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IN THIS ISSUE

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How safe are your patients who use oxygen? NPSGs focus on risk of fire

Improving oxygen risk assessment included in 2007 goals

Changes and additions to the Joint Commission on Accreditation of Healthcare Organizations' National Patient Safety Goals are minor and should not pose problems for home health agencies, say experts interviewed by *Hospital Home Health.*

With an addition to Goal 8B, which required HHAs to communicate a complete list of a patient's medications to the next provider of service when the patient is referred or transferred to a different setting, it is now required that a complete list of medications be given to the patient upon discharge.

"This won't be a problem for agencies that are meeting professional standards," says **Maryanne L. Popovich**, RN, MPH, executive director of the Home Care Accreditation Program at the Joint Commission. "This is already part of good practice for all agencies."

One question that might arise when home health managers first read the amended goal is how to handle patients who "disappear" before the final home visit, Popovich says. "Surveyors will expect home care nurses to provide the list of medications upon discharge only when they have an opportunity to see the patient," she adds.

If a patient goes into the hospital, goes outside the home care service area to visit family members, or goes into a nursing home before the final home visit occurs, a note in his or her chart indicating that there was no opportunity to give the list to the patient will be sufficient. Surveyors understand that patients and their families don't always notify home care agencies about a change in their situation in a timely enough manner to allow for that final visit, Popovich adds.

"I suspect that many agencies do give the full list of medications to specific patients and their families based on their condition; but this goal does make it necessary for all patients to receive the medication list," she says. The purpose of providing an updated list is to ensure that patients have a complete list to help them communicate with their next health care provider.

The only other change to the 2007 National Patient Safety Goals for home care agencies is the addition of Goals 15 and 15A. Goal 15 requires

the organization to "identify safety risks inherent in its population," and Goal 15A specifically requires the organization to "identify risks associated with long-term oxygen therapy such as home fires."

Identification and education about the risks associated with oxygen are "embedded in good home care practice," Popovich points out. The new goal does not indicate an increase in home fires or other sentinel events related to oxygen; it is meant to heighten awareness of the potential risk, she says.

Surveyors evaluating an agency for compliance with this goal will expect to see staff members not only assess risks upon the patient's admission to home care, but also reassess risks whenever there is a change in the environment or the patient's condition.

A sentinel event reported to the Joint Commission demonstrates the need for reassessment and re-educating. "The patient was admitted to home care in May, and the assessment and education related to oxygen risks occurred at admission," Popovich relates. A fire broke out in the patient's home in November due to the combination of oxygen and a kerosene space heater. While the safety education provided to the patient included warnings about open flames, it occurred at a time when no space heater was used; so the patient probably did not associate "open flame" with the space heater used in cold weather, she points out.

"This incident suggests that home care agencies might consider reassessment of risks in November or December in cold weather areas," Popovich suggests.

With cold weather and the use of fireplaces and space heaters in Pennsylvania, the staff at Titusville (PA) Hospital Home Health always reassesses the risk of fire for oxygen patients, says **Debbie Miller**, RN, policy regulation coordinator for the agency. "We always re-evaluate and reteach as cold weather approaches," she points out. The use of both written and verbal instructions, careful assessment of risks in the home, education of family members, and thorough documentation of assessments and teachings have worked well for the agency; so Miller does not anticipate major changes in their procedures.

The Joint Commission does not prescribe how agencies should comply with this goal, but Popovich recommends that each agency manager look carefully at the population, environmental factors, and family situations of each patient to thoroughly assess risk.

Overall, Popovich does not see these additions to the National Patient Safety Goals as a significant challenge for most agencies, though she admits, "Any time we introduce new patient

SOURCE

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safety goals or standards, there is a certain amount of anxiety about the interpretation of the requirements and the assessment of the agency's current practice.

"These goals, however, should only require a tweaking of current practice rather than development and implementation of new policies," she notes. ■

Verify medication lists to improve outcomes

Oral medication management real challenge

(Editor's note: This is the first of a two-part series identifying the obstacles home health staff members face when helping patients manage their oral medications. This month, we identify some major challenges that staff members face, along with strategies to overcome those challenges. Next month, we will talk about specific staff and patient education tactics to improve medication management.)

