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# Hospital Home Health®

*the monthly update for executives and health care professionals*

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## IN THIS ISSUE



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# New CMS rules on HHABNs expand applications; increase confusion

*Don't waste staff time; read instructions carefully and educate clinicians*

Do you take the ultra-cautious approach and issue a Home Health Advance Beneficiary Notice (HHABN) in any case in which you are not sure if the new rules apply, or do you take a chance and hope that you've interpreted the instructions correctly?

This is the dilemma posed by the mandate by the Centers for Medicare & Medicaid Services (CMS) that requires home health agencies to issue HHABNs in more situations than required before Sept. 1, 2006.

"In the past, the use of an HHABN was very specific and very limited in scope," points out **Rachel Hammon**, RN, BSN, director of clinical practice and regulatory affairs for the Texas Association of Home Care in Austin. While previously the use of an HHABN focused on the financial liability of a patient for whom services or equipment might not be covered by Medicare, the new rules expand the application to address issues not related to financial liability, she explains. In addition to issuing an HHBN if the patient will be responsible for costs of care, a home health clinician also must give the patient an HHABN if service is being discontinued because the agency can no longer provide service to that patient, or if the physician has changed the orders and determined that home care is not necessary.

In the initial changes introduced in May, home health agencies were given only two option boxes to check off on the HHABN; but after subsequent review and comments from the home health industry, a third option was added to the form, Hammon says. "I was glad to see that we are given the third option in which we explain to patients that the physician has changed his or her orders and we cannot provide care without a physician's orders."

Although the form has not changed from the one introduced in May with the exception of the additional option box, the instructions have significantly changed from what agencies have been using, says **Elizabeth E. Hogue**, Esq., a Burtonsville, MD, attorney. The instructions for the HHABN are hard to understand, she admits. "If you are in doubt as to whether or not an HHABN is needed, I suggest that you err on the side of caution and issue one."

While you can't get into trouble for issuing too many, there is a cost factor to the agency, Hammon points out. "Although you should make sure you issue HHABNs when needed, it is also important to save the time your clinicians spend on the forms by making sure you understand the instructions so that you don't issue unnecessary HHABNs," she suggests.

The instructions are fairly general, and the biggest challenge for all home health agencies will be interpreting the instructions and applying them to every scenario, says Hammon. "Every agency is different, depending on its size, patient population, and geographic area," she says. "Also, if durable medical equipment is part of your agency's services, then another set of situations will have to be addressed."

### Review CMS information

Although there is a Q&A on the CMS web site **(see resource box, below)** to help home health managers figure out what is required, the questions and answers have not been updated since June. "I expect to see updated information as more agencies submit questions now that the HHABN rule is in place," Hammon says.

The best way to know what is required is to review the instructions and the existing Q&As carefully, she suggests. "Identify situations that are most likely to occur in your agency and decide if they require an HHABN."

Every nurse, therapist, case manager, supervisor, and manager needs to be educated, says Hogue. Agencies need to determine who makes the final decision to issue an HHABN and clinicians need to understand what situations might require one so that no one misses a situation for which one is required, she says. "There are exceptions to the HHABN requirement," she points out. "Specifically, if the patient is moving to a different level of care, such as the hospital or a nursing home, there is no need to issue an HHABN," she says. **(For other exceptions, see story, p. 99.)**

A good resource for training is your state association, says Hammon. "Most state associations have partnered with vendors to provide seminars on HHABN rules and are also posting information

### SOURCES/RESOURCE

For more information about the Home Health Advance Beneficiary Notice, contact:

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**For instructions, forms, and Q&As related to the Home Health Advance Beneficiary Notice**, go to www.cms.hhs.gov. Scroll down to "Browse by provider type" and choose "Home Health Agency Center." Under "Initiatives," select "Beneficiary Notices Initiative." Under "Downloads" select "August 2009 OMB approved HHABN notices and instructions" and "HHABNs Qs and As."

