Providing the highest quality information for 23 years

Hospital Home Health®

the monthly update for executives and health care professionals

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial Disclosure:
Editor Sheryl Jackson, Managing Editor Jill Robbins, Editorial Group Head Coles McKagen, Board Member Elizabeth Hogue, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

MARCH 2006
VOL. 23, NO. 3 • (pages 25-36)

Cut hospitalization rates with 24-hour availability, extra visits at start of care

Top performers share best practices in national study

(Editor's note: This is the first of a two-part series addressing reduction of hospitalization and strategies to improve performance in Home Health Compare measures. This month, findings of the National Home Health Hospitalization Reduction Study are discussed, with tips from the best performers. Next month, strategies that help successful home health agencies reach the top 10% of Home Health Compare categories will be discussed.)

As performance improvement programs and the ability to track data and trends from OBQI reports have become more sophisticated, home health agencies report improvements in all categories, except hospital readmission rates.

That lag was the primary reason hospital reduction was chosen as the topic for a national home health study conducted by the Briggs Corp. and co-sponsored by the National Association for Home Care & Hospice and Fazzi Associates Inc.

"The national average for hospitalization from the home health care setting is 28%," points out **Robert Fazzi**, Ed.D, president and CEO of Fazzi Associates, a benchmarking and consulting company in Northampton, MA. While the average has not changed significantly in a negative direction, it also has not improved over the years, he adds. "We wanted to identify the best performers, the agencies that were in the top 10% of this category, and document what strategies they were using to reduce their hospitalization rates," he explains.

After identifying and contacting slightly more than 700 agencies that are in the top 10% of agencies with the lowest hospitalization rates, more than 200 agencies were resurveyed in the final stage of the study, which focused on specific strategies used to reduce hospitalization.

"While 333 agencies responded to the first contact with descriptions of strategies they used, we went back to the final 205 because they were intentionally using these strategies in an effort to reduce hospitalization," he explains. "We did find that the most successful agencies used multiple strategies rather than only one," he adds.

The most prevalent strategies used to prevent hospitalization by study participants were:

• Fall prevention

The elderly population cared for by home health makes fall prevention a high priority for many agencies, Fazzi points out. A total of 66% of survey respondents use environmental assessment of the home, evaluation of medications that can cause dizziness, and identification of balance difficulties as key efforts to prevent injuries from falls, he adds. **(For information on falls in home care, see "How do you rate? Benchmark study identifies frequency, causes of falls," *Hospital Home Health*, August 2005, p. 85.)**

Hospital Home Health® (ISSN# 0884-8998) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: ahc.customerservice@thomson.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 contact hours per year.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This activity is intended for nurses, mangers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues. It is in effect for 24 months from the date of publication.

Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@thomson.com).

Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

• Front loading

The most unexpected strategy to make the top of the list was front loading, a method used by 64% of agencies in the study, says Fazzi. "These agencies identify patients at risk for hospitalization and adjust their visit schedule to see the patient more frequently in the first few weeks after admission," he explains.

The staff at Washoe Home Care in Reno, NV, attribute their agency's hospitalization rate of 17% to front loading. "We work closely with the hospital discharge planner to identify high-risk patients and we meet with the patients before their discharge," says **Martina Petersen**, RN, interim director of the agency. "If home care is appropriate for the patient but we think the patient and the caregiver will need extra support, we schedule extra visits in the first two weeks to provide extra care and education," she explains. **(For more details on the agency's strategy, see p. 28.)**

• Management culture and support

Sixty-one percent of agencies in the study identified their organization's culture as a key factor in reducing hospitalization, Fazzi says. "All staff members are involved and no person puts a 2 p.m. crisis on hold. Everyone addresses a patient's problem as soon as possible so that the patient doesn't feel like he or she needs to go to the hospital for care," he explains.

"All of our staff members know that outcomes matter," says **Patricia Fleming**, RN, chief clinical officer for VNA of Rhode Island in Lincoln. "Outcome data are presented every two months to our board members, every quarter to our quality council, and every month at our supervisors' meeting," she says. Supervisors share information with their staff members and outcome data are posted on bulletin boards, she adds.

Before you can share outcome information, you should ensure that someone is reviewing and evaluating the data on a regular basis, Fleming points out. While she is the point person for reviewing the data, all staff members become involved in identifying areas that need improvement and tactics to improve outcomes.