With the Centers for Medicare & Medicaid Services (CMS) emphasizing the reduction of hospital readmissions as one way to cut the overall cost of health care for Medicare patients, home health agency managers have evaluated different ways to improve this outcome for their agencies.

While there are many strategies that work for different agencies, improving patients' medication management is a strategy used by 59% of participants in the recent National Home Health Hospitalization Reduction Study, points out **Diana Hildebrand**, RN, BS, CPHQ, project coordinator at TMF Health Quality Institute in Austin, TX. **(See "Cut hospitalization rates with 24-hour availability, extra visits at start of care," *Hospital Home Health*, March 2006, p. 25.)**

"With the shortage of family caregivers and the shortage of money to hire caregivers, it is important for home health agencies to promote patient self-management of oral medications," she says. Not only does proper use of oral medications improve the patient's medical condition, but it improves the overall quality of life for the patient, she adds.

Improvement in the patient's ability to manage oral medications has been a part of the data collected for and reported on the Centers for Medicare & Medicaid Services (CMS) Home Health Compare web site as part of a home health agency's public record. Most home health managers expect this outcome to become part of the pay-for-performance program that will be implemented by CMS, says Hildebrand, adding that home health nurses face many challenges with improvement of this outcome. But it can be done, she notes.

"A nurse may start the admission visit with a list of medications provided by the referring hospital but it often does not match the full list of medications used by the patient," says Hildebrand. Because older home health patients often take a number of medications, it is important to verify the list as soon as possible and look for medications that may interact with each other or medications that are duplicates of each other, she suggests.

"If possible, a home health agency representative should visit a patient before discharge from the hospital to begin developing an accurate list of medications," she says. "A home health nurse's ability to visit the patient before discharge will depend on the relationship with the hospital and the hospital's interpretation of HIPAA privacy rules."

EMR helps ID interactions

Building an accurate list early in the patient's care is important because it gives nurses time to find duplicate prescriptions and potential interactions, says **Lisa Sprinkel**, RN, BA, MSN, executive director of home health and hospice for Carilion Home Care Services in Roanoke, VA. "We use an electronic medical records [EMR] system that automatically checks for drug-to-drug and drug-to-food interactions when a nurse enters a new drug into the patient's chart," she explains. When the software detects an interaction, the nurse prints the information and faxes it to the physician for his or her review.

When the system was first introduced, physicians' reactions varied, Sprinkel says. "We had some physicians who appreciated the information and the fact that our nurses were reviewing the medications closely, and we had other physicians who thought it was a waste of time."

Even though there were some skeptics, Sprinkel's agency continues to use the system because it saves nurses' time as they can tailor medication evaluations to the patient and it provides documentation for the physicians.

"There is evidence that drugs affect the elderly differently from younger people," says Sprinkel. "An older person's decreasing liver function

means that the body does not metabolize medications in the same way." Her agency uses Beers Criteria to evaluate medications for interactions as well as increased risks to older patients. **(To access a free copy of Beers Criteria, see resource box, this page.)**

Education of Sprinkel's staff and resources such as the EMR software and Beers Criteria, help her nurses partner with physicians to become proactive in their efforts to reduce the risk of medication-associated adverse events, Sprinkel says.

Pharmacists help organize medications

Other obstacles home health nurses must overcome when developing an accurate medication list for their patients are usually related to the patient's age, the number of medications used, and the ability to double-check interactions.

• **Patients use multiple pharmacies.**

"Some patients may fill a prescription at the pharmacy close to a physician's office after one visit, then fill another prescription close to home another time," Hildebrand points out. "Some prescriptions may be filled at a pharmacy close to a family member's workplace or home because it is more convenient for them." When multiple pharmacies are used to fill different prescriptions, you lose the benefit of a pharmacist who can detect potential interactions or duplicate medications, she says.

When a patient is using between 20 and 30 medications at one time, not only does the risk of potential interactions increase, but the schedule for taking medications becomes very complicated, says Hildebrand. "A patient takes some medications twice a day, other medications three times a day, some medications with food, and others without food; it is overwhelming for most patients to manage," she says. A home health nurse should help the patient and the family caregivers identify one pharmacy to use for all prescriptions so that the pharmacist can serve as an extra checkpoint for interactions and duplicates.

