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NHPCO rolls out its national quality initiative in September

Hospices will work together for performance improvement

Hospice organizations and professionals pride themselves on their attention to quality care. But the federal government's new focus on performance improvement and quality programs will mean that quality efforts will need to be documented, measured, and compared.

The Centers of Medicare and Medicaid Services (CMS) will require hospices to implement quality improvement programs after the final rule for the Conditions of Participation is published in 2008. But hospice directors will not have to face this deadline alone.

The National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, is launching its own Quality Partners initiative at the 21st Management and Leadership Conference, held Sept. 11-13, 2006, in New York, NY. The initiative will assist hospice professionals with creating and starting their own performance improvement projects and programs.

"We are designing some projects and a framework for hospices to use to improve their quality, to do some assessment of their operations, and to also get them ready for the new quality assessment performance improvement (QA/PI) project," says **Judi Lund Person, MPH**, vice president of quality and access at NHPCO.

Quality Partners will focus on 10 areas for quality and performance improvement. They are as follows:

- Patient and family-centered care;
- Ethical behavior and consumer rights;
- Clinical excellence and safety;
- Inclusion and access;
- Organizational excellence and accountability;
- Workforce excellence;
- Standards;
- Compliance with laws and regulations;

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- Stewardship and accountability;
- Performance measurement.

“Medicare has always asked for quality measures in hospice, but this time there is a much stronger focus on making it transparent how the quality is being achieved in hospice care,” says **Lin Noyes Simon**, PhD, RN, CHPN, quality and research specialist with NHPCO.

“They’re asking hospices to do a 360 degree evaluation of themselves and see where their strengths and weaknesses are,” Simon says. “And if they do find weaknesses, they have to show what they will do to try to improve those areas.”

NHPCO’s quality program operates under the premise that hospices will be able to meet this challenge better prepared if NHPCO and hospices work together, Simon notes.

“In my past, I’ve worked on collaboratives with other areas of the health care field and sometimes with hospices, and I’ve found it to be a very useful way for groups of people to learn

how to make changes that improve their organizations,” Simon says.

The goal is to apply the scientific process to a quality improvement plan and to use the PDSA process of Plan-Do-Study-Act, she adds.

Under the PDSA model, hospices will decide on a process to improve, make changes in hopes of improving the process, study the results to see if the changes made the desired improvement, and act according to what evidence suggests, either adopting the change or adjusting if the outcomes suggest it was not successful.

“The big part of this is to find out what changes we can make that will result in improvement,” Simon says.

Many hospices have quality improvement programs and have studied their outcomes, but to other organizations, this will be an entirely new venture, and it’s through collaboration that hospices might learn from one another about better processes, best practices, and tools that will assist them with meeting their goals, Simon says.

For example, one organization that has already achieved positive outcomes from a year-long quality improvement project is the Center for Hospice and Palliative Care in Cheektowaga, NY.

The hospice has successfully piloted a project in which a long-term facility collaborates with the hospice in identifying patients who qualify for end-of-life care, says **Kathy Chowaniec**, RN, hospice/nursing home/professional relations liaison.

“We’re trying to take hospice to where the people are,” Chowaniec says.

Previously, the hospice had passive business relationships with long-term facilities, but there was no structured, formalized process for introducing hospice care to their patients, she says.

So about a year ago, the hospice approached an area senior care center to discuss forming a more active collaboration in one of the center’s long-term care facility buildings on a pilot study basis, Chowaniec says.

The result has been a 25 percent increase in the length of stay (LOS) among patients in that building, Chowaniec says. (See story about how hospice developed QI project, p. 100.)

Achieving buy-in from staff at both the long-term facility and the hospice was not easy, and the changes were tweaked over time, but the effort was successful, Chowaniec says.

Hospices who are undergoing a performance improvement initiative for the first time should keep in mind that it’s challenging to incorporate

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changes in the daily routine, but it ultimately will result in a greater focus on quality care, Chowanec says.

"If hospices can support each other through that, and if those with quality improvement structures in place could support the organizations that don't have them in place thus far, then everyone will come out where they need to be in a few years (when the Medicare changes go into effect)," Chowanec says.

"If we try to go at it alone, there may be more difficulty in obtaining buy-in," she adds.

