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IN THIS ISSUE

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Improve outcomes, take step toward success with pay for performance

Disease management programs reduce hospitalization and number of visits

(Editor's note: This is the first of a two-part series that looks at how disease management programs within home health agencies can better position those agencies to be successful under a pay-for-performance program. This month we discuss the components of a disease management program, staffing, and education. Next month we look at how the program can be expanded to serve patients who are not homebound.)

As home health agencies look for ways to improve outcomes and increase their potential for success within a pay-for-performance reimbursement system, disease management programs that allow staff members to specialize in care for specific types of patients may be the road to success for some agencies, according to experts interviewed by *Hospital Home Health*.

Implementing a disease management program requires several components that increase staff members' competence and provides standardized guidance for care, says **Joan Haizlip**, RN, CS, MS, cardiopulmonary clinical nurse specialist at VNA First, a Willowbrook, IL-based network of community-based home care agencies that has developed diabetes and cardiac care disease management programs. "We saw disease management programs growing in importance a few years ago and we wanted to develop tools that agencies can use to set up programs for different diseases," she says.

"A true disease management program in home care incorporates evidence-based care and critical pathways, some form of remote monitoring, preventive education, the ability to work with other providers such as insurance companies, and the capability to care for patients beyond the traditional episode of care." To be successful with a disease management program, the home health staff have to go beyond thinking of home care only as skilled nursing, Haizlip says.

"At this point, disease management in home care is so new that we don't know what the implications for Medicare reimbursement will be in the future; but we do know that having a disease management program in place has allowed some agencies to market their services to private payers

on a fee-based service," she says. Other agencies do report better outcomes for patients and fewer rehospitalizations for high-risk patients, Haizlip adds.

"We implemented a cardiac disease management program in the past year and focused first on congestive heart failure [CHF] patients," says **Sharon Jones**, RN, MSN, executive vice president of clinical services for VNA of Cleveland.

"We have 11 nurses and two licensed practical nurses dedicated to the Care Watch team, which now cares for CHF patients, as well as diabetic patients who also have CHF," she says. The focused care received by cardiac patients has reduced her agency's rehospitalization or visits to the emergency room by cardiac patients by more than 30% since its implementation, Jones says.

Team approach works best

The team is multidisciplinary and, in addition to nursing staff, includes physical and occupational therapists, as well as a behavioral health nurse, says Jones. "The behavioral health nurse was already a part of the home health staff, but we now include her in the Care Watch program," she says.

"Many of our patients have a high anxiety level that makes them head directly to the hospital when experiencing difficulties instead of trying to talk to a nurse," Jones reports. The behavioral health nurse helps patients learn to deal with their anxiety so they can try self-help measures at home or take time to talk through their symptoms with a nurse before they panic and head to the hospital, she explains.

Education for patients in a cardiac disease management program is emphasized, focusing on enabling the patient to monitor his or her symptoms, follow medication directions, and assume responsibility for managing the disease, says Haizlip. "Standardized teaching booklets are important," she says.

Not only do nurses review the material during home visits, but telehealth nurses can reinforce teaching by saying, "Turn to page 10 of your booklet and let's see what is recommended when you notice weight gain." Consistent educational tools also mean that every nurse is teaching the same thing in the same manner, she adds.

Some form of telemedicine is essential for a disease management program, says Haizlip. For cardiac care programs, the telehealth staff member must be a part of the cardiac team and should use a questionnaire specific to cardiac care when making calls, she says. "It's important that the nurse making the call be good at recognizing symptoms of distress and be very familiar with cardiac illnesses because it will be this staff member who makes the decision as to the need for a nursing home visit or a visit to the emergency room," she explains.

"The telehealth component also increases contact with the patient to reassure them and to reinforce teaching without increasing visits," points out **Sharon Grubb**, RN, BSN, in-house nursing supervisor at Porter County VNA in Indiana.

"We find that patients are more compliant

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because they know that someone is concerned about them and will check on them to make sure they are taking medications correctly and monitoring their symptoms," she explains.

While some agencies choose not to designate one or two staff members as the full-time telemonitor staff, instead allowing all nurses who see patients to handle it, Jones has one advanced practice nurse, whose specialty is cardiac care, handle the telehealth calls. "She not only handles the telehealth calls to patients but she serves as a valuable resource to other team members," she adds.