Another service that many pharmacists will provide is special packaging to help patients know when to take medications. "Pharmacists can fill the prescriptions in blister packs that designate morning, afternoon, and evening medications," Hildebrand says.

• **Multiple physicians prescribe medications.**

"There is a big push now to simply medicate a patient to control different symptoms or conditions," Hildebrand points out. Unfortunately, with a patient who sees multiple physicians for different conditions, one physician may not be aware of other medications the patient is taking. "Not only does this increase the risk of interactions, but research has shown that once you take more than five to eight different medications, you may be producing disease rather than treating anything," she adds.

In this case, it is important that communication between the hospital or other referral source, the physician, and the home health nurse begin as soon as the referral is made. Not only should the list be verified upon the patient's admission to home health, but it should also be updated every time the patient makes another visit to the physician or other health care provider, says Hildebrand. This may mean that at every visit, the nurse should ask the patient or the family caregiver if there have been any physician visits or calls to a physician that resulted in a change in medication, she adds.

In addition to evaluating the new medication's potential risk for interaction with other

SOURCES/RESOURCES

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- A free copy of **Beers Criteria**, which lists medications that should be avoided or used carefully for patients older than than 65 years of age can be found at www.medqic.org. Choose "home health" on the top navigational bar, then choose "oral medications" under the "Publicly reported measures" category on the left navigational bar. Choose "tools" in the box on the right side of the screen, then scroll down to "Beers Criteria."
- **The Institute for Healthcare Improvement** 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 left navigational bar, choose "patient safety," then choose "medication systems." Under "medication systems," click on "tools," then choose "medication reconciliation."

medications, the nurse needs to determine if this is a replacement medication for another or an additional medication, because patients don't always understand if the physician intends for them to stop taking a previous medication when the new medication is prescribed, she says.

• **Patients hold on to "old" prescriptions**

Even when patients understand that they should stop taking a current medication, they don't always throw it away, points out Hildebrand. "They will hold on to the medication just in case they need it again, even when it is outdated," she points out.

Not only is using outdated medication unwise, but having old medicine around enables the patient to self-medicate without knowing about potential risks, Hildebrand adds. In these cases, it is important to make sure patients and their family members know to throw away old medications to prevent accidental interactions.

While there is no simple, one-step method to improve oral medication management, it is worth the time and effort a home health manager spends on the outcome improvement, says Hildebrand. "Improvement of this outcome is not only important to the agency's ability to perform under a pay-for-performance system, but it is important to the overall quality of life for the patient." ■

Home health branches into outpatient services

HHA nurse-staffed clinic extends care to patients

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

When Celina, OH-based Mercer Community Hospital's Home Nursing Care department implemented a cardiac disease management program, the service was not limited to home care patients.

"We opened an outpatient clinic at the same time we implemented our cardiac disease management program within our home care agency," explains **Laurie Bladen**, RN, BSN, MBA, director of community health at Mercer Health. Her reasons for implementing disease management programs within home care included the need for standards of practice and an emphasis on improving outcomes. "We worked with hospital staff to develop standards for treatment of congestive heart failure patients, as well as diabetic and wound care patients," she says.

While working with hospital experts in these diseases, Bladen realized the benefit of offering certain types of outpatient care to home health patients once they were discharged. "We want to reduce readmissions to both home care and the hospital, and one way to do so is to offer patients a way to continue care after they are no longer eligible for home care benefits," she explains.

"We might be seeing a patient for orthopedic care, maybe a surgical patient who needs wound care, but the patient might also have a secondary diagnosis of diabetes," Bladen points out. As the patient improves and is discharged from home care, the patient still may need assistance with or monitoring of the diabetes.

"Although our home care nurses educate the patient about nutrition and how to choose groceries, it is different when the patient actually goes into the real world," she says. "At the clinic, the patient can not only meet with a dietitian, but the dietitian will go to the store with the patient as part of the teaching."

In addition to providing follow-up care to diabetic patients, Bladen's wound care clinic has proved to be successful. "Wound care in home health is very costly but if we can get the patient ambulatory, we can then see the patient in the outpatient clinic," she says.