• 24-hour availability

Answering services, nurses on call, and triage teams are used by 59% of the study participants to keep patients at home, says Fazzi. "Some agencies even offer a guarantee of a returned call within one-half hour," he says.

"We are fortunate that our hospital has an RN-staffed answering service for patient calls after hours," says **Eileen Sube**, manager of regulatory

compliance for Conemaugh Home Health in Johnstown, PA. "The nurses use standardized protocols developed for our patients to triage the patient," she says. The protocols include questions to help identify the cause of the patient's symptom and offer suggestions on what the patient should do, she says. "If the nurse believes that the patient needs attention beyond the protocol, home health nurses are on call to make phone contact or visits to patients," she adds.

• **Medication management**

Because medication can affect a patient's risk for falls and different medications can interact with each other to create unanticipated complications, 59% of agencies in the study focus on accurate lists of medications that patients are using and regularly review this information, Fazzi says.

"Our patients may be on as many as 20 different medications so we check medications every time we visit the patient," Fleming says. Nurses and therapists are instructed to go through medications at each visit, update lists in the chart, and check for contraindications with software on their laptops, she explains. "We tell patients to place all of their medications on the kitchen table so we can be sure to see everything," she adds. "The only way we can avoid complications from medications is to check the medications every time and make sure patients understand what they are taking and how they should take it," she says. **(For more information about avoiding medication errors, see p. 29.)**

• **Case management**

Fifty-two percent of study participants use case management to manage patient care, says Fazzi. Having one person who oversees a patient's care, no matter how many disciplines are involved, increases the likelihood that a change in condition or symptoms that indicates a decline will be noticed, he adds.

While her agency doesn't use case managers, Sube points out that the use of a primary nurse for each patient also is effective. "Our nurses are responsible for between 10 and 25 patients that they visit," she says. "The nurses are also responsible for receiving communications about the patient from other staff members, such as therapists, who visit the patient," she explains. Because the primary nurse knows the patient well, she can identify changes or symptoms that might indicate a problem that could lead to hospitalization, she says.

• **Patient and caregiver education**

"We revised the teaching handouts that we have always used for patients and have found that improved education reduces trips to the emergency room and the hospital," Sube says. A total of 48% of the participants in the hospital reduction study reported that patient and caregiver education was crucial in their efforts to reduce hospitalization.

"We've always used written handouts for patients and their caregivers, but two years ago we rewrote the handouts to use lay language rather than medical language," explains Sube. "We also increased the size of the type to 14 points and we used bullet points and short sentences," she adds. The one-page handouts that are designed for different conditions clearly spell out signs and symptoms for which patients should be looking.

"By explaining the disease and by clearly and simply describing early warning signs of trouble, we are able to better educate the patient and caregiver," says Sube. Patients say that they refer to these handouts more often because they are easy to read, she adds, and nurses reinforce the information in the handouts by using them as teaching tools during visits.

SOURCES

For more information about strategies to reduce hospitalization and results of the National Home Health Hospitalization Reduction Study, contact:

- **Robert A. Fazzi**, Ed.D, president and CEO, Fazzi Associates Inc., 243 King Street #246, Northampton MA 01060. Phone: (800) 379-0361 or (413) 584-5300. Fax: (413) 584-0220. E-mail: bfazzi@fazzi.com.
- **Martina Petersen**, RN, interim director of professional services, Washoe Home Care, 780 Kuenzli Street, Suite 200, Reno, NV 89502. Phone: (775) 982-5860. E-mail: mpetersen@washoehealth.com.
- **Patricia Fleming**, RN, chief clinical officer, VNA of Rhode Island, 622 George Washington Highway, Lincoln, RI 02865. Phone: (401) 335-2400. E-mail: pfleming@vnari.org.
- **Eileen Sube**, manager of regulatory compliance, Conemaugh Home Health, 130 West Osborne Street, Johnstown, PA 15905. Phone: (814) 534-9150. E-mail: esube@conemaugh.org.

To obtain a copy of the National Home Health Hospitalization Reduction Study, go to www.fazzi.com and click on "National Quality Improvement Hospitalization Reduction Study" on home page, then click on the report to download a free copy.

Best strategies are low cost

"It is interesting that the top strategies don't cost a lot of money," Fazzi points out. "These strategies don't involve investment in technology or additional staff, but they do require development of policies and staff education," he says.