NHPCO will assist hospices develop formal collaborations with other hospices, including up to 20 groups of hospices that will meet for the first time at the New York City conference. The cost is \$4,000 per team, and it includes attendance at four learning sessions; participation in monthly coaching calls; faculty review of reports and guidance; a trained improvement advisor as guide; staff-coach support for reports, graphs, and data collection; 30 hours of continuing education credit, and recognition on the Quality Partners Web page.

"We've limited it to 20 groups, but will probably have 10 groups of three to six people from each hospice," Simon says.

From 30 to 60 hospice professionals will meet, first in September, followed by a December meeting in Alexandria, VA, and then at a third meeting in Washington, DC at NHPCO's 22nd Management and Leadership Conference, held April 19-21, 2007.

Eventually, all hospices will have the opportunity to form collaborations, Person and Simon say.

"We want to help as many people as we can," Simon says. "We recognize that the collaborative method is one way to improve quality as a business strategy."

The Institute for Healthcare Improvement (IHI) of Cambridge, MA, offers a model of collaboration that has been a resource for NHPCO's collaborative initiative, Simon says.

The IHI model calls for teams of four to six people, but no less than three, to work together on performance improvement. They will be trained at the NHPCO meetings, and they will complete these additional tasks:

- participate in monthly phone calls for nine months;
- write and send in monthly reports;
- test small scale changes;
- collect data each week;

- attend change team meetings to plan and analyze data;

- inform senior leaders and staff about changes.

"I think this IHI model for improvements offers people a tool they can keep in their toolkit and routinely build into their business strategy," Simon says.

"Through the first wave of collaborations, we'll follow the IHI model, and after that we'll see what makes sense," Simon says. "It may be we have to move to original collaborations so hospice staff won't have to travel so far."

Also, NHPCO officials are checking out the possibility of telephone or Web-based collaborations for small and rural hospices that could not afford to send three employees to a collaborative meeting, Simon adds.

NHPCO already has a hospice email list service that can provide new information and ideas about performance improvement, Simon says.

"So we're looking into alternatives, and we're open to suggestions about how to make this as useful as it could be to hospice providers," Simon says.

NHPCO officials have studied the quality requirements CMS made of other health care organizations, and they've based the 10 quality commitments on these, Person says.

"What CMS continues to talk about is a 360 degree surveillance of an entire hospice organization," Person says. "It's a clinical and administrative surveillance, looking at best practices and performance improvement practices from the boardroom to the bedside."

So far, 25 states have agreed to work with NHPCO on the quality initiative.

"We expect to see a lot of networks forming to improve quality, both at the state level and among folks using the same information technology software," Person says. "What we're trying to do is put out a framework, letting people know this is the framework that will meet the 360-degree requirement."

NHPCO also will assist hospices in their QI/PI projects through promulgating tools they can use as part of QI projects, Person says.

These tools will include self-assessment tools and others that have been used successfully by hospices or are recommended by certification boards and other organizations, Person adds.

NHPCO's other quality projects will continue to provide resources and information for hos-

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pices, including the on-line family satisfaction product, end-result outcomes measures, the national data set, etc., Person notes.

Hospice directors and boards interested in participating with NHPCO can sign an organizational commitment to quality pledge, which makes them a quality partner, Person says.

"Then they can go to our Web site and look at self assessment tools, which will help them move forward, as well as look at case studies from other programs," Person explains. "They will see how these match with NHPCO's standards for a hospice program of care." ■

New York hospice's QI project yields improvement in LOS

Education and training are crucial

The Center for Hospice and Palliative Care in Cheektowaga, NY, has a head start on many other hospices in the effort to develop quality improvement projects that will pass muster with the Centers of Medicare and

Medicaid Services when the new Conditions of Participation are published in two years.

The New York hospice already has a year-old performance improvement, pilot project that shows positive results.

The project involves collaboration with a local senior care company's long-term facility, bringing hospice care to the building's residents on a more structured basis than had been done before.

"What we found was the number of referrals has not gone up significantly, but the length of stay (LOS) has gone up," says **Kathy Chowaniec**, RN, a hospice/nursing home/professional relations liaison.

From the first quarter of 2005 to the first quarter of 2006, the hospice had a 25 percent increase in LOS within the building where the QI project is being conducted, Chowaniec says.

Before the QI project, the trend was for LT staff to make a hospice referral after a patient showed obvious changes in condition or entered a crisis mode, Chowaniec notes.