Although the clinic is staffed with home care personnel, the actual revenue from the clinic is counted as "hospital" revenue because of the way it is billed, says Bladen. "Medicare regulations require that we bill visits to the outpatient clinic through the hospital as outpatient hospital visits rather than home care visits; but both the hospital and the home health agency benefit financially from this approach to patient care because we are able to better manage the patients' care and reduce hospitalizations and readmissions," she explains.

Home health nurses staff the outpatient clinic, Bladen says. Not only does this improve the continuity of care for patients discharged from home care to the outpatient clinic, but it also enables nurses to continue following their patients, she points out. "Nurses in the clinic follow the same treatment protocols used in home care," she says.

SOURCE

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Because the clinic nurses are home care nurses who have cross-trained to work in the clinic, the transition to working with patients in a clinic setting is very smooth," she says.

"Nurses who work in the clinic volunteer to do so," says Bladen. Nurses like to work in the clinic for a variety of reasons, she says. "It is a change of pace and enables the nurse to see a variety of patients throughout the day and, at the same time, enables them to see home care patients they may have provided care to previously," she explains. "Home care nurses do get attached to some patients and they always enjoy seeing them as they recover."

The outpatient clinic staff consists of three RNs, a dietitian, a social worker, a medical assistant who helps with clinical and administrative tasks, and several physicians. Infectious disease, podiatry, interventional radiology, and vascular surgery all are specialties included in the medical staff of the clinic, says Bladen. "Although our patients have family physicians, many of them see the clinic physicians as their specialists," she explains.

Transportation to the clinic is an important issue to address, advises Bladen. "We work with the local Council on Aging to ensure transportation for patients from their homes to the clinic," she reports.

The outpatient clinic does not just see patients discharged from home care. "Some patients come directly from the hospital and some may come directly from a physician's office," says Bladen. Most, however, do come from home care with the original referral to home care from the hospital or a physician, she adds.

Billing and proper documentation to support billing are the biggest challenges when developing an outpatient clinic as an extension of home care service, Bladen admits. "Documentation required for home care services is slightly different than documentation required for outpatient services in some cases," she says. For example, home care infusion documentation requires only the starting time for infusion, and outpatient services documentation must include both the starting and ending times for infusion, she points out. The differences are minor but nurses do need to keep the differences in mind, especially if they are working in both the clinic and the home health agency, she explains.

Bladen is pleased with the success of both the home health agency's disease management programs and the outpatient clinic. She says, "Our industry is changing dramatically, with more emphasis on outcomes and quality of care as well as an efficient use of health care dollars. The combination of disease management programs and outpatient clinics gives home health agencies a way to meet all of these goals." ■

LegalEase

Understanding Laws, Rules, Regulations

High profit margins may be evidence of fraud

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

In *United States of America v. Hussein Amr,* the U.S. Court of Appeals for the Sixth Circuit concluded that extremely high profit margins may be evidence of fraudulent conduct.

In 1995, Hussein Amr established United States Medical Supply (USMS), a home medical equipment company. Based upon a complaint from an employee, the FBI began an investigation into possible fraud at USMS.

At the conclusion of the investigation, Amr was indicted. The indictment was based on evidence that: Hussein induced patients to purchase power wheelchairs they did not want or need, offered free lift chairs to induce patients to purchase power wheelchairs, failed to offer patients the option of renting rather than purchasing wheelchairs, charged for standard accessories that were already included in the price of wheelchairs, and inflated repair charges.

Amr primarily sold power wheelchairs. Evidence

was introduced at trial to show that USMS purchased power wheelchairs for $2,250. USMS billed Medicare $4,300 for the wheelchair and an additional $800 for accessories, for a total of $5,100. USMS would then receive a copay usually from either Medicaid or Blue Cross and Blue Shield of $1,200. USMS routinely received $6,300 for each wheelchair for which it paid $2,250, for a profit of more than $4,000 per chair.

USMS' profit margins were so high, in part, because it charged Medicare for more expensive products than it actually provided to patients. On every power wheelchair that USMS sold, for example, USMS billed Medicare $360 for a gel cushion; but it supplied foam cushions instead.

A part of the profits was obtained by charging extra for accessories that were standard on the wheelchair. USMS, for example, would charge Medicare separately for tire and electric controllers, which are standard equipment on all power wheelchairs.