Other strategies such as telemonitoring did not show up as top strategies but that doesn't mean they aren't effective, Fazzi adds. Only 8% of study participants used telemonitoring as a hospital reduction strategy. That parallels the fact that only 5% to 10% of all agencies in the country use the technology, he says. When more agencies are using telemonitoring for their patients, it might become a more frequently reported strategy, Fazzi predicts.

"We have used telemonitoring for any of our patients with chronic conditions that may require extra monitoring," says Fleming. By using a telemonitor to capture and transmit information, such as blood pressure, weight gain, and oxygen levels, nurses are able to intervene before the patient reaches a crisis point, she explains. **(For more information on telemonitoring, see "Use technology to improve your patients' health and your agency," *Hospital Home Health*, May 2005, p. 49.)**

Home health managers are fortunate that so many data on outcomes are collected and available in a benchmark format, but it is important to use the information to initiate improvement, suggests Fazzi. "Home health managers need to look at Home Health Compare, see where they rank in relation to other agencies, choose a quality improvement project, and set specific targets to reach. Studies that share best practices can help agencies identify ways to reach their goals." ■

Schedule more visits at start of care

See better outcomes, fewer hospitalizations

A hospitalization rate of 17% can be attributed to many factors, but the staff at Washoe Home Care in Reno, NV, are convinced that front loading the visit schedule is the key to a rate that is 11% below the national average.

"We start working with the patient before they are discharged from the hospital," explains **Martina Petersen**, RN, interim director of professional services for the agency. "We meet with the patient and the family caregiver to discuss what services home health will be able to provide and how often we will be coming to the home," she says. The key is to make sure expectations of the patient and the caregiver are realistic, she explains.

"If the patient lives alone or the family caregiver is not at home during the day, we evaluate the services that will be needed and we evaluate the patient's ability to care for himself or herself," Petersen says. If the home health nurse believes that the patient and the caregiver will be able to handle care at home but may be at risk for rehospitalization, the care plan will identify the patient as high risk and more visits will be scheduled for the first few weeks, she says.

Congestive heart failure (CHF) and chronic obstructive pulmonary disease patients, as well as elderly patients with elderly caregivers, are most often the patients who are seen more frequently at the start of care, says Petersen. "The extra nursing visits give agency staff members a chance to reinforce education and observe the caregiver or patient more closely as they change dressings or perform other activities," she says. The nurse can make sure medication is being taken as directed and that weight gain, oxygen levels or other vital signs are regularly recorded.

"If a holiday is approaching, we may also schedule an extra visit or time our visit so that we can meet with the patient and family to discuss extra precautions related to the holidays," says Petersen. "For example, ham is a traditional Easter meal, so we tell our CHF patients that we know they will eat the ham, but they need to eat in moderation and not add salt to anything," she says. "We want family members present so that when the patient refuses a second helping, they will understand the reason."

Even when patients are discharged from home care, the Medicare Health Maintenance Organization for their area has a program to continue management and evaluation of patients who are at risk for hospitalization, says Petersen. "We can stay in touch by telephone and even schedule visits to monitor the patient to prevent hospitalization," she says.

While nurses can evaluate edema, weight gain, medication use, and the patient's ability to take appropriate steps to control symptoms and

JCAHO alert addresses medication errors

Reconciliation prevents mistakes

More than 10% of all sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) relate to medication error; but in home care, more than 13% of sentinel events relate to medication error.

According to the Joint Commission, in a *Sentinel Event Alert* issued in January 2006, 63% of the medication errors that resulted in death or serious injury were a result of a communication breakdown. Half of the communication breakdowns would have been avoided with effective medication reconciliation, according to report authors.

To reduce errors related to medication reconciliation, the authors recommend:

• Put the list of medications in a highly visible place in the patient's chart and include essential information about dosages, drug schedules, immunizations, and drug allergies.

• Reconcile medications at each interface of care, specifically including admission, transfer, and discharge; the patient and responsible physicians, nurses, and pharmacists should be involved in this process.

• Provide each patient with a complete list of medications that he or she will take after being discharged from the facility, as well as instructions on how and how long to take any new medications. The patient should be encouraged to carry this list and share it with any caregivers who provide any follow-up care.

• Reconcile medications within specified time frames (within 24 hours of admission; shorter time frames for high-risk drugs, potentially serious dosage variances, and/or upcoming administration times).