"That's when the facility staff or physicians would contact hospice for collaboration," Chowaniec says. "We were hoping to change that awareness, so they'd notice the subtle declines and allow the residents earlier access to hospice."

Other positive results included a zero hospitalization transfer rate among the patients referred to hospice through the program, and the hospice and LT facility were able to meet 100 percent of the patient's wishes, Chowaniec says.

"Whatever their choice in pursuit of care or declining hospice, the facility through this process has been able to make sure that what they want is what they're getting," Chowaniec adds.

Here is how the hospice's QI process worked:

- **Identify a need:** In the summer of 2005, a local community health foundation asked organizations for ideas on how to improve outcomes for elders in the community, Chowaniec recalls.

As a result of this, the hospice approached ElderWood Senior Care and asked the company to take the relationship the hospice already had with the long-term care facility to another level in order to provide more thorough hospice referrals to LT care patients. Once the two organizations agreed on this idea, it was submitted as a proposal to the community health foundation, and the idea was accepted, Chowaniec says.

- **Propose a change:** The goal was to improve hospice access to LT care patients. Although patients were referred by LT physicians and staff, there was no structured process for hospice referrals, so the QI team identified an assessment tool that might help improve the process.

The Flacker mortality assessment scale provided risk assessment for the likelihood of a LT patient's death within one year, based on specific elements of the Minimum Data Set (MDS). The assessment scale looks at social engagement, among other qualities.¹

"Flacker and colleagues identified that if you were able to use the MDS measures you could link a person to better, enhanced, end-of-life services that were likely to include hospice," Chowanec says.

"We knew that tool was out there, and we knew some hospices on the West Coast had implemented a use of the tool, and we wanted to do the same thing," Chowanec says.

So the hospice and LT care QI team linked specific MDS data with the Flacker assessment tool, using the collaboration in such a way that met all regulatory standards for privacy.

"To date, I go into the facility weekly and work with a representative of the long-term care facility who is also on my [QI] team," Chowanec says.

- **Analyze process and results:** "Initially, our direct goal was to implement this tool to help facility staff identify decline and allow them to put certain things in motion," Chowanec says. "We were naïve and soon realized we needed to help them put these things into a protocol."

Also, the tool has been modified three times as a part of the collaboration, she says.

"At different parts of the process, we decided there were certain elements that didn't work for us, and we made these refinements until we came up with a tool that gave us what we really needed," Chowanec says. "Now we are at a point where the tool is not identifying anyone prematurely."

- **Educate, train, inform staff:** Both LT care staff and hospice staff needed to be educated on the QI process and changes, and there had to be some promotion of the benefits the improvements would provide to patients.

The collaborative team set up formal inservices and workshops, as well as participated in an awareness campaign, Chowanec says.

The LT care staff incorporated education in the morning meetings, and they let everyone know

that the two organizations were entering into a structured collaborative, she adds.

"Then we targeted units that were trained in use of the Flacker tool, and we helped them understand how they would incorporate the tool into their daily routine," Chowanec says.

Then as the change resulted in measurable improvements, staff was told of the successful outcomes, which helped to facilitate even more buy-in, Chowanec says.

"We've seen a shift in focus and awareness in the [LTC] building," she notes. "There's a better understanding of residents' decline, and there's a better understanding of what residents' wishes are."

Also, the LT care staff is less likely now to avoid the patient who has been referred to hospice care, Chowanec says.

LT care staff now will rally around the dying residents and attend their deaths, as well as participate in the end-of-life process in a way they never had before, she says.

"They have found this time shouldn't be a discontinuation of everything, and the staff and faculty have found creative ways to celebrate the individual's life," Chowanec says.

Hospice physicians initially resisted the change because use of the tool identified LT residents for end-of-life care at a point sooner than what doctors were accustomed to, Chowanec says.

"It took us out of our comfort zone," she adds. "Here we are in hospice, and we've expressed a desire to promote earlier access, and when we promote an activity that moves us in that direction, we suffered some unease with it."

Marketing of the collaboration and changes continues in some subtle ways, including the ongoing presence of hospice staff in the building, she adds.

- **Incorporate QI success into organization's long-term goals:** Now that the QI project has evolved for a year, producing positive outcomes, the next step will be to help it grow beyond the pilot project stage, Chowanec says.