In addition, Amr routinely steered patients toward purchasing power wheelchairs rather than other less expensive equipment. No one ever advised patients that they had a right to lease wheelchairs. In fact, more than half of the patients who purchased power wheelchairs from USMS didn't want or need power wheelchairs.

Amr was convicted; he appealed the conviction.

He argued to the appellate court that the court should not have allowed evidence about the high profit margins at USMS because it was irrelevant. On the contrary, the court said, evidence of huge profit margins Amr earned on selling power wheelchairs was highly relevant to support the conclusion that he steered patients to purchase power wheelchairs they did not need and, thereby, engaged in fraudulent conduct.

In short, there *is* such a thing as too much! Providers with extremely high profit margins on any service or product or very rapid growth should be on notice, based upon this case, that this fact may induce regulators to scrutinize them more closely. ■

Cancer patients find symptom relief in art

Anxiety, fatigue showed greatest improvement

New research shows that cancer patients who engage in one hour of art therapy show immediate improvement in eight of nine symptoms, with the greatest improvement noted in anxiety and fatigue

Art therapy provides a benign way for people to deal with their feelings, says **Nancy Nainis**, MA, ATR, LCPC, an expressive arts therapist with Northwestern Memorial Hospital in Chicago.

For example, a patient who may find it too overwhelming to express his anger over his cancer diagnosis might be able to express his anger through his art.

"I had someone who created angry Easter eggs once, and a lot of feeling came out while he was making those eggs," Nainis recalls.

Nainis and co-investigators studied the impact of a one-hour art therapy sessions provided on an individual basis by Nainis on 50 patients at an inpatient oncology unit in a large urban academic medical center.

Most of the patients, within an age range of 19 to 82, had leukemia or lymphoma and had been diagnosed within the prior two to three years.[1]

Participants in the study included African Americans (26.5%), Hispanic/Latino (4.1%), and Asian (2%). About one-third were single, and 56% were married, while 10% were divorced.[1]

Using the Edmonton Symptom Assessment Scale (ESAS) and the Spielberger State-Trait Anxiety Index (STAI-S), investigators measured the patient's severity of nine symptoms, on a scale from zero to 10, both before and after the art therapy intervention. The symptoms included pain, tiredness, nausea, depression, anxiety, drowsiness, lack of appetite, their well-being, and shortness of breath.[1]

With the exception of the symptom of nausea, there was a significant improvement noted in all of the symptoms after the art therapy intervention.[1]

"I was absolutely blown away by the results," Nainis says. "This was a pre-/post-test, so I don't know if the improvement was sustained a day or two, but immediately afterwards, there was this positive reaction."

Art therapy energizes patients

The symptoms of anxiety and fatigue were highly significant, making this the first study finding that art therapy energizes people, Nainis says.

"It was cute because the research assistant said,

'What do you do with the patients? I go in and do the pre-test and they're very tired and just lying there and can barely talk. Then I go back, and they're sitting up and their eyes are sparkling,'" Nainis recalls.

Creative activities can be very empowering, but more research is needed to find out more about the whys and hows, she says.

"Everyone knows distractions help patients, but does art therapy do more than that?" Nainis says. "We need to do more research to really know."

Helps patients focus

At the very least, art therapy distracts patients and helps them focus their minds on something besides their symptoms and illness, Nainis says.

"When people were asked how art therapy affected their quality of life, some people said it made them feel more worthwhile, and most people said it was fun and relaxing," Nainis says.

Nainis has ideas about why art therapy provided some symptom relief to the cancer patients, but she would like to see research continue with the purpose of determining how art therapy helps.

"We just wanted to see if there was credible evidence that art therapy impacted symptoms, and we didn't match what the patient chose to do with what their symptoms were," Nainis says.

Future research could look at the impact on symptoms of individual types of art therapy, she suggests.

For example, she has found that when patients wrap something, such as wrapping yarn around a stick, it helps with pain. And some patients find it helpful to engage in a repetitive activity, working with soft materials, such as cloth and yarn, Nainis says.

With the art project of taking broken pieces of glass and making mosaics, there is an emotional metaphor inherent in the art work, Nainis notes.