Use clinical pathways

Clinical pathways that are evidence-based are another important component of a disease management program, says Haizlip. The use of pathways ensures that all patients in the program are receiving the same standard of care and that every treatment option is considered, she explains.

Some nurses may be reluctant to commit to what they perceive as a very structured plan of care that a critical pathway represents, says Grubb. "Participating on a disease management team is more difficult because technical skills must be higher and there are more protocols to follow," she admits.

"We did expect staff members to be tentative about the program and were not surprised to hear questions about how the program would work and would it really affect outcomes," says Jones. Because she did not have to hire new employees to form the Care Watch program, she asked for volunteers who wanted to move to the dedicated staff. "I found that a lot of nurses wanted to be a part of the program for several different reasons," she says.

Continuing specialized education for treatment of cardiac patients as well as association with the telemedicine component of the program were key attractions, says Jones. "Many nurses saw this as a way to advance their skills and be a part of a prestigious unit of the agency," she says.

Choosing the right people for the disease management team was important, says Jones. "We looked for nurses who did have experience in acute or cardiac care even though we knew we'd be offering them additional training," she says. "Although the RNs came from existing agency staff, we did hire two LPNs with acute cardiac experience from the community." It is important to find staff members who are interested in staying on top of the latest research about cardiac care, she adds.

Just as it is important to choose staff members carefully, be sure you recognize which patients are appropriate for a disease management program, says Jones. "Because our program focuses on cardiac disease, we admit patients with a cardiac-related primary diagnosis," she says.

Patients must be able to manage care for themselves or have a caregiver who can oversee medication, dietary restrictions, and monitoring, she says. This means that patients with cognitive problems, no caregiver, or a history of noncompliance are not appropriate, she adds.

"We also look for patients with disease management in their mindset," points out Grubb. "We want them to assume that they are responsible for their care as opposed to thinking that the doctor will take care of them," she explains.

"I believe that our disease management program gives us a definite advantage as we approach pay for performance," says Jones. "It gives us some tools to use to better manage our patients' care and it does improve outcomes." ■

Abbreviations, falls risk top compliance issues

Monitor staff for compliance

Only 76.8% of home health agencies surveyed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations were found to be in compliance

with the National Patient Safety Goal (NPSG) that requires standardization of abbreviations in 2005. For the patient safety goal that requires evaluation of patients for risk of falls, only 82.4% of home health agencies were found to be in compliance.

"Standardization of abbreviations has been a continuing problem for home health organizations for years," reports **Maryanne L. Popovich**, RN, MPH, executive director of the Joint Commission's Home Care Accreditation Program. "While we have seen some important progress there are still problems," she says.

Surveyors are reporting that most of the noncompliance is related to individuals within agencies, as opposed to agencies, who are not putting processes into place to meet the patient safety goal, says Popovich. "Agencies seem to have the standardized lists and other tools needed but there are staff members who still use 'u' for unit and other prohibited abbreviations," she explains.

"It's important to note that surveyors do not survey computer systems for compliance," Popovich points out. This means that if an agency's software was created before standardization of abbreviations and creation of "do not use" lists and the agency has no reasonable way to alter the automated programming, surveyors will not count this as a sign of noncompliance. "If, however, a staff member sits at the computer and types in a prohibited abbreviation, this is cited as noncompliant," she explains.

"The abbreviation issue goes beyond developing processes, tools, and educational sessions," Popovich points out. "We are asking people to change behavior that they may have learned 30 years ago in nursing or medical school." It is not easy to alter behavior but it is necessary for home health managers to be diligent and continuously monitor their staff for compliance, she adds.

"As with any performance improvement project, chart audits can help identify the problem," suggests Popovich. When reviewing charts for compliance with abbreviation requirements, be sure that the sample reviewed includes some charts from every employee, professional, and nonprofessional, she recommends. "We don't just have RNs making notes in the chart, we also have home health aides," she says. Every employee must comply with the patient safety goal, she points out.

"We have narrowed the focus of the patient safety goal to emphasize medications and physician orders, so the audit can focus on these items alone," says Popovich. This focus may help larger agencies with many staff members, she says.