"I believe this project will be readily acceptable by us on the hospice side, and if we can continue to promote it to long-term care, it will easily be incorporated into the natural routine," Chowanec says. ■

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Here are the nuts and bolts of starting a hospice program for dementia patients

Education is comprehensive for staff

Hospice of the Valley in Phoenix, AZ, has a comprehensive dementia care program that has resulted in an increase in dementia patient referrals.

"As we provide education, we know that dementia is going to touch everyone's life in some way or another," says **Maribeth Gallagher**, RN, MS, NP, dementia program psychiatric nurse practitioner and music consultant for Hospice of the Valley. [See additional stories about treating dementia patients in the August, 2006, issue of *Hospice Management Advisor*.]

The hospice has created a sing-along CD for dementia patients, and there's a Stimulation Of Senses (SOS) program in which sensory bags are given to clinical staff to use with dementia patients, says **Jan Dougherty**, RN, MS, dementia program director.

"We've given the sensory bags to our team members who have the highest concentration of dementia patients," Dougherty says. "And we say on every visit, 'You need to make a sensory connection.'"

About 200 hospice employees have the SOS bags, which contain aroma bags and spray, tactile balls, and a book that is illustrated for older adults.

Music is an important part of the sensory bags because music holds a lot of potential for stimulating people with moderate to advanced dementia, Gallagher says.

"Music that is heard over a lifetime is associated with positive feelings," she notes.

Hospice of the Valley's dementia program also includes extensive education for staff, as well as training for teaching caregivers about dementia and behavior. Gallagher and Dougherty describe the key elements of the program, as follows:

1. Distribute SOS (sensory) bags to patients and caregivers.

Hospice employees have reported many positive stories about responses from patients who have received the SOS bags, Dougherty notes.

For example, the book contains words, such as "I love to eat warm apple pie and vanilla ice cream," and dementia patients will giggle in delight when this is read to them, Dougherty says.

"The sensory bags have bubbles to blow around the person, and we have balloons that we can blow up for them," she adds. "We end our visits with a Hershey's Kiss candy because chocolate is so wonderfully good and positive."

For the sense of smell, there are lemon and lavender aromatherapy spray and vanilla-scented lotion, which could be used during a massage.¹

The idea is for hospice staff to use one or more items from the sensory bag at each visit, spending five to 10 minutes on stimulating the patient's senses. And hospice employees are expected to make a connection with the patient, using these items, Dougherty says.

The SOS bags also contain a sing-along CD and a CD player, and the music can be played during the patient's bath or other daily activities, Dougherty notes.

"A person who was once combative is now relaxed, singing along, and relaxing," Dougherty says. "So we receive the most amazing anecdotal reports of how people reveal themselves, even if just for a moment, and the families will say it's wonderful and they didn't know the loved one was present in that way."

2. Make familiar music an important part of patient care.

Hospices often use music and music therapy in patient care, but for dementia patients, Hospice of the Valley has gone the extra mile.

Gallagher, who is a professional musician, as well as a nurse practitioner, has personally seen how music can form a powerful connection with people, whether it's in a nightclub venue such as when she used to sing on stage or in a church.

When the hospice formed the dementia care program, she did a little research about dementia to see how music was being used in patient care.

Since everyone has heard music since childhood and many people have had their strongest connections to songs during their teenage years, Gallagher decided to produce a CD of songs from most hospice patients' youth.

"I read somewhere that the parts of the brain that process music are some of the last to deteriorate in illnesses affecting the brain," Gallagher says. "So at the Hospice of the Valley we want to celebrate any residual abilities a person has, exalted, and celebrate." (See story about a sing-along CD for dementia patients, p. 104.)

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3. Educate staff and caregivers about hallmark behaviors and disease progression with dementia.

"We talk about what confusion is and how it can be a delirium, which is an acute altered mental status, or it could be dementia," Gallagher says. "Delirium can be caused by a medical problem, or if someone with dementia has a urinary tract infection, we can see a behavior change, and the problem can escalate."

Staff and caregiver education also focuses on behaviors of dementia patients.

"We look at the person in the context of his or her environment and figure out what are the contributing factors that could be causing this behavior," Gallagher says. "We look at behavior as a form of communication that is used by someone whose language ability is impaired."

Hospice staff is taught to ask themselves, when they see a change in behavior, "What is the unmet basic need that this person could be trying to communicate?" Gallagher says.