"It's like taking bits and pieces of your life and making something of it," she says. "You're giving meaning to your life, and this helps us cope spiritually, mentally, and physically."

For the study intervention, Nainis showed patients a cart that held a variety of materials, and they were asked to select what they wanted from the cart.

The art therapy supplies included cards and envelopes, jewelry and beads, clay, journals, sketch pads, collage materials, paper pulp masks, fancy papers, paints, feathers, finger paint, felt, stained glass, foam shapes, tempura, glitter glue, watercolor, glue sticks, rainsticks, magazines, stained glass sun catchers, pipe cleaners, stamps, sequins, wooden boxes, tissue paper, wooden frames, yarn, pencils, charcoal, pastel chalk, markers, pens, and oil crayons.[1]

Then Nainis followed a standardized script of introducing herself and explaining that the art project wasn't about talent, but about allowing oneself to try something new, Nainis says.

"I'd explain what the materials were and the possibilities," she says. "Then, they selected a project, and I helped them with it."

Nainis had patients whose arm swelling was so severe that they couldn't manipulate the art objects on their own, so Nainis became their hands.

"So they'd pick a project and tell me what they wanted, and I would do it for them," she says.

"People tend to focus on images that are relevant to their issues," Nainis says. "One gentleman focused on a picture of a woman with a long neck, and that made him think of his wife."

The man talked about how much he cared for his wife and how his illness made him worried about what would happen with her when he died, Nainis recalls.

"We were able to talk about this issue because we looked at this picture that he chose to focus on," she says.

After patients selected their art goal, Nainis would ask more probing questions only when patients indicated they were interested, she says.

"A number of people would say, 'I just want to do this for fun, and then they'd ask me, 'If you were going to analyze this, what would you do?'" Nainis says. "I'd say, 'When you chose those colors were you thinking of anything in particular?' and then I'd take the image and put it on the wall so this would change their point of view and provide a different perspective."

A natural fit

Art therapy is a natural fit with hospice care, Nainis notes.

"What's wonderful about hospice is when you go into the home you have access to their photos and their things," Nainis says. "One hospice patient was teaching her art therapist crocheting stitches, passing on her legacy, knowing it would go beyond her."

Other hospice patients have enjoyed putting together scrapbooks and other arts and crafts

items to leave a legacy for their families.

"They use these to express some fears," Nainis says.

For example, Nainis worked with an incurable cancer patient who knew she was dying.

"We had a project where she and her four nephews made a mural, and they each made representations of themselves and of their aunt, and then we created an environment to place all these things," Nainis says. "It helped everybody see what their relationships were and how they felt about each other, and it was a marvelous vehicle to share their love and feelings."

The boys were between 8 and 13 years old, and at that age they typically find it hard to verbalize feelings, she notes.

But through their mural artwork, they were able to express themselves as plants or animals and create a flower that represented their aunt, Nainis says.

"Their aunt made animals to show how she saw her relationship with them and who they were in her eyes," she adds. "They made this castle, and she was kind of in the center, and it was beautiful and a wonderful way to share their love."

The woman brought the mural home and died shortly after the experience, Nainis recalls.

"I can see art therapy as being really helpful in situations like hospice, where families are brought together and given a way to focus their feelings without being overwhelmed," she says. "Then you have this art, this evidence, this piece you can keep together and look at years later." ■

Reference

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Model of care improves outcomes, ADLs for elderly

Results: Lower costs, shorter LOS, more discharges

When older, frail patients are hospitalized at Akron City Hospital in Akron, OH, they're likely to be placed on a home-like unit with carpeted floors, a common area with a parlor and a stocked kitchen their families can use, better lighting, and furniture designed so older people can easily get in and out of it.

The 34-bed unit is called an Acute Care for Elders (ACE) unit, and it's designed to provide patient-centered care for older patients in an environment that helps them return more quickly to their homes.

The ACE initiative, which provides care by a team specializing in geriatric issues, has resulted in shorter lengths of stay, lower costs, fewer readmissions, and other positive outcomes for elderly patients at the 550-bed teaching hospital, which is part of Summa Health Systems in Akron, OH.