"If you discover a few employees that consistently use prohibited abbreviations, it is simple to work one-on-one with them to retrain, monitor, and change their behavior," Popovich says. "If the problem is widespread, it requires more creativity and more effort to change the behavior," she admits. **(For tips on standardizing abbreviations, see "Sharpen your pencils: Nurses writing more as abbreviations disappear," *Hospital Home Health*, March 2004, p. 25.)**

A widespread problem with the abbreviation safety goal might also indicate a need to invest in software that ensures the use of correct abbreviations, suggests Popovich. "If your problem is widespread, be sure you address system changes that might support your staff's efforts," she adds.

Assess all patients for falls risk

In the 2005 NPSGs, Goal 9A required home health agencies to assess the risk of all patients for falls. Because home health agencies have always known the risk of falling in the home, the 82.4% level of compliance with this goal might surprise some people. "It is surprising, but surveyors find that with this safety goal, also, agencies have the procedures in place, but individuals don't always follow them," says Popovich.

Surveyors find that while agencies may assess high-risk patients, they are not assessing all patients as required, says Popovich. "Elderly patients almost always are assessed for their falls risk, but other patients may appear to be without ambulatory or cognitive problems, so they are not assessed," she says.

Pediatric patients are almost never assessed for risk of falls because everyone assumes that it is normal for them to fall, she points out. This doesn't let the home care nurse off the hook though, she adds. "Why wouldn't we check for gates on the stairs, raised rails on the cribs, and no access to items that will tip over when climbed upon, such as chairs?" Popovich asks. Even if the nurse knows that children will fall, it is important to minimize the risk of falls to prevent unnecessary injury, she asserts.

"We also discovered that even when assessments are done, they are not always comprehensive," Popovich points out. "A nurse may assess the physical environment but not look at medications that increase the risk of falls." To perform a complete assessment, the nurse must assess the patient's physical and cognitive condition, the environment, medications, and the type of illness

SOURCE/RESOURCES

For more information about National Patient Safety Goal compliance, contact:

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To view a full copy of the 2005 National Patient Safety Goal compliance data, go to www.jointcommission.org. Choose "patient safety" on the top navigational bar and then click on "National Patient Safety Goals." Scroll down the page to "Additional Resources" and choose "NPSG 2005 Compliance Data." Also located on the National Patient Safety Goals page are FAQs related to specific goals, including falls reduction programs; a "do not use" abbreviation list; a list of look-alike, sound-alike medications; and implementation tips for standardizing abbreviations.

For copies of reports and presentations related to the Missouri Alliance of Home Care Falls Reduction project, go to www.homecaremissouri.org and click on "MAHC Benchmark Projects" on the right navigational bar, and then choose "Falls Reduction Project."

or injury, she suggests.

In addition to the assessment, the surveyor is looking for strategies to reduce the risks identified in the assessment, Popovich points out. Even if an agency relies on OASIS data, the nurse must perform a separate assessment to ensure compliance, especially if the patient is a child, she adds.

The big change between the 2005 NPSG and the 2006 NPSG related to falls prevention is that the 2006 goal requires the implementation of a falls reduction program throughout the agency, Popovich says. This means that agencies surveyed in 2006 have had to show a comprehensive effort to reduce falls throughout their entire population. **(For information on falls reduction programs, see "How do you rate? Benchmark study identifies frequency, causes of falls," *Hospital Home Health,* August 2005, p. 85.)**

First-quarter data on compliance for 2006 show no significant improvement for the goals related to abbreviations and falls, and even show a slight decline, says Popovich. "Of course, this trend may change as more agencies are surveyed throughout the year, but we know that these have been the two most difficult challenges for home care and they will continue to be so for some time." ■

DM program keeps AIDS patients out of hospital

One-on-one education is the key to success

An intensive one-on-one case management program helps people with AIDS stay adherent to their medication regime, avoid hospitalizations and emergency department visits, and learn to self-manage their disease.

Positive Healthcare Florida, the disease management program of the AIDS Healthcare Foundation, is the only National Committee for Quality Assurance-accredited disease management program for HIV-AIDS in the country. The program received a score of 98.4% out of a possible 100% during the survey.

RN care managers with extensive HIV-AIDS expertise oversee the care of 10,000 Medicaid patients with AIDS across the state of Florida.

"We've been successful because of the intense one-on-one and face-to-face work with the patients. The nurses follow them closely and develop a wonderful rapport. The core of our program is education and one-on-one coaching to improve the patients' quality of life and to keep them out of the emergency department and out of the hospital," says **Gene Bundrock**, MS, RN, CCM, statewide director for AIDS Healthcare Foundation's Positive Healthcare Florida.

