospice at Northwestern Memorial.

Sometimes the rehabilitation is short term, in which case patients must learn a skill such as dressing changes while recovering from surgery. However, home care staff often work with patients learning to manage a chronic illness, such as diabetes, in which success has a long-term impact.

"Generally, the focus of home care is to rehabilitate the patient or at least get them to a point where they can continue their own care," says Martinez.

While the educational process is a continuum of the teaching that took place in the hospital, often the patient will learn better in familiar surroundings.

"It is becoming well known that if you want a patient to recover get them back into familiar surroundings where the stress is decreased. The home is where the best teaching and learning take place," says McFadden.

There are many reasons why teaching in the home care setting frequently leads to better results than those achieved in the hospital setting.

There is no better way to see the whole person than in home care, says McFadden.

"We in home care have a very special and unique role. We are allowed very close, intimate, and personal contact with the patient and families in their situation," she explains.

By going into the home environment it is easier to assess what some of the obstructions and barri-

ers to health and learning might be, as well as the patient's and family's values, interests, motivation, and real goals.

The home environment is usually less distracting than the hospital where visitors and medical staff come in and out of a patient's room all day and education is interrupted for lab work or other patient care needs. If there are distractions in the home, such as small children running around or a loud television, nurses can work with patients to eliminate them, says Martinez.

Connecting choices and consequences

When working with the patient at his or her home it is much easier to help them see the connection between the choices they make and the consequences of those decisions. "We can give patients direct feedback and support in order to correct their behaviors," says McFadden.

The feedback can be obtained by contracting with telemedicine companies that call the patients frequently to determine if they are making choices that will result in good health outcomes.

For example, congestive heart failure patients learning to monitor their weight and determine what can cause a sudden weight gain might weigh each morning and report to a telemedicine company. If there is a sudden weight gain, home health would follow up to help the patients determine the cause and see the link between their food choices and the sudden spike in weight. Home health nurses are able to help patients sort out what may or may not be good choices for them, says McFadden.

"The home is where the actual change in the patient's behavior needs to take place so the clinicians are able to observe the patient's actual follow through, or lack thereof. By starting where patients are, allowing them to see their progress, and obtain observable goals, long-term results and sustained change are possible," says McFadden.

In a hospital setting, clinicians must rely on information provided by patients concerning such matters as the ability to purchase medications and nutritional food or whether patients have family support. When in the home setting, a team from home health can observe barriers to education and recovery. Home health nurses become very good at assessing situations quickly, says McFadden.

Family dynamics can be either supportive or challenging, she says.

It is easier to know what would motivate a person to comply with treatment regimens and instructions when in a person's home, says Martinez. For example, they may be motivated to complete certain exercises so they will be able to walk because they have a garden with many walking paths they want to enjoy again. (To learn how to use the home environment to improve cultural assessments, see article below.)

Because nurses return to the patient's home time and again for repeat visits they are able to observe the patient's progress after he or she has had time to practice a technique such as insulin injection. Often people think they will not be able to master a skill but a home health nurse can help them through the process until they have a sense of control. In addition, patients can call the home health agency when they have problems, says Martinez.

Also, home health nurses can help patients become better organized to handle the changes in their lives that must occur in order for them to live with their illness or health problem.

For example, taking 10 medications can be very overwhelming, yet a home health nurse can help patients organize them in a way that works. In a two-story home patients might keep the medicines they take at bedtime in the bathroom next to their bedroom and their morning medications downstairs.

"Nurses can do a lot with patients to help them become better organized in their home setting," says Martinez.

Successful teaching sessions

Teaching sessions can be very successful because the home health nurse sets up the time for the visit in advance and is able to discuss with patients what they will need to be ready to learn, as well as the information to be covered. For example, the nurse may want to go over the patient's ability to monitor his or her blood glucose levels.

Before a visit, the nurse will determine whether or not patients have been able to get the equipment they need, such as a blood glucose meter. If patients cannot get the equipment the nurse will find resources to help them obtain supplies.

Also, the nurse can make sure everyone who needs to be present at the time of teaching will be in the home. In home health it is important that a family member or other caregiver be in the home at the time of the visit to learn as well, says Martinez.

Valuable teaching sessions in the home setting also depend on accurate documentation of patient education. When multiple nurses are visiting the patient, as well as physical and occupational ther-

apy, communication must take place so each discipline knows not only what was taught but also what teaching must be reinforced, says Martinez.

If educational needs are not well documented insurance companies may deny subsequent visits because the need is not evident, she adds.