The ACE model is a multi-component intervention that improves outcomes for older patients hospitalized with an acute medical illness, says **Carolyn Holder**, MSN, RN, geriatrics coordinator of post-acute senior services for Summa Health Systems in Akron, OH.

"Older adults often experience a loss of function and independence during hospitalization for an acute illness. Loss of function is associated with negative outcomes for the patient, including prolonged hospital stay, need for nursing home placement, and death. The ACE model was designed to prevent functional decline and maximize independence," Holder says.

The ACE unit was developed in the 1990s by clinicians and researchers at University Hospitals of Cleveland, and demonstrated a positive impact on patients, who were more functional and less often discharged to long-term care, she says.

"In 1994, Summa Health System conducted a randomized trial of the ACE intervention over a three-year period and concluded that ACE makes a difference in preventing functional decline of hospitalized adults," Holder says.

During the study, the team found that the elder patients improved in mobility and other functions from the time of admission to discharge, no matter what illness caused the hospitalization. There was a decrease in discharges to long-term care facilities among patients in the ACE program and an increase in patient satisfaction.

There was significantly less use of restraints on the ACE unit. "Because of changes in the process of care, there were fewer patients who were ordered bed rest, fewer on high-risk medication, and significantly less use of restraints," Holder says.

Depression was recognized and treated more often. All of the factors contributed to an overall reduction in expenses for patients in the pilot project. "ACE is designed to prevent older adults from declining physically and functionally. It not only made a difference in their function, it was more cost-effective and decreased length of stay.

The results were positive for the hospital as well as the patients and their family members," she adds.

Patient-centered care

The interventions were so successful that in addition to admitting patients at highest risk to the dedicated ACE unit, the hospital has adopted the ACE interventions for elderly patients in the stroke, heart failure, pulmonary, orthopedic, and psychiatric units.

"This model is the way that care should be delivered to elders as well as other chronically ill patients in every hospital unit. When the team sits down and puts their heads together, they can accomplish so much for people who are so complicated and so at risk," Holder says.

At Akron City Hospital, patients ages 70 and older who are at most risk for functional decline are admitted to the ACE unit. "We screen patients who are at high risk for losing function, such as people who had problems with mobility before they came in, those without social support, or who have depression or memory problems. We look for cues that say a patient needs more support," Holder says.

The team meets five days a week for one hour and brainstorms on how to improve the plan of care for patients identified as at high risk for decline. The plan they develop is shared with the primary care physician and the rest of the staff.

The unit provides patient-centered care by an interdisciplinary team led by a clinical nurse specialist. The team includes a geriatrician, physical therapist, occupational therapist, dietitian, social worker, a pharmacist who specializes in geriatric medications, spiritual support, and the patient's nurse. The geriatrician consults with the team informally and is available for a formal consultation if the primary care physician requests it.

All members of the ACE team are trained in geriatrics. "We have the level of expertise so that the most challenging are referred to us," Holder reports.

The team works with the patient's primary care physician to develop treatment plans based on best practices of care for the elderly.

The traditional hospital environment and the process of care are designed for clinical efficiency by the providers and often do not take into account the needs beyond the acute illness, Holder points out.

For instance, Holder describes a scenario, in which an 80-year-old woman who lives alone develops simple pneumonia and comes to the emergency department, where an IV is started. She may be confused because of the illness and not eating for a few days and may try to get up to go to the bathroom. As a result, a catheter is inserted, and the woman is restrained and possibly given medication to control her behavior. She is admitted to the medical unit with an order for bed rest, which is maintained for several days, leading to immobility, weakness, and functional decline.

In this scenario, the patient was living independently when she was admitted. At discharge, she needs assistance with activities of daily living and walking and requires placement in a skilled nursing facility.

"Many older patients never regain preadmission functional status despite hospitalization. In fact, hospital care may contribute to adverse outcomes in older persons," Holder says.

The ACE model includes a multidimensional assessment, which is a holistic evaluation of the patient, looking at the medical assessment and history. It includes a functional assessment, including activities of daily living, such as dressing and toileting, instrumental activities of daily living, including cooking and managing finances, cognitive and depression screening, that patient's support system, and discharge planning information.

By having a geriatrician on the staff, the team can suggest revisions of the plan of care to the primary care physician by pointing out the latest evidence-based care recommended for treating the elderly.