The field-based care managers work out of their homes and manage the care of patients in the counties in which they live. They work closely with the patients' physicians, often accompanying patients to their office visits, and working with them to coordinate care.

"Positive Healthcare takes a different approach to disease management. We do a lot of face-to-face assessments. The care managers get to know the provider and work closely with them. They meet with social service agencies in the community and incorporate them in the plan of care," says **Donna Stidham**, chief of managed care for the AIDS Healthcare Foundation.

Publicly supported patients with AIDS present a challenge to providers. They are poor. Many don't have telephones. They often live with relatives and move around a lot, Bundrock says.

The program uses representatives from the community who help find patients and call the care manager. The representative makes an appointment for the patient with the care manager, who

sees him or her within three days.

"Our care managers will meet with them anywhere — the home, the doctor's office, in a restaurant, or even under a bridge. We'll go anywhere the patient feels comfortable and where their confidentiality won't be breached," Stidham says.

When new patients are identified for the program, the nurse contacts them and makes an appointment to see them, preferably at their home.

"It helps the nurses manage the care if they can see their patients in the home environment and become aware of their living conditions. Some don't have electricity. Others may not have a refrigerator or cooking facilities. It helps us tailor a care plan when we can see firsthand what the patient is facing," Bundrock says.

Patient assessments

The care managers conduct an extensive assessment that categorizes patients by severity level and acts as a guideline for the number of interventions the patient received. They determine the patients' needs and barriers to care, such as transportation, and get a consent form allowing them to go into the physician's office and examine the patient's medical record.

"These patients are not good historians on previous hospitalizations. They may know they had a cough but not whether it was pneumonia. Our nurses examine the medical record to find out what we need to know to manage the disease," Bundrock says.

The care managers zero in on patients with a high acuity level who are frequently hospitalized, not adherent to their medication regime, and are substance abusers.

"Once the nurse has seen the patient in person, some of the work can be done telephonically. She might not need to see patients every month if they are doing OK, the lab work looks good, and she knows they are being adherent with their medications," Bundrock reports.

The disease management nurses remind patients if they have physician appointments, check to see that the appointment has taken place, and visit the physician's office to review the chart. They give the patient a pillbox to help them organize their medications and stress the importance of taking the medication until the physician discontinues it.

Because confidentiality is an issue with AIDS patients, Positive Healthcare mails AIDS-related educational materials only to patients who have given their permission. Otherwise, introductory and follow-up letters are very generic.

The care managers know their community well, often serving on local health planning councils. They know the practitioners in the community and know how to guide their patients through the complex medical system to get help.

The care manager can mine the database for claims data and talk to the physician if a patient is making frequent trips to the emergency department.

"These patients have a lot of mental health issues as well. Depression is a huge problem, and many are on psychiatric medication. Physicians can't get the patients interested in caring for themselves until their mental status is stable," Bundrock says.

Dental care is another problem for AIDS patients on Medicaid.

"The state doesn't pay for dental work of any kind, but Medicaid patients still get toothaches. We try to get them access to dental care so they won't go to the emergency department or hospital with an infection that's the result of a dental problem," he says.

A team of nurses and an LPN care partner manage the care of the population in each area. The LPN takes care of telephone calls and other reminders for patients who are at severity level 1, allowing the care manager to concentrate on the more complex patients who are in and out of the emergency department, helping them avoid admissions.

For instance, AIDS medications often cause adverse reactions until the patient gets used to them, causing trips to the emergency department for pain and nausea. The care managers encourage them to try alternatives.

Working with physicians

"Now instead of going to the emergency department when they start a new medication and have cramps, they call the care manager who helps them understand that it might be a side effect of the medication. They suggest that they use an over-the-counter medication rather than going to the emergency department," Bundrock explains.

The care managers work closely with the physicians and nurses in physician offices to make sure that the patients are getting the recommended care. They refer any problems they spot to Bundrock or the medical director, who contacts the physician and educates him or her about evidence-based

guidelines for the treatment of HIV-AIDS.

Positive Healthcare holds six educational programs a year in each region, informing physicians about the latest information from the scientific community.