Both caregivers and staff are given as part of their dementia education a book, titled, *Joining the Journey*, which provides an overview of dementia, categories of memory, and observable changes in behavior, according to the stage of dementia, Gallagher says.

"We like to make sure people know where a person is in the disease state and what they may need to do to optimize the person's experience," Gallagher says.

It's difficult for caregivers, who perhaps have known and loved this person for decades, to acknowledge all of the changes that have taken

place, Gallagher notes.

"It helps to show them pictures of the brain and its deterioration and to explain that no matter how many times they ask their spouse to do something, the person just can't do it anymore," Gallagher says. "Then with that knowledge, hopefully, the caregiver can move on to exploring new ways of maintaining a meaningful connection." ■

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Solve oral medication management problems

Unintentional noncompliance easier to address

(Editor's note: This is the second of a two-part series that identifies the obstacles home health staff members face when helping patients improve their oral medication management. Last month, we highlighted some major challenges staff members face along with strategies that can be used to overcome them. See the July 2006 issue of Hospital Home Health for the first part of this two-part series.)

A range of factors affects a patient's ability to manage oral medications: cognitive ability, number of medications, and understanding why and how to take medications. To help patients better manage their medications, it is important to identify the reasons they don't and address those in the simplest manner possible.

"There are several reasons for noncompliance and some reasons are unintentional and others are intentional," says **Diana Hildebrand**, RN, BS, CPHQ, project coordinator at TMF Health Quality Institute in Austin, TX. The main unintentional reason is lack of education, leading to misunderstanding the reason for the medication and how to take it, she says.

As a home health nurse, not only do you need to continuously educate patients about medication, but when you evaluate patient education techniques don't forget that illiteracy may be a problem that patients won't readily admit, Hildebrand points out. "Even if the person can read at some level, he or she may not be able to comprehend medical information easily."

Hospice produces its own sing-along CD for dementia seniors

Patients respond with calmness & delight

The National Hospice & Palliative Care Organization of Alexandria, VA, is developing a diversity toolkit to assist hospices with their efforts to diversify their patient population.

The preview toolkit includes these suggestions of measures to increase the success of an agency's diversity plan:

1. Know your community. Who are the respected leaders? What are the community's strengths and needs? Go to the community for answers.

2. Be cautious in rolling out a mandatory cultural competence initiative. That could lead to resentment, poor adherence to policies and superficial responses by staff. Instead, gradually infuse cultural proficiency into the organization's culture.

3. Employ a manager of cultural proficiency to emphasize and help organize the commitment to diversity throughout the organization.

4. Establish a cultural diversity advisory board that includes representatives from the organization, as well as the community to help guide the delivery of culturally competent care.

A professional singer, who also is a hospice nurse practitioner, developed a CD of sing-along songs for dementia patients and found that it works wonders at curbing certain behaviors and stimulating their memories.

Maribeth Gallagher, RN, MS, NP, the dementia program psychiatric nurse practitioner/music consultant for the Hospice of the Valley Dementia Program in Phoenix, AZ, selected songs dementia care patients have heard repeatedly since their youth, and she recorded sing-along versions of the songs.

Sing-along recordings already available commercially tend to be too high-pitched and too fast for patients to keep up with, she notes.

For the dementia care CD, Gallagher sings in an almost nasal tone, without inflection, and much slower than she would sing normally.

"I wanted patients to hear the beginning of the words to cue their residual memories and have a successful sing-along experience," Gallagher says. "From what I've read, the patients' response doesn't have anything to do with the quality of the singing."

At first the hospice staff was reluctant to join in the singing, but as they saw their patients' positive responses, it moved them so deeply that now many of them will sing along with CD, Gallagher adds.

Hospice staff uses the CDs to calm patients during activities of daily living, the way new mothers croon to their infants to keep them calm.

"We find that if the hospice worker goes in and holds the person's hand and slowly sings, 'You are my sunshine,' there is something that happens where the patient interprets it that this person is singing to me, so I know this person will do me no harm," Gallagher says.

The sing-along CD also contains only the chorus of songs because most people haven't learned all of the verses, Gallagher notes.

The CD's songs include the following:

- "You Are My Sunshine;"
- "Take Me Out to the Ballgame;"
- "Let me Call You Sweetheart;"
- "Shine on Harvest Moon;"
- "Bicycle Built for Two;"
- "How Much is that Doggie in the Window?"
- "I've Been Working on the Railroad;"
- "My Bonnie Lies Over the Ocean;"

Two additional selections that wouldn't be a music therapist's pick, are "Show Me the Way to Go Home" and "Side by Side," Gallagher says.