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on their web sites," she says. Take advantage of these opportunities and keep reviewing the CMS Q&As to stay up-to-date, she suggests.

It is important to be clear about when an HHABN is needed, says Hogue. "CMS is saying that state surveyors will survey for compliance with the new HHABN rules immediately," she says. "It is unclear, though, how surveyors will be able to judge compliance with the same broad instructions that agencies have," she adds. "The inclusion of HHABN compliance does increase the importance that agencies work to identify the proper application of the rule." ■

## Exceptions to the rule: Know when to use an HHABN

For every rule, there are exceptions, and the new instructions governing the use of Home Health Advance Beneficiary Notices (HHABNs) also have their exceptions to the rule. According to the most recent postings on the Q&A section of the CMS web site, the following questions identify exceptions to the HHABN rules:

**Q.** *Is an HHABN required when we refer/coordinate a transfer to another HHA? What about home attendants obtained through another HHA?*

**A.** HHABNs are not required in these situations. Transfers are discussed in Section IV of the revised HHABN instructions posted on the CMS and Regional Home Health Intermediary (RHHI) web site in February. Beyond that, liability notice policy only requires that rendering or billing providers give notice.

**Q.** *If the patient is a Medicare beneficiary and is receiving skilled services paid by Medicare, and the patient would like to pay privately for additional custodial care, what notice would we give?*

**A.** No notice is necessary since this is considered an increase in care, which is not a triggering event.

**Q.** *What if the patient takes a turn for the worse and his or her home health care is put on hold — the patient is not discharged, but hospitalized. This means the patient's plan of care has changed. Do we need to give an HHABN?*

**A.** Again, HHABNs are not required when the level of care increases, or when an individual is hospitalized.

**Q.** *What if a staff member gets sick and we are not able to get someone to the patient's home on a certain day, do we need to give an HHABN?*

**A.** No. An HHABN is necessary in emergency or unplanned situations.

*Source:* Centers for Medicare & Medicaid Services, *HHABN Q and As.* Web site: www.cms.hhs.gov.

# Adopting new technology? Understand staff fears

*Loss of job tops list of fears for all staff members*

Increased efficiency, improved documentation, and faster reimbursement are all reasons to upgrade your agency's technology. Unfortunately, the challenges to upgrading technology in home health go beyond financial concerns and a desire to find the right vendor.

Even with the timesaving benefits that they will likely enjoy once you've upgraded the agency's technology, reluctant staff can negatively affect the success of new computer software and hardware, says **Dale Reis**, RN, BSN, senior implementation specialist at CareCentric in Atlanta. To improve your chance of a successful implementation, be sure to address staff fears early in the evaluation process of new technology, she says. "The biggest fear among home health employees is that they will be replaced by a computer," she explains.

Saving some money in salaries and benefits by reducing some full-time equivalents (FTE) within the agency is one benefit of upgrading any system, but you can reassure your employees that the new system doesn't guarantee that anyone loses their job, says **Leslie Halchak**, RN, director of professional services at Home Health Management in West Columbia, SC. "We did eliminate 2½ FTEs when we implemented our new system in 2005, but we knew well ahead of time that we would be cutting those staff positions once the system was up and running," she says.

Because she knew about the staff reduction, Halchak used a combination of attrition and redistribution of duties to make sure that no one was laid off. "When one employee in the area where the positions would be eliminated left the agency, I used a temporary employee to cover the job until we finished implementation and no longer needed

that position," she explains.

Although the fear of losing a job is found mainly in the office areas of a home health agency, field clinicians' biggest fear is not being replaced, but the technology itself, Reis explains. "Agencies that introduce point-of-care technology, such as tablets, laptops, or personal digital assistants [PDAs], find resistance from their more experienced nurses, because many of these clinicians may not know how to type and may not use e-mail or even have a computer at home," she explains. "I've seen nurses react to a PDA placed in their hands the same way they would react to a hot potato in their hands. They want to drop it just as quickly."