"We stay up on new treatment regimes and make sure the physicians know about them. A bad regime can have a bad outcome, which in turn can cost hundreds of thousands of dollars," Bundrock says.

Physicians in the AIDS Healthcare Foundation's disease management programs work with the physicians who care for the patient.

"They don't want to interrupt the physician-patient relationship but they do want to enhance the physician's access to knowledge about the condition," Stidham says.

In California, the AIDS Healthcare Foundation began operating one of the first Medicaid managed care programs specially designed for people with AIDS in California in 1995. The foundation has received approval to operate a Medicare Advantage plan, allowing the patients to get their drugs through Medicare Part D.

The Medicaid program covers the sickest of the sick, only people with AIDS. HIV-positive patients are not eligible.

The state of California compares the foundation's costs to the fee-for-service Medicaid program and splits the savings with the foundation on a 50-50 basis.

"Our patients have always had better outcomes, shorter lengths of stay, and less cost than the fee-for-service patients," Stidham says.

Patients in both the Medicare and Medicaid programs are assigned an RN case manager who has HIV expertise. All of the primary care physicians and specialists in the network have experience working with people with AIDS, and the formulary is designed with people with AIDS in mind. ■

Network targets barriers for unfunded patients

Strategies include paying for a lower level of care

When patients at hospitals in Seton Healthcare Network are ready for discharge and don't have funding for post-discharge services, the hospital may pay nursing homes to provide care until their Medicaid eligibility is determined or place patients in assisted living facilities temporarily until they fully recover.

"It simply does not make sense to have the bed filled with someone who does not meet acute care criteria and who can't pay the bill. Paying for the care patients need after discharge is a good move because the patient is no longer in an acute care bed when they don't need to be there, and the hospital can fill that bed with a funded patient. It allows us to increase revenue while saving costs," says **Pat Beal**, LCSW, case operations manager for Seton Northwest Hospital and outpatient case manager.

Austin, TX, where Seton has headquarters, has a huge homeless population. Since it's in a border state, the city also has a high number of undocumented workers, says **James Brown**, MD, vice president and medical director for Seton Health Plan and case management.

The health system takes a proactive approach to planning the discharge destination for homeless and unfunded patients and ensuring that they are not readmitted.

Each weekday, Brown meets with the case management and social work staff for complex discharge rounds, during which they discuss patients who have been in the hospital for at least five to 10 days. The number may be considerable. For instance, one day recently, there were 44 patients in Brackenridge Hospital whose stay exceeded 10 days.

The team identifies barriers to discharge and comes up with ways to address the issues, particularly related to unfunded and homeless patients. "We make sure we have a disposition plan and start planning a discharge destination," Beal explains.

A few years ago, Brackenridge Hospital had a lot of patients with Medicaid or SSI disability coverage pending who had extended stays because they were too sick to be discharged to home but nursing homes wouldn't take them until their eligibility for Medicaid was assured, a process that can take as long as 10 months, she says.

The hospital has arranged to pay the Medicaid TILE rate for nursing home care until Medicaid approval comes through, if a cost-benefit analysis shows that the hospital will save money by doing so. In that case, the nursing home bills the hospital monthly for what Medicaid would have paid. When the patient is approved for Medicaid, the nursing home will get a check from the Centers for Medicare & Medicaid Services for the back payments and reimburse the hospital.

"It's a great thing. It gets the patient to the proper level of care and opens up beds for patients who do need nursing care. We haven't recouped 100% of the money we've paid to the nursing homes, but we have been correct in determining that the patient will eventually be approved for Medicaid," Beal says.

Before the hospital agrees to pay for a patient's nursing home care, Beal does a cost-benefit analysis of moving the patient.

She determines the average cost of the patient's last six days of care, using 30% of charges as the cost basis. Beal then compares that to the cost of transporting the patient, providing medication, and the average daily rate that Medicaid will pay to a nursing home.

"The hospital's chief operating officer signs off on the transfer. It's always turned out to be a tremendous cost savings for us," she says.

Beal also compares what the hospital will be paying to the nursing home with what the hospital could recoup by putting a funded patient in the bed.

"The program has been extremely successful. It's helped us to get the patients to the right level of care and to a place where they are not susceptible to hospital-borne illnesses. The hospital has avoided being on diversion, and we can increase our revenue if we have a funded patient in that bed," she reports.