"Show Me the Way to Go Home" was a song that one generation of elders used to sing at parties, Gallagher says.

"One line is 'I'm tired and want to go to bed,' and when patients hear this they start laughing," she explains.

Likewise, "Side by Side" contains the verse, 'Oh, we ain't got a barrel of money, maybe we're traveling side by side,' and another line is '. . . what if the sky should fall, as long as we're together it doesn't matter at all.'

"I put that song on the CD for the wife to sing to the husband," Gallagher says.

"A lot of patients have a Christian tradition, so I included the chorus of "Amazing Grace," and put it at the end of the CD, so patients who wouldn't like a spiritual song wouldn't have to listen to it," Gallagher says.

Anecdotal evidence suggests the CD works precisely as hoped.

"We had an elderly couple who had been married for more than 60 years, and the husband was a war hero," Gallagher recalls. "He became increasingly restless, and she was taking care of him alone despite cardiac problems."

The husband's restlessness resulted in repeated calls to 911, but once the hospice gave the woman the CD to play for him, his behavior improved, Gallagher says.

"This man who looks incredibly vulnerable and frail sang out in this huge voice, and at the end of the song he would yell 'Yahhh' and start laughing," she adds.

The songs helped the man transcend his disease, and his wife could play him the CD when she needed to do household chores, and she knew he would be calm while he was singing along, Gallagher says.

During one visit with the couple, Gallagher discovered that the couple's wedding song was "Apple Blossom Time."

At her next visit, she brought words to the song and told the couple, "I'm so impressed by your devotion and love, and I would like to sing this for you," Gallagher says.

"So I started singing, 'I'll be with you in apple blossom time,' and the wife's reading the words with me, and the husband's eyes are filling up with tears and are beaming," Gallagher recalls. "She started choking up and crying in a good

way, and then she stopped and I stopped singing, and her husband looked into her eyes, and it was one of those beautiful moments.

Later, the wife told Gallagher: 'It's like having my old Johnnie back.'

Building on the first CD's success, the hospice next had a cantor singer sing Jewish songs for patients who were Holocaust survivors, and the next project is to identify music for Mexican American elders and have these sung in Spanish, Gallagher says.

The CDs can help caregivers manage those difficult situations they encounter each day.

For example, if an Alzheimer's Disease patient becomes antsy while riding in the care to the medical center, the caregiver can put in the CD, creating a pleasurable environment and calming the patient, Gallagher says. ■

When talking with the patient and the patient's family at the first visit, ask questions about daily routines, such as brushing teeth and meal times, Hildebrand says. "Their answers to these questions will tell you how organized they are and how well they stick to a schedule," she points out, adding that this information will help you tailor your education and will provide tips on managing medications.

Because helping the patient understand the proper timing and dose of each medication, a medication calendar or schedule posted in an easy-to-find location is important. Write the name of the medication exactly as it appears on the label so there is no confusion, Hildebrand suggests. If the patient is not able to read, paste one of the pills to the calendar, she says.

"Even if the patient can't read, he or she can match the pills in the bottle to the pill on the calendar." If you do paste pills to the calendar, be sure to check the prescriptions regularly to make sure that the pharmacy has not changed brands of the medication, as this may mean a change in the color, size, or shape of the pill, she warns.

You also can add a label to the bottle to identify the medication's purpose, suggests Hildebrand. "Water pills or heart pills are easier to understand and a label with larger print is easier to read," she says.

Ask patient to demonstrate understanding

"Our nurses don't just ask the patient to show us where the medications are; we also ask them to open the bottle, take out a pill, and tell us why they take it and how often," says **Lisa Sprinkel**, RN, BA,

MSN, executive director of home health and hospice for Carilion Home Care Services in Roanoke, VA. "This gives us a chance to evaluate their manual dexterity and ability to open the medication, and it gives us a chance to see how well they can read and understand the labels." If the patient is unsure about a medication, the nurse can immediately explain the reason for taking it, she adds.

Not all patients remember to ask for bottles with traditional caps as opposed to child safety caps, so be sure to tell patients that they can ask for traditional caps for all of their medications, Sprinkel suggests.