### Have staff evaluate hardware

The best time to address clinicians' fears of technology is as you begin selection of the hardware and design of the forms that will appear on the point-of-care technology, suggests Reis. "Agency management can narrow the selection to the three items that fit the needs of the agency but include a key group of field staff in the final evaluation of the three items and ask for their recommendations," she says. In addition to inviting staff members who are natural leaders among their peers, be sure to invite some staff members who have spoken against use of point-of-care technology, Reis recommends. "Of course, when you invite these staff members, be sure to ask them if they can participate with an open mind."

Once you've chosen the equipment that field staff will use, let them play with it, Halchak says. "Before we went live with the system, we gave all of our clinicians the tablet and let them play with it," she says. "We had software that allowed them to get use to the login process and we had games that they could play to become accustomed to the stylus," Halchak says. "Playtime" with the tablet meant that staff were comfortable with starting the computer, using the stylus, and maneuvering around the system before implementation occurred, she explains.

A survey of staff during the evaluation process asked them to describe their level of computer knowledge and enabled Halchak and her staff to find out what scared staff about the use of computers. "As a result of our survey, we chose a tablet that has a touch screen and a keyboard so clinicians can choose which way they want to enter information," she says.

Another approach that eased the implementation of the new system throughout the three-office agency was a gradual introduction, says Halchak. "We piloted the project at my location before we introduced it to the other two offices," she says. The entire system was not implemented at the same time, either. "We used the system in our back office for six months before we introduced it in the field," she says. "Then when we had our field staff using the point-of-care tablets; we implemented it in steps."

The first step for the field staff was the itinerary and activity log to get everyone accustomed to uploading and downloading information, says Halchak. "Then, we introduced the OASIS portion of the system for nurses and the last part of the system to be implemented was OASIS for therapists," she explains. Because it was introduced one step at a time, everyone had a chance to become accustomed to the system without being overwhelmed, she adds.

"It is important to run a pilot test of any new system," Reis says. If you are not a multi-office agency, you can choose a small group of clinicians to act as the pilot group, she says. "The pilot group needs to understand that their purpose is to use the system in order to identify the bugs that need to be fixed."

Your pilot group will be very helpful once the system is introduced to the whole agency, Reis points out. "The initial group of field staff members can serve as a resource for other staff members," she says. While you will need someone who can provide hardware and application support, nurses and therapists can help each other with questions about specific forms and entering information. Some of your pilot group members also might act as trainers as you introduce the system to other employees. **(For other staff education tips, see story on p. 101.)**

If you address employee concerns at the start

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of any technology upgrade, you can have a smooth transition, says Reis. "I'll always remember that in one of the agencies in which I worked, a nurse with 35 years of experience was the most vocal staff member in opposition to the use of PDAs. We included her on the evaluation and pilot teams. One month after full implementation of the system, she showed up in my office with a PDA that was not working properly and said that she was not going to admit one more patient until we gave her a working PDA."

She laughs and says, "That's when I knew we had done all the right things to introduce the new system." ■

# 'Train the trainers': How to introduce new technology

*Be flexible with training schedule*

Ensuring successful implementation of any new technology requires a great deal of preparation. Not only do you have to make sure you choose the right system with all of the components you need, but you also have to make sure your staff members know how to use it correctly in order to get the most benefit from your investment.

"We used a 'train-the-trainers' approach in which we had the vendor train a core group of staff members and then had them train employees throughout the agency," says **Leslie Halchak**, RN, director of professional services at Home Health Management in West Columbia, SC. Not only does this give you employees who can act as resources for others in the agency, but the training is more effective because it is presented by a staff member who really understands what is involved in home health, she says.

In addition to using traditional classroom seminars and system tutorials to teach employees how to use the new system of software and point-of-care tablets, Halchak's agency handed each clinician the tablet to play with during the class. "It was important that as they marked the location of wounds on an anatomical drawing of a man, they got to see that three light touches of the stylus would leave three marks," she explained.