The hospital is willing to pay for the nursing home care only if there is a likelihood it will be reimbursed, she adds.

Paying for home care

The hospital has a partnership with an acute rehabilitation facility that offers two acute rehab charity beds each day, with the stipulation that the patients need to be in rehab only two weeks. In addition, the hospital pays for whatever equipment unfunded patients may need in order to go home. For instance, the hospital has rented wound vacs or provided special mattresses so patients can be discharged.

Each hospital in the Seton Healthcare System pays for the cost of its patients' home care if they lack resources.

"Paying for home care makes good financial sense because the patient is no longer in an acute care bed when they don't need to be there," Beal says.

When patients are too sick to be on the street but not sick enough for skilled nursing care, the case managers sometimes can find them a place at a community facility to continue their recovery.

The Salvation Army sick bay will accept some patients for a limited amount of time. The City of Austin operates The Arch, with a six-bed infirmary where homeless patients can get care.

"On very rare occasions, we have discharged a patient to a hotel and arranged from them to have meals from a soup kitchen. This is only in cases where the patient needed bed rest for a short time, such as recovering from a sprained or broken limb and there is no other placement option available," she says.

When patients need long-term care and don't qualify for disability because they are going to heal, the hospital contracts with assisted living facilities or group homes where they can get their meals and receive home health services if necessary.

These may be patients with two broken legs or those who need IV antibiotics. "The ones we can't do anything about are IV drug abusers who need IV antibiotics. We can't send them out with an open line so they're here for the duration of the IV antibiotic therapy," Beal says.

Seton Healthcare funds and operates three primary care clinics for indigent patients in parts of the city where there is a need, Brown says.

The clinics help keep nonemergent patients out of the hospital and provide continuity of care in management of chronic conditions such as high blood pressure and diabetes.

"When patients come to the emergency department for primary care, they are treated by whoever is available. When they go to our clinics, they see the same provider over and over. We hope that we can manage the care for patients in our clinics and help them ward off costly complications of their chronic diseases," Brown says.

When indigent patients present at the hospital, they go through a screening process to determine what kind of aid they might qualify for, such as Medicaid or one of the federally and county-funded programs in Austin that provide care for unfunded patients.

If they don't qualify for any other care, when they are discharged, they are referred to a Seton clinic to use as their medical home. They pay a nominal fee for their care, based on their income and other resources.

To accommodate the burgeoning numbers of indigent patients, Seton Healthcare has expanded its clinic hours to give patients a chance to come into a clinic in the evening hours, instead of using

the emergency department for primary care.

The clinics are funded through the health care system's charity care funds and donations from the community.

In addition, the hospital has arranged for specialty providers in the city to provide free care for indigent patients. The hospital provides hospital and ancillary services for these patients.

Approximately 5,000 of the uninsured patients using the Seton Clinics for primary care have been enrolled in a health plan "look-alike," according to Brown. They pay a nominal amount for office visits and prescriptions, based on a sliding scale according to income.

"We manage the patients who use our clinics as if they have health insurance. They get a card that they present for treatment. Our goal is to manage their care, to prevent readmissions, and to try to educate them not to use the emergency department as their only source of care," he explains.

(Editor's note: For more information, contact ***Pat Beal****, LCSW, at e-mail: pbeal@seton.org.)* ■

Can surrogates really know patients' wishes?

Just more than half of surrogates get it right

Making end-of-life decisions for incapacitated patients most often falls to surrogates chosen by the patients, or to next of kin. But a recent review of the literature indicates that surrogates are only slightly better than physicians at making decisions that the patient would make if he or she were able.

Terri Schiavo's dilemma — being the center of a struggle over end-of-life decisions between her husband, who Florida state courts recognized as her legal next of kin for decision-making purposes, and her parents — has prompted many Americans to sign living wills and talk to their next of kin about what end-of-life care they want or do not want.

But according to **David Wendler**, PhD, of the National Institutes of Health's Department of Clinical Bioethics, a review of studies that provide data on how accurately surrogates predict patients' treatment preferences indicates that while those discussions are certainly better than doing nothing, surrogates in the studies predicted patients' treatment preferences with 68% accuracy.

Surprisingly, they did even worse after discussing treatment preferences with the patient.