• Adopt a standardized form to use for collecting the home medication list and for reconciling the variances (includes both electronic and paper-based forms).

• Develop clear policies and procedures for each step in the reconciliation process.

As part of its current National Patient Safety Goals, the Joint Commission also requires that each accredited health care organization:

• Implement a process for obtaining and documenting a complete list of the patient's current medications upon admission. This includes a comparison of the medications the organization provides to those on the list. The patient should be asked to describe or confirm any prescription medications, over-the-counter medications, vitamins, herbs or other supplements that he or she takes.

• Communicate a complete list of the patient's medications to the next service provider when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. ■

RESOURCES

To see a full copy of the *Sentinel Event Alert*, go to www.jcaho.org and choose "Sentinel Event Alert, Issue 35: Using medication reconciliation to prevent errors" in the "headline news" section.

The Institute for Healthcare Improvement's web site includes a section on medication reconciliation review, including samples of a reconciliation tracking tool and a medication reconciliation flow sheet. Go to www.ihi.org, click on "topics" on the left navigation bar, choose "patient safety," then choose "medication systems." Under "medication systems," click on "tools," then choose "medication reconciliation" to see a list of forms and tools that can be used for medication reconciliation.

avoid a crisis, there may also be psychological benefits to the additional visits, says Petersen.

"A few years ago, we had a patient who would have panic attacks on Fridays and would go to the emergency room and sometimes end up in the hospital," she says. "We started scheduling a visit with her mid-afternoon every Friday," she explains. The nurse would take her vital signs, ask how she was feeling, and talk to her. "We were able to stop her visits to the emergency room and keep her out of the hospital," she adds.

"Every now and then the front loading does strain staffing," admits Petersen. But the strain is short-lived as patients are discharged and other new admissions don't require extra visits, she says. "The benefits of front loading outweigh any extra effort on our part because the patient's outcome is better and the patient doesn't go back in to the hospital." ■

Data show minorities' views of hospice

Researcher suggests barrier breakers

Despite national and various regional focuses on improving minority access to hospice, many challenges remain, hospice diversity experts say.

The National Hospice & Palliative Care Organization (NHPCO), of Alexandria, VA, first assembled a task force on access to care of minorities in the late 1980s, and NHPCO began addressing the issue at annual conferences in the early 1990s, says **Fay A. Burrs**, RN, BSN, director of access and diversity at NHPCO.

While the national organization's attention to the issue has helped improve minority access to hospice, African-Americans account for roughly 9% of hospice patients, which is less than their 12.4% representation in the United States, Burrs says.

For the Latino/Hispanic population, hospice use is even rarer with Hispanics accounting for only 4.3% of hospice patients, while the minority group accounts for 12.8% of the U.S. population, Burrs adds.

"So we still are vastly underserved when we look at the racial and minority mixture," Burrs says.

A variety of barriers have prevented some African-Americans and other minorities from seeking hospice care, a hospice researcher says.

There are at least five major barriers within hospice that impact the access to hospice care by minorities, says **Dona Reese**, PhD, MSW, assistant professor in the school of social work at the University of Arkansas in Fayetteville.

First as a hospice social worker and later as a hospice researcher, Reese became interested in the topic of hospice care and cultural differences back in the 1990s.

"In 1990, I found that the African-Americans who were in hospice care tended to be young and have AIDS," Reese says. "At that time we had AIDS patients dying in hospice, and those patients didn't have good social support and were different from what you'd expect if you knew some information about the African-American culture."

When Reese interviewed African-American ministers about the AIDS patients, she often was told that the hospice was all that the dying young men had since they weren't hooked into the African-American community and its traditional church-based support system.

Later, Reese's research found that the vast majority of staff, volunteers, and patients in hospice care are white.[1]

Her research has identified a variety of individual, family, cultural, and religious barriers, including:

- denial;
- lack of understanding of hospice philosophy;
- private personality;
- lack of ability to care for a patient in the home;
- home visits seen as intrusion;
- taboo regarding discussing death;
- the idea that "we are to take care of our own;"
- role of extended family in caring for patient;
- most people want curative care and don't want to give up;
- hospice programs are threat to religious leaders; and
- religious beliefs influence treatment choice.[2]

However, there are barriers that are specific to hospices, including fear of harm, misconceptions, and lack of diversity among hospice staff, she says.