Another option to explore with pharmacists is the use of blister packs, suggests Hildebrand. "Some pharmacists will package individual doses for the day in a blister pack from which the patient can easily pop the pill," she says. Not only is it easier to open but if all of the medications that are to be taken at one time are together in the pack, the patient won't forget anything, she adds.

If there is a physical reason that the patient cannot open the medication, ask for a therapy consult, suggests Hildebrand. "There are a number of assistive aids that can be used to help patients open bottles," she explains.

Financial concerns also might cause a patient not to fill the prescription when needed, says Hildebrand. "If finances are a challenge for the patient, ask a social worker to visit to find out what assistance is needed," she recommends.

There are instances in which patients choose not to follow instructions about medications, says Hildebrand. "Intentional noncompliance is usually the result of a patient's opinions, beliefs, and values, as opposed to physical, mental, or financial

reasons," she explains. "A patient might believe that suffering is a part of life because this is part of the patient's cultural background."

Other patients might be afraid of becoming addicted to the medication, Hildebrand points out. While there are medications that can be addictive, proper education about the use of the medication might alleviate some of these patients' concerns, she says.

"You can also offer alternatives, such as ointments, muscle rubs, or heat, as one way to reduce pain or soreness and reduce the need for pain medications," says Hildebrand. These alternatives might also be more acceptable for patients who don't want to use multiple medications due to their beliefs, she adds.

While there are many reasons for a patient's mismanagement of oral medications, the key to improving the situation is to first identify the real cause of the mismanagement, says Hildebrand. "It is impossible to find the best solution if you don't start by finding the cause of the problem." ■

Ignorance 1: Education 0 Time to mandate flu shots

Voluntary vaccine approach has failed

Voluntary annual influenza immunization programs that use educational efforts and other incentives to vaccinate health care workers have been an abject failure, a leading proponent of mandatory flu shots said in Tampa at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"We have to acknowledge that voluntary immunization programs have never resulted in high immunization rates in any setting for any age at any time for any reason at any location with any vaccine," said **Gregory D. Poland**, MD, director of the vaccine research group at the Mayo Clinic in Rochester, MN. "It does not work. Those data are clear and unambiguous. We have got to get past this."

Moreover, decades of voluntary programs chock full of incentives and educational outreach have reached a level of diminishing and dismal returns: little more than one-third of health care workers bother to be vaccinated during any given flu season.

"I want to believe and you want to believe that education works," Poland said. "It does not when it comes to this topic. I am sorry, it doesn't work. I wish it were otherwise. No study has been able to demonstrate significant sustained [vaccination] increases for any sustained time period as a result of educational efforts. It is not the answer. This has failed as the only strategy we have had — trying to encourage people, provided free [vaccine and] education. It simply hasn't worked."

The health care system will "either lead or be lambasted" on the issue given trends for patient safety and empowerment, consumer demand for health care accountability, and increasingly negative press coverage.

"We have to take responsibility for this parade of deaths that happens year in and year out in our hospitals," Poland said. "Personal preference, I do not believe, is defensible in any way for a health care worker. We will be called to account here. Only 36%-40% are getting immunized each year. The vast majority of us are not getting the vaccine."

Given the situation, the APIC board of directors voted earlier this year to endorse mandatory influenza vaccination for health care personnel who have direct contact with patients. "I am just overjoyed that you took one of the early leadership positions in this and endorsed mandatory flu immunization," Poland told APIC attendees.

Ethical duty becoming a legal one

Health care workers and their employers have an ethical and moral duty to protect vulnerable patients from transmissible diseases, Poland said. "I believe they will have a legal duty, too," he added, noting that flu vaccination for health care workers in acute care is now mandatory in seven states. Fifteen states mandate the shots for workers in long-term care, he said.

"There are now six lawsuits against physicians and health care institutions that failed to deliver the vaccine, and there was the suspicion that [flu was nosocomially] transmitted," Poland said. "You leave yourself vulnerable."

While short of a mandate, the current standard of care is requiring workers who decline flu shots to sign declination statements. "This should be seen as a matter of meeting professional and ethical standards, not personal preference," he said. "Unvaccinated health care workers should be excluded from direct patient care."

The situation is particularly disconcerting in

an era of patient safety, when more and more public and media attention is focused on adverse outcomes in health care.