Surrogates get it right sometimes

The analysis, conducted by Wendler and colleagues at the National Institutes of Health and Johns Hopkins University, examined 151 role-playing scenarios that were presented to 2,595 patient/surrogate pairs.[1] The "patients" in some cases were healthy subjects asked to assume they were incapacitated and others who were actual patients not at the end of life.

In the studies, the next of kin or surrogate decision makers were asked to decide whether the patients would want certain medical interventions, often ones that physicians deemed necessary to keep the patients alive. The patients were asked, independently, what their preferences would be.

A sample hypothetical scenario was: "You recently suffered a major stroke, leaving you in a coma and unable to breathe without a machine. After a few months, the doctor determines that it is unlikely that you will come out of the coma. If your doctor had asked whether to try to revive you if your heart stopped beating in this situation, what would you have told the doctor to do?" Patients and surrogates were free to choose to accept or reject the proposed treatment.

Leaving the decision up to doctors resulted in a rate of 63% accuracy at predicting what the patient would want. Surrogates or next of kin fared only slightly better at 68%.

Of the 16 studies reviewed, 12 assessed the errors surrogates made when they misjudged patients' preferences. Three studies found that they erred by choosing interventions that the patients said they would not want. One study found that surrogates erred by withholding interventions the patients would want, and eight studies found no consistent trend in surrogates' miscalculations.

The studies showed only one percentage point difference in the accuracy of patient-chosen surrogates (69%) and legally assigned surrogates (68%).

"In general, we thought the way to explain people not being as accurate as you hope they are was that they are unwilling or reluctant [to make the decisions]; but we found you really can't say one way or the other," says Wendler.

Talking about preferences doesn't help

It would be natural to assume that if patients and their surrogates talk about preferences

beforehand, the surrogates' decision making would be more accurate.

Natural, maybe — but wrong, according to the two studies that examined whether discussion improved accuracy.

One study found no change in accuracy, while the other found a slight but statistically significant worsening of surrogates' accuracy after they talked with patients about their wishes.

"It was a little surprising that talking didn't change accuracy, and we don't really know why that is," says Wendler. "Our hypothesis is that the kinds of discussions you can have tend to be very general and not sufficiently rich to capture the complexity of real cases."

Wendler says patients should be encouraged to think about what is important to them and what they envision happening in certain circumstances.

"A lot of time, it's not clear," he says. "If you like to talk, read, and walk, then would it be acceptable to you to be on a ventilator? Also, medical probabilities are involved [in real-life situations], and doctors can't tell you what those are for sure."

According to **Cynda Rushton**, DNSc, RN, FAAN, clinical nurse specialist in ethics at Johns Hopkins Children's Center in Baltimore, a positive benefit to emerge from the Schiavo case is that the number of people who are considering the importance of designating health care agents and preparing living wills has jumped dramatically.

"We are encouraging living wills and for patients to converse with their surrogates early and often," she says.

Rushton says a study conducted at Johns Hopkins, which examined the process of selecting and communicating with surrogates, found that while many had definite ideas they wanted surrogates to adhere closely to, others said they wanted family members to do what they thought was best under the circumstances.

Maryland is in the process of revamping its advance directives, to encourage people to indicate how they want their living wills interpreted — literally or by surrogates applying their best judgment at the time.

Wendler says surrogates were most accurate in making decisions in situations where the patient was in good health before becoming ill and the intervention was relatively sure to return him or her to good health.

"They're good at predicting in those situations, because that's easy," he says. "If you're a healthy 50-year-old and you get pneumonia and you need to be on a respirator but will recover, everyone will say 'yes' to that.

"The ones that give you trouble are the [exercises] where you start radically changing their cognitive state. That's when the preferences aren't as clear and surrogates misestimate it. But also, people have doubts about what their own preferences would be in those circumstances, for example, if they have Alzheimer's.

"For me this suggests that we need more data on what people really care about," says Wendler. "Argument points to using next of kin [for end-of-life decisions], but if you find out that the next of kin is not that accurate, then you have to ask yourself what the impact is for using family members as surrogates, and whether the impact is positive or not. Legislating [next of kin as surrogates] is a reasonable way to go, but you never know. These are hard decisions to make, and it may be a burden."