"My results showed that 94% of staff were white and non-Hispanic, and 96% of volunteers were white and non-Hispanic," Reese says. "That's shocking because that's one of the major barriers to having a diverse hospice group — being approached by an all-white hospice."

Racial and cultural groups that have experienced past discrimination and oppression are fearful when approached by white health care providers, Reese adds.

"We did a study in a rural area in a Southeastern state and interviewed African-Americans who have used or not used hospice services," Reese says. "And some who had not used hospice had never even gone to a doctor because of a fear of the white health care system."

Reese says there also is a perception among some African-Americans that when they're dying white people will show up at their door for the first time in their lives and tell them to sign an agreement that says, "If you're heart stops beating, we will not resuscitate you."

Real or imagined, the fears are based on their own negative experiences in the health care system, including affordability and access issues, or on

the experiences of people they know, Reese says.

The negative information often is inaccurate.

For example, one person interviewed by researchers said, "Hospice will kill you." The person had heard about how hospice uses strong medications such as morphine and had heard about palliative care that may involve the withholding of nutrition, and so the person was afraid that a hospice would use these means to kill patients, Reese says.

Empowerment is the major issue, she says.

"The major theme I picked up on was they wanted to be empowered to care for their patients themselves in their homes," Reese says. "They were afraid the hospice staff would come in and take over."

In the cases of African-Americans who accepted hospice care, the major reason they gave for using hospice services was that they had a doctor they trusted who had introduced hospice staff to them, Reese says.

"They would meet with them personally and reassure the family and patient that the hospice staff would not take over or do anything that the caregiver did not give them permission to do," Reese says. "That was very important, and they thought they could trust the hospice staff because the doctor they trusted had recommended the hospice."

Reese's research has also shown that African-American ministers and many people in the African-American community believe that the hospice philosophy of accepting one's death would be seen as a lack of faith.

"They believe God will perform a miracle, and that's what they're praying for; so to accept their death would be an alien point of view," Reese says.

Although the problems with access to hospice services among African-Americans are long-standing, the same issue is becoming an even bigger problem among Hispanic populations, according to Reese's research.

"We had an 800% increase of Hispanics in our community in the last few years, and our hospices aren't serving them," Reese says. "It's not that they haven't tried, but I think hospices need a lot of guidance on how to do this."

NHPCO is developing a diversity toolkit for hospices and organizations that would like to improve hospice access to minorities, Burrs says.

"The toolkit has all of the components that people need to address the issue organizationally, personally, and with specific focus and features on end-of-life care and what we're charged to do," Burrs says. "Phase II of that project is to take all that information and then provide a template, a curriculum to give the organization a step-by-step process for unfolding this diversity initiative at their organization."

A 130-page preview version of the toolkit, which is expected to be made public next year, includes checklists, charts, definitions, and tips for identifying barriers and overcoming them. **(See diversity plan suggestions from toolkit, p. 35.)**

Also, various hospices and hospice organizations around the country have worked with NHPCO to address diversity issues. One such effort is the Opening Doors Project of Hospice Minnesota in St. Paul.

"Several years ago, Hospice Minnesota was very aware that multicultural and minority populations in Minnesota and also throughout the country in general were not receiving, and were not aware of, end-of-life services for family members," says **Barbara Greene**, MPH, a multicultural and diversity consultant with Custom Health Consultants of St. Paul, and also program director/multicultural consultant with Hospice Minnesota, the state hospice organization that represents about 70 hospices.

Hospice Minnesota conducted a statewide survey of hospice organizations, asking them how much they served minority or multicultural families and patients, including the Hmong community, which is one of the largest in the country, Greene says.

"For the most part we found great work needed to be done," Greene says. "While a few

SOURCES

For more information contact:

- **Fay Burrs**, RN, BSN, director of access and diversity, National Hospice & Palliative Care Organization, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314. E-mail: fburrs@nhpco.org.
- **Barbara Greene**, MPH, multicultural and diversity consultant, Custom Health Consultants, 1417 Fairmount Ave., St. Paul, MN 55105. Phone: (651) 690-5526. E-mail: barbara-greene@comcast.net.
- **Dona Reese**, PhD, MSW, assistant professor, school of social work, University of Arkansas, 106 Academic Support Bdg., Fayetteville, AR 72701. E-mail: reese@uark.edu.

hospices had bilingual staff and were knowledgeable in how to use interpreters and were aware of a diversity of beliefs around end of life and communications patterns, most hospices had not gone down this path before."