While in the classroom, the clinicians also looked at all of the forms that would be included on the system, and practiced entering information and moving from one screen to another, says Halchak. "One of the key actions we took before implementing our new system was to redesign all of our printed forms to look exactly like the computerized forms."

By having nurses and therapists already using the forms that would appear on the computer, Halchak was able to focus on training for the use of the computer, not training on both the computer system and the new forms.

When planning your education sessions, don't forget your PRN staff, warns Halchak. "You have to be very flexible and offer training sessions at unconventional times such as Saturday morning or early evening," she says. "Be aware that your PRN staff will require more training and will probably take longer to learn the system because they are not using it every day."

### *Use your own guidebook*

To help PRN and regular staff with day-to-day operation of the computers, the agency produced its own guidebook. "It starts with the very basics, such as, 'Turn your computer on with the button shown in this picture,' and goes on to show pictures of icons that the nurse needs to click," says Halchak. Even after several training sessions and practice at home, staff members like having the guidebook handy, she adds.

In-house or office staff members usually are more computer-savvy than the majority of field staff because they traditionally have been working with computers, points out Halchak. It is important to train them on the system, then switch over to the new system all at once, she says. "Some agencies choose to run dual systems, both the old and the new, at the same time for 60 days to give employees a chance to get used to the new system," she says. The difficulty with running both systems is that 60 days later, you may still be waiting for payments to post to the old system, and if you are asked a question about an account during the 60-day period, you have to figure out which system the account was entered in, she explains.

"We chose to bite the bullet and switch over all at once," says Halchak. "We worked weekends and late nights to key data into the new system from the old one; but once we switched over, everything went smoothly because everyone had to learn and use the new system at the same time."

In addition to training staff and providing resources to answer their questions, it is critical to talk positively throughout the process, says Halchak.

"Everyone involved with the implementation knew that we had to be positive. When we encountered problems, we discussed them behind closed doors in order to solve them without giving employees a negative impression of the system before it was implemented." ■

**LegalEase**

*Understanding Laws, Rules, Regulations*

# Fraud and abuse: Violating the False Claims Act

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

*McNutt v. Haleyville Medical Supplies Inc.* (D.C. Docket No. 01-03156-CV-AR-J, Sept. 9, 2005) makes it clear that providers who violate any requirement of the Medicare/Medicaid programs and submit claims for reimbursement also have violated the False Claims Act.

The government alleged that companies owned by Gerald and Frances Burleson violated the anti-kickback statute by paying kickbacks camouflaged as rental payments and commissions to pharmacists and other individuals. Specifically, the Burlesons issued monthly checks to referring pharmacists. The amount of the checks was a percentage, typically 20% to 25%, of the amount the Burlesons received from Medicare for services provided to patients referred by those pharmacists. The Burlesons characterized each check as "rent" in the memo portion of the check in order to conceal the true nature of the kickback payments.

The government also claimed that the Burlesons paid kickbacks to two respiratory therapists and a doctor's patient representative for referring Medicare patients to the Burlesons. The government identified specific claims submitted by the Burlesons to Medicare for reimbursement for services that were rendered to patients referred by individuals receiving kickbacks. The government alleged that, by virtue of these acts, the Burlesons knowingly presented, or knowingly caused to be presented, false or fraudulent claims for payment in violation of the False Claims Act.

The government further alleged that Medicare and Medicaid providers are required to sign a provider agreement with the government. Under the terms of these agreements, providers certify that they will comply with all laws and regulations related to "proper practices for Medicare providers." One of the laws included in these certifications is the anti-kickback statute. According to the government, a Medicare provider's compliance with its provider agreement is a condition for receipt of payments from the Medicare/Medicaid programs and other federal and state health care programs.