"The physicians love it, and so do the patients and their families. The team provides extra support for the patient. We don't just look at the acute illness. We look at the comorbidities and help the physician and family address other issues, such as end-of-life issues, if it is appropriate," she says.

The team starts working on discharge planning as soon as the patient is admitted. "When we talk

about discharge planning, it's not just the immediate discharge. It's the big picture. If patients need to go to a rehab or skilled facility, we look at what the plan should include beyond the rehab stay," Holder says.

The plan may include referrals to a community agency, such as the area Agency on Aging, to provide long-term assistance with self-care and care management. "We look beyond the episode of illness that brought the patient to the hospital. We look at how we can keep patients healthy and functional after discharge," Holder says.

The team recognizes early on what the patient will need after discharge. If it's home health care, the team arranges for a home evaluation to look at safety issues, medication, and nutrition.

"The holistic assessment often uncovers unrecognized problems, such as cognitive issues, depression, and nutritional issues, which the primary care physician may not be aware exist. In addition, families often are challenged in managing problems such as self-care issues and impaired cognition. The ACE unit provides interventions to support both the family and the physician in maximizing the patient's independence," Holder says.

The team often holds patient and family conferences to develop a comprehensive plan.

The ACE interdisciplinary team process involves each member of the team contributing his or her expertise as well as all disciplines learning from each other. For instance, in the ACE model, it may be the dietitian who recognizes the symptoms of depression as she talks with the patient and brings them to the attention of the team.

The team carefully scrutinizes the medications the patients are taking to make sure the medication and dosages are appropriate for older people and makes recommendations to the primary care physician for changes.

Depression often is overlooked in the elderly, Holder points out. The ACE unit staff and team provide further assessment of patients with symptoms of depressions and make recommendations for follow-up.

Holder supervises the advanced practice nurses working for Summa Health System covering several other units with the ACE model in other hospitals in the Summa system. "We're spreading the model. About 85 other hospital systems across the nation have come to us to learn how to do this," she says.

(For more information, contact ***Carolyn Holder****, MSN, RN, e-mail: holderc@summa-health.org.)* ■

NEWS BRIEF

Home care, assisted living upstage the nursing home

A trend seems to be growing. More seniors are leaving nursing homes in favor of other types of care, including home care and assisted living facilities.

New York, like many other states, has applied for a federal waiver to allow up to 5,000 elderly and disabled nursing home patients on Medicaid to get that care elsewhere. **Mary Kahn**, a spokeswoman for the Centers for Medicaid & Medicare Services, says too often elderly patients sent to nursing homes for short-term treatment wind up staying

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. ■

there much longer. "Also, hospitals tend to discharge patients to nursing homes rather than look for more appropriate alternative care options that might be in short supply."

With the federal waiver system, social workers and nursing home administrators try to identify those seniors and disabled patients who can thrive in assisted living centers or at home with aides. ■

CE *questions*

13. What did Maryanne L. Popovich, RN, MPH, suggest as one way a HHA could demonstrate compliance with the new National Patient Safety Goals that requires home health agencies to assess the risk of oxygen use in a patient's home?
A. Ask patients to complete a questionnaire about oxygen risks.
B. Educate patients about risks of fire and oxygen at initial admission visit.
C. Re-educate patients at different times of year, such as start of cold weather.
D. B and C

14. According to Diana Hildebrand, RN, BS, CPHQ, what might prevent a pharmacist from identifying potential interactions between medications?
A. The patient does not fill all of his or her prescriptions.
B. The patient uses multiple pharmacies to fill prescriptions.
C. The patient asks family members to pick up prescriptions for him or her when they are ready.
D. The patient sees different physicians for different conditions.

15. What is one reason that home health nurses at Mercer Health volunteer to work in the outpatient clinic, according to Laurie Bladen, RN, BSN, MBA?
A. Higher pay
B. Extra benefits
C. Opportunity to see patients they treated in the home
D. Less travel

16. At Akron City Hospital, patients eligible for the ACE (Acute Care for Elders) program are at least 70 years old and at most risk for functional decline during their hospital stay.
A. True
B. False

Answer Key: 13. D; 14. B; 15. C; 16. A.

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. ■

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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**. ■