Indeed, in home health it is important to be goal- and objective-oriented and make every visit count because insurance companies can limit the number of visits, says McFadden. It is important for members of the health care team to know that a certain portion of the education has been completed and the objective has been met.

"Documentation of the education in the home is critical so we stay on task to help the patient reach these goals in as short a period of time as possible," says McFadden.

To help with documentation and make sure objectives are met, care pathways are often used at VNA Home Health Care Services. "Care pathways also help members of the team assess where the patient is and determine where he or she wants to go," explains McFadden.

It's important to communicate with the physicians who are seeing the patients as well, she adds.

"We use liberal amounts of faxes to keep the physician apprised of the patient's progress. The physician is key in developing the plan of care," says McFadden.

Yet, communication is not limited to home health teams and the patient's physician. It begins at the point of discharge between home health care and discharge planners at the hospital.

It's a good idea to have a copy of the written discharge instructions so there is consistency in what was taught at the hospital, says Martinez. It also is important to have the protocols from physicians on what they want their patients to be taught, especially for patients recovering from certain surgeries, such as hip replacement or undergoing certain treatments, such as chemotherapy.

When multiple services are involved with patient care it is helpful to provide patients with a folder to keep all their instructions and handouts together.

"The more the hospital and the home care agency or the physician's office and the home care agency can communicate the better it is for the patient," says Martinez.

Although hospital clinicians try to provide all the necessary instruction to patients before discharge, they do not always retain all they have been taught, says McFadden. Therefore it is important for a home care agency to know what has been taught during the hospital stay so they can reinforce the teaching. In addition, it is important to know what triggered the hospital admission so the issue can become a focal point for teaching, she says.

"Our goal is to delay, reduce, or eliminate repeated hospitalization by helping the patient understand the process. Only by instruction and education can the causes of the changes in their health status become known to them so they can learn disease management," explains McFadden. ■

SOURCES

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CHF project aims to bridge gap between providers

Ultimate goal is better outcomes, fewer readmissions

Drawing on 20 years of quality improvement experience, MPRO, Michigan's Health Care Quality Improvement Organization, is bringing together hospitals, home health agencies, and physician practices to come up with solutions to communications barriers between providers, with the ultimate goal of improving outcomes for the state's cardiovascular disease patients.

"In the state of Michigan, no one has brought different groups from across health care settings together at one table. This pilot project is the first time that hospitals, home health agencies, and physician offices come together to work together for better patient outcomes," says **Linda Charles**, RN, BS, project coordinator for MPRO's hospital quality improvement team.

MPRO has been awarded a contract with the Michigan Department of Community Health for the pilot project "Cardiovascular Health Project." The goal is to reduce the number of hospital readmissions for patients with cardiovascular disease,

Cultural cues important in home health care

Come armed with cultural knowledge

When a home care patient is from another culture it is a good idea to learn as much as possible about his or her cultural beliefs before the visit, says **Jeanne M. Martinez**, RN, MPH, CHPN, former quality and education specialist at Northwestern Memorial Home Health Care in Chicago and now a quality specialist with palliative care and home hospice at Northwestern Memorial.

"Find out as much about the general cultural values and beliefs as you can, but then be very cautious you don't assume each patient and family member ascribe to all of those values and beliefs because often they don't," says Martinez.

People are acculturated at different rates. There may be a lot of differences in the same family between who is acculturated and who has more core values and beliefs of the culture from which they came, particularly between generations, says Martinez.

"It is very important to always do an individual assessment and not assume because the culture at large believes X that your individual patient believes that as well. But if you observe some customs in the home at least you have some background information of where the patient might be coming from," says Martinez.

For example, the home may have several religious artifacts that signal a person's faith is important to them. Or the female patient may be wearing a traditional, floor-length dress that signals privacy issues are important. A nurse raised in the United States may think nothing about exposing the lower leg to examine a wound with a male in the room, however in other cultures that action may not be acceptable. Therefore it is wise to ask first, says Martinez.

Cues to appropriate behavior can also be spotted with careful observation. For example, if everyone has their shoes lined up at the door the home care visitor should take his or her shoes off, too.

Sometimes it is a good idea to curtail certain behavioral habits if it is uncertain how a person from another culture will react to them. "You may be the type of person who puts your arm around a patient and hugs them routinely; however in a culture you are not familiar with that might not be the thing to do," says Martinez. "You need to be careful about how you touch people."