## Reasonable and necessary

The office of the Inspector General (OIG) of the U.S. Department of Health and Human Services made it clear some time ago that providers implicitly make certain promises when they submit claims for payment to all federal and state health care programs. Specifically, the OIG says that, consistent with the False Claims Act, providers promise that the care they rendered was reasonable and necessary for every claim submitted for payment. If claims are submitted for unreasonable or unnecessary care, they may be "false claims." Providers that submit false claims are subject to criminal prosecution and civil enforcement action, including suspension or exclusion from participation in the Medicare and Medicaid and other state and federal health care programs and civil money penalties.

In the McNutt case, the government clarifies that providers also violate the False Claims Act when they submit claims for care rendered to patients and illegal kickbacks were paid to induce referrals of these patients.

In addition, providers should note that the McNutt case seems to say that if providers violate any requirement of federal and state health care programs, including, for example, requirements that providers must comply with all state and federal laws and regulations, the claims involving noncompliance are false.

The consequences of noncompliance for providers are becoming more serious. Yet, there are still providers who "thumb their noses" at fraud violations. Ignoring compliance hurts providers and the health care industry. Providers who ignore fraud issues also hurt patients, a result that is unacceptable to us all. ■

# Asthma management program shows a 2-1 ROI

*Program provides home visits for the severely ill*

Optima Health's asthma disease management program has generated $2.10 in savings for every dollar spent on members who have been continuously enrolled over a five-year period.

In addition, the Virginia Beach, VA-based program, which provides home visits by a respiratory therapist or a nurse for severely ill asthma patients, has resulted in a 20% decrease in emergency department visits.

About 10,000 of the health plan's 350,000 members have asthma. More than 60% of the members are part of Optima's Medicaid health plan.

Members are identified through claims and pharmacy data, primary care and specialist office visits for asthma, inpatient admissions, or home health care with a primary diagnosis of asthma, according to **Janis Sabol**, RRT, team coordinator for the asthma program.

Once members are identified, they are stratified into risk levels by their resource consumption and the number of interventions their asthma has required.

Members at highest risk are eligible for a home visit by a nurse or a respiratory therapist, who conducts one-on-one asthma education and does an environmental assessment of the home, looking for mold, dust, or other allergens and offering suggestions for how the member can remediate them.

The health plan contracts with a home care agency, which sends a nurse or respiratory therapist into the home as often as necessary and assumes responsibility for coordinating the care of the member for a one-year period.

The lowest-risk members, about 80% to 85% of members with asthma, receive educational brochures and a card with the name of a contact person they can call with questions or concerns.

The case managers concentrate on the moderate- to high-risk patients — those who don't access emergency department care but have the potential to have a severe asthma attack if they don't change the way they are managing their disease.

"We are aware that you can throw a lot of time and energy into the sickest individuals. With some of the more severely ill members, we tend to be spinning our wheels. Sometimes we think we make an impact and then they end up back in the emergency room or hospital again and again. It depends on the nature of their disease, their desire to treat the disease, and their attitude toward health care," Sabol says.

When members are identified as being at moderate to high risk, the case managers call them and discuss their disease.

"We find out what medications they are taking and when, whether they've seen their doctor, if they have identified their asthma triggers, and other asthma-specific information. We ask questions to get the total picture and to offer assistance in whatever area they need most," Sabol says.

The case managers periodically check back with the members, depending on their needs, and help them overcome any obstacles to care.

For instance, one patient who lives in a rural area was supposed to be getting injections for an allergy, but her pulmonologist died suddenly and she had not been able to find another physician. The case manager helped her find a doctor and checked on her frequently until her condition was stabilized.

To overcome the transportation barrier for its Medicaid population, Optima Health Plan has contracted with a transportation service that members can use to get to and from their physician appointments. ■

# Developing competent teachers among staff

*Research can uncover targets for improvement*

To improve patient education, institutions must develop competent teachers. Some patient education coordinators have found that a survey tool is a good strategy for improving patient education competency among staff members.

Not your average tool, but one that measures "personal skill level" and the "importance of the skill."