The hospices were very interested in learning how they could provide culturally proficient services for multilingual communities, Greene notes.

"So over the last three years, we have looked at this issue, and my role is to help guide and facilitate and bring together hospices throughout Minnesota to improve their cultural proficiency on end-of-life care," she says.

The hospice organization has provided training at seminars, workshops, special events, and conferences and has had a variety of hospice materials translated into the Spanish and Hmong languages, including patient and family information that can be distributed in those communities, Greene says.

Fourteen hospices in Minnesota have joined to be part of a pilot project in which they work together on multicultural end-of-life issues, Greene notes.

"This year we're going to have some very targeted training sessions for hospices on the use of interpreters at the end of life," Greene says. "It's a very critical need."

At the organization's web site (www.hospicemn.org) there are diversity materials posted, including brochures and pamphlets that have been translated into other languages, Greene says.

"It's an ongoing priority of Hospice Minnesota and their board of directors, and I guess we're finding it's of great national interest," Greene says.

"I think people who choose to work in the field of hospice are some of the most sensitive and dedicated people," Burrs says.

"We keep hearing from hospice staff that they want to diversify and do it right, but they don't have the resources to do so," Burrs adds. "So the diversity toolkit is a response to hospices wanting to do the right thing."

References

1. Reese DJ, Melton E, Ciaravino K. Programmatic barriers to providing culturally competent end-of-life care. *Am J Hosp & Pall Med* 2004; Sept/Oct:357-364.

2. Reese D, Braden L, Smith M. African American Access to Hospice: An interdisciplinary participatory action research project. Paper presented at National Hospice & Palliative Care Organization conference, held in March 2004, in Las Vegas. ■

NHPCO toolkit offers ideas for building trust

Spend time in community you want to reach

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, has developed a diversity toolkit designed to help hospice organizations with their efforts to improve diversity among their patient base.

A preview look at the toolkit, which will be published within the next year, provides these suggestions for how hospice staff can build trust and develop a relationship in a minority or culturally diverse community.

- Recognize that diversity exists.
- Obtain a broader current understanding of diversity.
- Develop a desire to learn about other cultures, races, and religions.
- Listen and learn from those who are different.
- Respect the dignity of the person. Demonstrate respect for people as unique individuals, with their culture, race or religion as just one factor that contributes to their uniqueness.
- Develop compassion.
- Learn to be present.
- Adhere to ethical principles and practices.
- Become informed — taking better advantage of available diversity resources.
- Don't assume anything.
- Ask and clarify as you seek to understand.
- Do not expect all members of one cultural group or family system to behave the same way.
- Appreciate that each person's cultural, racial, and religious values are deeply ingrained.
- Refrain from making assumptions and generalizations about a group of people.
- Be willing to modify health care delivery in keeping with the patient's cultural, racial or religious preferences.
- Do not take others' behavior personally. Their reactions to you may have less to do with you than to factors such as your age or gender. (For example, some cultures do not accept females taking care of males.) ■

Preceptors can improve retention of new nurses

Individualized programs create better results

A new job can be overwhelming no matter what industry you may choose, but when the new job is in home care, saying that the job is overwhelming may be an understatement. Traditional orientation programs don't always take into account the myriad details that a home care nurse needs to know to both succeed in the job and to be happy with it; so two agencies are handling new employee orientation with preceptors.

Since her agency started the preceptor program four years ago, new nurse retention has been higher and employee satisfaction has increased, as well, says **Suzanne Van Loon**, RNC, BSN, MPH, director of clinical services at VNA of Somerset Hills in Bernardsville, NJ. "Our new hires have been split 50/50, with half of the nurses having home health experience and half of the nurses not having home health experience," she says. "Our three-month orientation program gives all new nurses a chance to adjust both to our agency and to home health if this is a new field for them."

The preceptor's responsibilities are to introduce the new employee to the different protocols and processes of the agency, assess the new employee's learning needs through discussion and observation, and plan the new employee's learning experience, says Van Loon. "Because the preceptor spends so much time with the new employee during the first four weeks, her case load is reduced," she says.