Another obstacle to teaching a patient from another culture could be a language barrier. Interpreters sometimes accompany home health nurses to the home of a patient but when this is not possible telephone interpreter services can be used instead.

Pictures come in handy as well, says Martinez. She likes to have pictures to help reinforce education in any home but for patients who do not speak English or have low literacy skills they are vital teaching aids.

When two people do not share the same cultural expectations and do not know what to expect from each other the home visit can be tense; it is important to come armed with as much knowledge of the culture as possible. It is also a good idea to bring teaching sheets in the patient's native language as well, says Martinez. ■

especially congestive heart failure (CHF) by reinforcing education and self-management before and after hospitalization.

The project aims to improve the consistency of documentation, patient assessment, and reporting of clinical findings and to close the gap between the hospital, home health agencies, and physician offices.

"The goal of the heart failure collaborative across settings is not just to decrease readmissions; other goals are to reinforce heart failure patient education and self-management prior to and after hospitalization and to help the patients gain more control over the disease process," says **Teri Aldini**, RN, MS, project manager for the home health and hospital team.

Heart failure is the leading diagnosis for Medicare patients in the state of Michigan and is among the leading diagnoses for hospital readmissions.

The 325,000 patients discharged with a diagnosis of heart failure last year incurred about $226 million in hospital costs. About 25% are discharged from Michigan hospitals with a home health referral.

"When we worked on cardiovascular quality improvement projects in the past, our team had observed the disconnect between the hospital, the home health agency, and the physician office. We wanted to create a collaboration between the hos-

pitals and home health offices, realizing that the physician's office is an integral part of post-acute care," Charles says.

The disconnect appears to occur when patient care is managed by a cardiologist while the patient is hospitalized, and following the patient's discharge home, care is then resumed by the primary care physician.

Typically, the cardiologist will discharge the patients to home with home health and the patient receives post-discharge instructions from the hospital, but it takes a while for the discharge summary to reach the physician's office. If the patient has a question or an acute event or the home health agency calls for further orders, the physician does not have the information he or she needs to prescribe follow-up care.

"Even if a primary care physician assumes care in the hospital and writes a home health referral, he has the knowledge of what happened in the hospital but the office staff may not, and they are the ones who typically triage the patients," Charles says.

The project aims to integrate care across all settings to improve patient outcomes by bringing together hospitals, home health agencies, and representatives from physician offices for two intensive learning sessions during which the providers share ideas about improving communication.

"We serve as facilitators at these sessions, bringing different stakeholders together and giving them the opportunity to identify where the problems are and work on solutions to overcoming barriers. It's the responsibility of the providers to adapt the lessons they learned when we were together and change the process of care in their individual settings," Charles adds.

MPRO holds a monthly conference call in which participants report on what they have implemented.

Participants include hospital and home health quality improvement staff, home health administrators, hospital discharge planners and offices managers, and sometimes nurses from physician practices. The pilot project with the Michigan Department of Community Health involves two hospitals, three local home health agencies, and four physician practices.

Other initiatives

The organization has led a number of other cardiovascular quality improvement initiatives, including the Michigan Heart Failure Discharge Documentation program, developed with Blue Cross and Blue Shield (BCBS) of Michigan and the Michigan chapter of the American College of Cardiology.

The aim of the project is to ensure that admission and discharge orders meet the core measures for quality established by the Centers for Medicare & Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations.

"Heart failure discharge instruction rates throughout the nation are extremely poor. Those statistics, coupled with the fact that heart failure represents a significant health care expenditure, is what precipitated this project," Aldini says.

The team brought together 39 participating Michigan hospitals for intensive learning sessions and sharing ideas to make sure the quality initiatives are being met.

"The goal of the program was not just to increase the rate of discharge instructions documentation but to increase patient knowledge and to give the patients more tools to help them control their disease process and adapt their lifestyles," Aldini says.

The hospitals received a template document designed to improve the documentation for the six core measures for heart failure and were encouraged to use it or adapt it.

MPRO followed up with conference calls in which hospitals reported their use of the tools provided.

As a result of the project, hospitals in Michigan have begun sharing tools that help them address the core measures and other quality initiatives, Aldini says.

The project has improved heart failure discharge instruction documentation significantly. The baseline measurement showed that an average of 50% of hospitals were meeting the core measures for heart failure. After a year, the average rose to 68%. Following on the success of the initial project, MPRO, the Michigan chapter of the

American College of Cardiology, and BCBS of Michigan are expanding the program statewide and held their first learning session in October. ■

Nurse line checks up on patients after discharge

Referrals made for patients who need follow-up

When a case manager or social worker at Saint Luke's Medical Center is concerned about a patient who is being discharged, he or she asks the RNs staffing the hospital's Nurseline to make a follow up call after the patient gets home.