**Doris Doherty**, BSN, RN, patient/family education coordinator at Franciscan Skemp Healthcare in LaCrosse, WI, helped implement such a tool in the fall of 2005 after returning from a Health Care Education Association conference.

She says while her institution would look at different competencies each year, they had not surveyed nursing staff to find out what the

nurses wanted to know. The survey helped identify a focus for creating a plan. Also, the use of a survey adhered to the adult learning methods. "If adults can identify what it is they would like to know more about, they will easily learn it," she says.

A survey with nine statements was mailed to about 800 RNs and LPNs in the health care system that includes multiple clinics, three hospitals, subacute and rehabilitation facilities, and nursing homes.

The statement that showed measurements of lowest proficiency and highest importance was: "Determines the patient's ability to read, understand, and act on health care information (health literacy), and adjusts teaching methods accordingly."

Those responding were asked to rate the importance of each statement in the survey by marking one of the following: not at all; of little importance; important; very important; critically important. They also were asked to rate their personal skill level for each competency as: little or none, basic, adequate, proficient, or expert.

The presentation that prompted Doherty to form a task force to conduct a survey to identify competencies for nursing staff was delivered by **Jean Just**, RN,C, MSN, director of staff development and patient education at The Ohio State University James Cancer Hospital and Solove Research Institute in Columbus.

Just was part of a professional development committee initiated within the Cancer Patient Education Network (CPEN). One of its charges was to identify competencies for cancer patient educators.

To develop the survey tool, the CPEN committee looked at the literature to see what staff members needed to know to facilitate learning among cancer patients.

"Based on our review of the literature, we compiled the competencies and then we had the competencies further reviewed and refined by the members of our professional development committee. We came up with 38 competencies," Just says.

The task force that Doherty helped form at Franciscan Skemp Healthcare included members from the staff development and patient education committees and a market analyst who had expertise in setting up a survey tool and analyzing data. This team chose eight statements from the 38 identified by the CPEN committee. It created one statement of its own pertaining to diagnosis-related patient care standards.

The task force determined that 38 statements were too many because they did not have staff to handle the analysis of extensive data and some of the statements were unique to cancer nurses.

The purpose of the CPEN survey was to identify competencies for those who provide education for cancer patients. "We thought there were perhaps some things that were a little different with educating a patient with a cancer diagnosis," says Just.

The survey was distributed via a listserv to cancer patient educators. When the results were evaluated, the CPEN committee found the most important competency for cancer patient education is to consider the impact of a cancer diagnosis on learning.

Patient educators must be able to assess where the patient is emotionally and then take steps to reduce the emotional impact so the patient can retain information.

"We all know anxiety is a big barrier to taking in and retaining information," Just says.

### Creating a plan for competency

Once the results of a competency survey have been tallied, a plan to target the learning needs identified is the next step.

Doherty says the task force at Franciscan Skemp Healthcare is in the process of putting together an education plan for 2006 and will follow up with an evaluation in 2007 to determine if the plan was successful.

The team used the statement from the survey

**SOURCES**

For more information on strategies for improving patient teaching competencies, contact:

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that showed lowest proficiency and highest importance to form a focus, which is "nurses will demonstrate assessment skills in determining the patient's ability to read, understand and act on health care information, and adjust teaching methods accordingly."

In the process of assembling a self-learning packet the committee has looked at a lot of information and is developing education around a video produced by the American Medical Association titled "Health Literacy, Helping Your Patient Understand."

A plan to improve patient teaching competency can be simple or quite extensive. The work at University Health Network, a large health care organization in Toronto, began in 2002 and still is a work in progress.

It began with a competency survey to establish baseline teaching skills, similar to the one CPEN created. **Audrey Jusko Friedman**, AC MRT(T), MSW, director of oncology patient education and survivorship at Princess Margaret Hospital within University Health Network, was part of the CPEN committee creating the competency survey.