"Your colleagues do not necessarily understand," Poland said. "The reason for them to get vaccine is to protect somebody else. That is the primary reason — first, do no harm. It is a patient safety issue and a moral and ethical imperative. It is a win-win-win-win: the patient benefits, the employee benefits, the institution benefits, and the community benefits."

Poland cited numerous studies showing nosocomial transmission of influenza from unvaccinated workers to patients. "Influenza-infected health care workers transmit this deadly virus to their patients," he said. "A fact many of you do not know is that health care workers with asymptomatic influenza can transmit this virus to patients and to other staff. In fact, they can do so for about 24-36 hours before they develop symptoms or even if they never develop symptoms. Multiple studies show that about 70% of health care workers continue to work despite the fact that they are symptomatic for influenza."

Complications of influenza are particularly burdensome on certain subsets of patients, including children younger than 2 years old. "Until recently I was not aware of this," Poland said. "They have a mortality rate as high as 15%. That is sort of stunning."

Poland cited a flu outbreak in an NICU in which a baby died after being exposed to infected health care workers. "This one is a tough one for me," he said. "Try to get your head around this. You go to a hospital to deliver your high-risk baby in the United States in 1998 — best health care system in the world, right? And your baby dies of an infection that was preventable by a \$15 vaccine. In fact, for the health care worker, it wouldn't have cost anything at all."

Other vulnerable patient groups include the elderly, the immunocompromised, and critically ill patients. Patients acquiring flu in the hospital results in increased costs, extended lengths of stay, and death.

Surprisingly, nursing is the health care work segment with the greatest entrenched resistance to being vaccinated against flu, Poland said.

"[Nurses] have consistently lower vaccination rates than any other group, and the big concern is that there is no other group of health care workers who have closer and more prolonged contact with patients," he said. "There are no data that show education changes this. Furthermore, nurses have more reasons for rejecting vaccine than all other health care workers and are more likely to believe it is not safe or effective."

'Ignorance is killing people'

The reasons typically given by health care workers for refusing the vaccine include that they never get the flu, pose no risk to patients, fear of vaccine side effects, fear of needles, or belief that the vaccine causes flu. The vaccine is safe and effective and does not cause the flu, Poland emphasized, adding that he personally conducted a study that showed that a sore arm at the immunization site is the only actual side effect that has statistical significance when comparing flu vaccine to a placebo.

Beyond the health care setting, flu is somewhat underappreciated as an infectious disease threat during a typical, nonpandemic year. Yet seasonal flu kills an average of 36,000 Americans annually, almost as much as breast cancer (40,000), and three times as many as HIV/AIDS (14,000).

"If I got up here today and announced we had discovered a safe and effective vaccine against breast cancer, do you think it would take me six decades to get 36% of the women of this room to take that vaccine?" Poland said. "One out of every 10,000 Americans that are alive today will be dead by next flu season because they didn't get a flu shot."

While it is not clear how many flu deaths are directly linked to health care, all evidence shows transmission is occurring. "We know from serologic studies that about 25% of health care workers each season actually have antibodies that show that they are infected with one of the currently circulating strains," he said. "About 50% of the health care workers who have that evidence were unaware that they had influenza. One of the things that I hear a lot is that 'I never get the flu.' Yes you do, you just don't know it, and that ignorance is killing people." ■

COMING IN FUTURE MONTHS

■ "Share the Care" provides group help for seriously ill patients

■ Telehospice care model reveals some benefits

■ Healing Quilt brings patchwork of grieving kids together

Oxygen study shows true cost of equipment

Nearly three-quarters (72%) of the cost of providing home oxygen therapy to Medicare patients in their homes represent services, delivery, and other operational expenses that benefit patients, according to a new survey of current costs by Morrison Informatics, commissioned by the American Association for Homecare. Only about one-quarter, or 28%, of the cost represents oxygen equipment.

"The study shows that, contrary to some perceptions, home oxygen therapy involves much more than a piece of equipment," said **Tom Ryan**, chairman of the American Association for Homecare and CEO of Homecare Concepts in Farmingdale, NY.

Morrison collected and analyzed data from 74 home care providers that collectively serve more than 600,000 Medicare beneficiaries receiving oxygen therapy in their homes, which represents more than half of the Medicare population receiving oxygen therapy at home. To access a copy of the free report, go to www.aahomecare.org. Under the heading "Advocacy Updates" on the home page, choose "Morrison Informatics Oxygen Study." ■

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