At first, the new employee will make visits with the preceptor, but she also will spend time with other agency employees, Van Loon points out. "New employees spend days with our clinical director, our quality improvement director, rehab employees, OASIS coordinator, intake employees, our respite department manager, and our nursing secretary," she explains. "This gives each new employee a real understanding of all of the agency's activities and introduces key people that she will need to know," she adds.

Even though the preceptor and the new employee are not together every day once the orientation period begins, they have regular progress meetings, along with the new employee's supervisor, to review what has been learned and to identify areas that may need to be enhanced, such as computer skills or OASIS training, explains Van Loon. The training is designed to meet the individual's needs, not a time frame, she adds.

"It is a very positive relationship that develops," she says. "It is nonthreatening and it makes it easy for the new employee to ask questions without worrying that admitting a lack of knowledge may result in a poor review," she adds. While the orientation period is defined as three months, the preceptor relationship can be informally extended as needed, she says.

"We select case managers to serve as preceptors," says **Vikki Prochaska**, RN, MSN, CNAA, director of home care at Kenosha (WI) Visiting Nurse Association. During the first week of training, the new nurse spends time learning the computer system and OASIS entry, she says. "The next two weeks, the new nurse works with her preceptor, visiting patients, completing documentation, and talking about agency operations," she says. After two weeks with her preceptor, the new nurse will spend the next few weeks visiting patients with a variety of other nurses, she says.

"We like for a new nurse to see how a variety of nurses handle patient visits and paperwork because everyone develops their own way to do the job and you can learn something different from each nurse," she explains. The new employee does stay in contact with her preceptor and the preceptor reviews the new employee's progress.

Prochaska's program is 90 days and comprises orientation and evaluation, but it is very individualized, with different nurses progressing at different paces, she says. "It is important to tailor the training to the nurse's experience and ability so that the job doesn't overwhelm and frustrate the new employee," she explains.

Selecting the right employee to serve as a preceptor is just as important as selecting the right nurse to hire as a home health nurse. "We require that our preceptors have a minimum of two years' nursing experience and at least one year of home health experience," says Van Loon. "We also want someone who loves being in the field and is very organized with a natural talent for teaching," she adds.

"I look for preceptors who consistently do their job the right way, without taking a lot of shortcuts," says Prochaska. "While everyone develops

shortcuts as they learn their job, it is important for a new nurse to learn every step of the process the correct way so that mistakes can be easily found and fixed," she explains. "Preceptors also have to be ready to become the new nurse's best friend during a trying period of her life.

"We also encourage our preceptors and our new employees to let us know if personality conflicts do arise," says Prochaska. While she tries to match preceptors and new employees on the basis of personality as well as skills, there may be times that the new employee needs to move to a different preceptor, she says. A move from one preceptor to another does not reflect the skills or ability of either the preceptor or the new employee; it is strictly a personality issue, she emphasizes.

"A preceptor who is very confident may seem intimidating to a nurse who is less assertive, so the new nurse will feel free to ask questions of, and learn more from, another preceptor with a different personality," she explains.

A reduced workload for preceptors does mean an increased workload for other nurses, but everyone in the agency appreciates the value of a preceptor-based orientation, says Van Loon. While the individual training and orientation may seem costly as first, the real savings are seen in the retention of new employees, instead of a revolving door of nurses who stay fewer than three months, she adds.

Not only does this approach to orientation solve retention problems, but it also is a recruiting plus, Van Loon points out. "Nurses who are new to home health are relieved to find out that that they will have one person, other than a supervisor or manager, to whom they can go with their questions," she says. "This removes a lot of their anxiety about working in a new field and makes them look forward to learning a new job," she adds.

A preceptor-based orientation also addresses the fact that home health care cannot be learned in a classroom, says Van Loon. "The only way to learn home health is to do it. This approach gives new nurses a chance to do home care in a safe, supervised environment." ■

LegalEase

Understanding Laws, Rules, Regulations

Expedited review notices: Key issues

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

There is still confusion in the home health and hospice industries regarding the use of expedited review notices. Although key issues remain unresolved, the following may be helpful to providers with their compliance efforts:

- Providers should never delay discontinuation of services in order to issue expedited review notices.
- Providers should never make additional visits in order to issue expedited review notices.
- Providers may not be required to provide additional services to patients who no longer meet the eligibility criteria of the Medicare program.