Reference

1. Shalowitz DI, Garrett-Mayer E, Wendler D. The accuracy of surrogate decision makers: A systematic review. *Arch Intern Med* 2006; 166:493-497. ■

COMING IN FUTURE MONTHS

- Create a culture of technology
- Pain control techniques for pediatrics
- Market your telehealth program for success
- Use community clinics to expand revenue sources

NEWS BRIEFS

AHRQ launches web-based tool for state performance

The Agency for Healthcare Research and Quality (AHRQ) has released an interactive web-based tool that presents data that can be used to measure health care quality. The State Snapshot web tool is based on the 2005 National Healthcare Quality Report and the 2005 National Healthcare Disparities Report.

Data provided for each state include information on the type of care provided, such as prevention, acute or chronic, and the settings of care, such as home health. Comparisons to regional and national performance can be made and a special section focuses on diabetes care in each state and region.

The information can be used to identify opportunities for improvement in care for statewide organizations as well as groups of local organizations. To see the tool, go to www.qualitytools.ahrq.gov/qualityreport/2005/state/summary/intro.aspx. ▼

Some HHAs will get five days notice from JCAHO

Although unannounced surveys became the norm for most organizations surveyed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, some organizations, including some home care agencies, can relax, knowing that they will receive a telephone call from the Joint Commission five days before their survey.

Home health organizations that are subject to the five-day notification include agencies that offer only one of the following services: home health; personal care; support services with an average daily census of between one and 30; hospices with average daily census of no more than 10; pharmacies with average daily census no more than 50; and home medical equipment with an average daily census no more than 50.

The only exception to the notification is for special unannounced surveys, such as those conducted for cause. ▼

CMS extends coverage for some O^2 patients

The Centers for Medicare & Medicaid Services (CMS) will extend coverage for the home use of oxygen to Medicare beneficiaries enrolled in a CMS-approved clinical trial sponsored by the National Heart, Lung & Blood Institute.

Medicare currently provides coverage for home oxygen for beneficiaries with partial pressure measurements at or below 55 mmHg or oxygen saturation at or below 88%. If certain other diseases/conditions are present, coverage is provided for patients with an oxygen partial pressure of 56-60 mmHg or an oxygen saturation of 89%.

The trial will include Medicare beneficiaries with arterial oxygen partial measurements from 56 mmHg to 65 mmHg or whose oxygen saturation is at or above 89% who do not meet the current Medicare coverage requirements for home oxygen. ▼

Can it be true? In health care, less means more

While the amount of money Medicare spends on chronically ill patients varies greatly from state to state, researchers at Dartmouth Medical School found no correlation between higher spending and better health. In fact, they said patients in states spending the least actually were better off than their counterparts in states spending the most.

The researchers looked at how often Medicare patients went to the hospital in their last six months and the number of times those patients went to the doctor in that time period. They found higher mortality rates in states with the most intense care. Their conclusion: the government could save tens of billions of dollars a year while improving care if it prevented overuse of health care.

"We need to redirect resources away from acute care and invest in infrastructure that can better coordinate and integrate care outside of hospitals — for example, home health and hospice care," the report said. ■

CE *questions*

9. Why is it important to standardize patient education in a disease management program, according to Joan Haizlip, RN, CS, MS?
A. It saves money on printing costs.
B. It shortens amount of training that HHA staff need.
C. It allows telehealth nurse to know what fields clinicians have taught.
D. It increases insurance reimbursement.

10. Why are home health agencies having a hard time complying with the National Safety Patient Goal that requires standardization of abbreviations, according to Maryanne L. Popovich, RN, MPH?
A. Writing full words takes up too much time.
B. Older computer software programs don't have lists built into them.
C. Agencies have not provided staff members with tools needed.
D. Clinicians have a hard time changing behavior they learned a long time ago.

11. At Positive Healthcare Florida, once a patient has an appointment with a care manager, the care manager sees the patient within what length of time?
A. The same day
B. Three days
C. Five days
D. One week

12. Wendler, et al, found that which of the following is most likely to be the reason surrogates did a worse job of predicting patient wishes after discussing preferences with the patient?
A. Discussions are typically general and not as detailed as the actual event would be.
B. Surrogates put their own values ahead of what the patient wanted.
C. Patients were reluctant to talk about end-of-life decisions.
D. Physician input clouded the discussion.

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

On-line bonus book

Readers of *Hospital Home Health* who recently have subscribed or renewed their 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 this semester's activity with the **September** 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. ■