Since the program began in May 2004, more than 100 patients have been referred to the Nurseline for follow up and only eight of these have been readmitted — none for anything connected with the original admission, says **Anita Messer**, RN, MHSM, ACM, director of care integration for the Kansas City, MO, hospital.

The Nurseline originally was created so patients could call in with questions after they left the hospital. The program has been revised to include outbound calls for patients who are flagged by case managers or social workers for post-discharge telephone calls. The initiative is budget-neutral since the hospital already had the Nurseline in place.

"These are patients we're concerned about after they leave the hospital. They aren't sick enough for home health care, but the social worker or case manager has identified some issue about their safety. They may not understand their discharge instructions and may need more help with this after they get home," says **Melissa K. Thomas**, RN, MSN, CPHQ, clinical project manager.

The hospital has follow up for patients with some chronic diseases, such as congestive heart failure, but there are others who need assistance but don't qualify for post-discharge services.

"One of the main goals of the program is to catch patients who in the past may have fallen through the cracks. These are other patients who are not sick enough to qualify for home health or other services but are at risk for having to be readmitted if they don't make a doctor's appointment or get their prescription filled," Thomas says.

The order in which the discharged patients are called is based on an acuity system.

If a nurse or case manager identifies a patient as high acuity, the process is followed to flag Nurseline, and the patient is called the day after discharge.

If patients are low acuity, the Nurseline nurse calls them a few days later to make sure they are taking their medication, that they've scheduled a follow-up appointment with their physician, and are experiencing no signs or symptoms that might indicate complications.

When a case manager or social worker identifies a patient who meets criteria, they put it in the chart. The information assistant (or unit secretary) flags the patient on the electronic medical record and faxes the discharge summary to the Nurseline. The fax includes information about the acuity level of the patient's follow-up needs, what follow up should be done, what medications were prescribed, and what the discharge instructions are.

"This initiative allows us to follow our patients after discharge and gives the nurses, the case managers, and social workers peace of mind. We've been able to prevent complex medical problems from occurring and to ensure that the patients are doing everything they need to do to recover quickly," Messer says.

For instance, when the Nurseline nurse called a man who was recovering from cardiac surgery, he reported having chest pain, which he thought was normal. The nurse evaluated his pain, determined it wasn't normal, and made an appointment with his physician, who adjusted the medication, potentially preventing a readmission down the road.

Another patient who had a surgical procedure reported a fever several days after discharge. The Nurseline nurse got her an appointment with her physician and it was determined that she had a postoperative infection.

If the Nurseline nurses feel it's needed, they make an appointment for the patient to see their physician. In some cases, they call the physician and ask for a home health visit if the patient is

homebound or doesn't have transportation.

Patients who are designated high acuity may be those on multiple medications who seemed confused about which to take when. They may live alone in a rural area or be someone who has had frequent readmissions.

"This is a transitory town. We have a lot of seniors who don't have family around. The nurse line gives us a checkpoint to make sure they're safe and understand their discharge instructions," she says. ■

CE *questions*

9. What is the main recommendation that **Stan Sweeney**, RN, executive director of the Oklahoma Association for Home Care in Oklahoma City, has for agencies in his state after witnessing the aftermath of hurricanes in Louisiana?
A. Plan for flood damage
B. Make sure your emergency plan includes employee phone numbers
C. Stock extra clinical supplies in main office
D. Prepare for backup office location in the event your office is completely destroyed.

10. What is key to successfully implementing a "do-not-use" abbreviation list in your agency, according to **Sue Gibson**, RN, director of Midwest Home Health in Del City, OK?
A. Use large type on list
B. Develop comprehensive list
C. Keep list simple and as short as possible
D. Post list in a visible spot in the office

11. Teaching in the home setting can be beneficial for which of the following reasons?
A. Home environment less distracting.
B Barriers to education more easily assessed.
C. Can show choice consequence connection.
D. All of the above.

12. When teaching in a home setting cultural cues can often be found by observing which of the following?
A. Religious artifacts
B. Family wears traditional clothing
C. Family takes off shoes at door
D. All of the above

Answer Key: 9. D; 10. C; 11. D; 12. D.

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. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

Hospital Home Health
2005 Index