Delays in discontinuation of services

The initial or generic expedited review notice must usually be provided to patients at least two days in advance of the date on which services will be discontinued. However, if staff members learn of circumstances requiring the immediate or abrupt discontinuation of services, they should give the notice immediately and discontinue services immediately. Home health agencies and hospices are not required to wait for two additional days before discontinuing services. Examples of such circumstances include notification from physicians that home health or hospice services are no longer needed, or information that patients are no longer homebound.

It appears that some agencies and hospices are

providing two days' notice before discharging patients with the understanding that no additional services will be provided during this two-day period. This is a potentially risky practice and is not required in order to achieve compliance. When agencies follow this practice, they continue to assume responsibility for patients. If patients need additional services during this time period and agencies and hospices do not provide them, they may incur liability.

Consequently, based on requirements of the expedited review notice process and sound risk management, agencies and hospices should discontinue services to patients and discharge them when they receive information that such actions are warranted.

Making additional visits

Agencies are not required to make additional visits to patients for the sole purpose of delivering expedited review notices. So, if providers learn that expedited review notices must be issued, but will not be making visits to patients for other purposes when notices are supposed to be delivered, they are permitted to deliver the notice to patients via telephone. They must then mail a copy of the notices to patients.

The Centers for Medicare and Medicaid Services (CMS) indicates that agencies and hospices must make efforts to retrieve signed copies of notices that are mailed to patients.

Practically speaking, this responsibility should be delegated to support staff members; professional staff members should not be utilized for this purpose. Support staff can send follow-up letters or make telephone calls to remind patients to return the signed notices. Their efforts should be documented with copies of letters sent and dates and times of telephone calls. Although CMS has not indicated how many times staff must follow up to attempt to obtain signed notices that were mailed to patients, three well-documented attempts are likely to be sufficient.

Additional services

It appears, at least at this time, that agencies and hospices are not required to provide additional services to patients who appeal to the quality improvement organizations (QIOs). Agencies and hospices may choose whether or not they wish to provide additional services, if they conclude that patients no longer meet the eligibility criteria of the Medicare program.

When QIOs conclude that patients still meet the eligibility criteria of the Medicare program based on patients' appeals, patients may seek additional services from other Medicare-certified home health agencies or hospices. Practically speaking, it may be appropriate for home health agencies to decline to provide additional services to patients as soon as they conclude that patients no longer meet the eligibility criteria of the Medicare program.

This aspect of the expedited review process, however, is clearly more confusing because CMS does not require patients to adhere to applicable time frames. That is, the process originally required patients to submit their appeals along with a certification from physicians that they would experience significant harm if services were discontinued within the two-day time period between when providers issued notices and discontinuation of services. Now CMS has stated that QIOs must accept appeals from patients whenever they are filed and that patients have up to 60 days after filing an appeal to submit certifications from physicians. Consequently, agencies that elect to provide additional services while appeals are pending may do so for very long periods of time only to learn that they cannot turn to patients for payment because QIOs agree that patients no longer meet the eligibility criteria of the Medicare program.

Additional clarification is still needed with regard to the expedited review process as indicated above. Agencies and hospices look forward to "fine tuning" the process in order to eliminate confusion for both staff and patients and in order to use increasingly limited resources of agencies and hospices as wisely as possible. ■

CE *questions*

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

21. What was the most surprising strategy to make the top six strategies used by home health agencies to reduce hospitalization in the National Home Health Hospitalization Reduction Study, according to **Robert Fazzi,** Ed.D, president and CEO of Fazzi Associates?
A. Patient education
B. Front loading visits
C. Use of community resources other than home health
D. Fall prevention programs

22. How do staff members determine which patients will benefit from extra visits at the start of care, according to **Martina Petersen**?
A. Current staffing levels
B. Availability and age of family caregiver
C. Health status
D. B and C

23. Approximately what percentage of home care sentinel events reported to the Joint Commission on Accreditation of Healthcare Organizations are related to medication error?
A. 7%
B. 10%
C. 13%
D.17%

24. **Dona Reese**, in studying hospice care and cultural differences, found that African-American patients' fear of hospice care was mitigated when a doctor they trusted introduced them to hospital staff.
A. True
B. False

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

On-line bonus book for *HHH* subscribers

Readers of *Hospital Home Health* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2006 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2006 on-line bonus report, visit **www.ahcpub.com**. ■

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 the semester's activity with this issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion.** ■