In addition to a survey, committees established to work on the program as part of an interdisciplinary task force benchmarked evidence-based practices and competencies about patient teaching. They also looked at identifying a target audience, developing a curriculum, determining how to provide delivery of information or a strategy for teaching staff, and evaluating patient teaching competency.

Several strategies have been put in place to improve patient teaching competency. One committee did an extensive literature review, and from the information gathered, developed annotated bibliographies and summaries of all the material they found. From these findings, they created a document titled "Teaching Effectively to Advance Care and Health by Educating Staff."

These evidence-based guidelines provide six steps for creating a teaching plan and are available via the institution's Intranet to people throughout the organization. The steps include identifying a problem, conducting a needs analysis, developing goals and educational objectives, sequencing instruction, instructional strategy design, and evaluating learning outcomes. Each step has a detailed bibliography on the evidence to support the execution of each step, says Friedman.

Curriculum also was developed to improve patient teaching. "Maximizing Your Patient Education Skills" has three parts and people can enroll in one or all of the sections.

The first part of the course is designed to enhance the delivery of patient education by focusing on principles of adult learning and identifying communication styles. It helps staff become competent at recognizing the different learning styles of patients and families and adjusting their teaching style to those different learners.

### Use hands-on approach

While part of the class is a lecture, the students also do an exercise that provides hands-on learning. During this exercise, class participants are divided into small groups and they take turns working with four different patients, portrayed by trained actors, who have a particular learning style and communication preference that must be identified. The groups must interact with each patient and develop a teaching plan.

The second part of the course is based on the six-step strategy for developing a patient teaching plan. Participants in this course receive a sample teaching plan and learn how to identify educational objectives, the sequence of instruction, the instructional message including materials that could be used, and ways to evaluate the instructional message.

The third part of the course focuses on leadership development and mentoring skills to facilitate patient education competency among one's colleagues. People participate based on the recommendation of a supervisor or manager.

Friedman says the first two courses will eventually be delivered on-line as well as face-to-face instruction so those who cannot find the time to attend a class will be able to participate.

The next step in the process to improve patient teaching competency across the organization is to develop a way to evaluate whether the curriculum is on target. Some have suggested conducting a pre- and post-test using the trained actors posing as patients. They could interact with the "patient" in a preplanned scenario before taking the course and then after they have taken the course and worked in the field for six months.

Another evaluation strategy being considered is to look at changes in patient behavior after teaching. For example, with more competent teaching is the patient better able to use a particular device or participate more successfully in a treatment plan?

"This is a work in progress. Intuitively, we believe it is improving patient teaching but, we now need to know more about that," says Friedman. ■

# Hospice patients, families receive special support

*No 'I love yous' left unsaid*

For most people at the end of their lives, it's a comfort to know that their lives touched others and that some part of them will live on within the ones they love. With this in mind, Faith Hospice in Irving, TX, has created the Faithful Presence Program in which families can record on a professional-quality CD their thoughts and feelings about the person who is dying.

The patient is presented a copy of the CD as a gift from the family, and the patient's family receives copies as a legacy.

"Our purpose is to help the dying person get closure on his life and find meaning in his life," says **Don Weaver**, PhD, a consultant with Faith Hospice and a psychologist in private practice in Addison, TX.

"But most of all, the purpose is to help patients deal with the crisis of terminal illness in a way that enriches them," Weaver says. "What we do is rely on the family to help accomplish that."

The CDs include the family's memories, presented as vignettes about the patient, illustrating the patient's character and life interests, Weaver says.

For example, one patient's granddaughter recounted how her Christmas days were the only days of the year when she didn't feel like the "little poor child" because her grandfather pretended to be Santa and made certain she had gifts under the tree.

Family members will comment on the patient's positive qualities and resources, Weaver says.

"We have them say directly, 'I love you,' to the patient, and all of their comments are directed to the featured person, the dying person," Weaver says.

"Then we pull out the best of these remarks and put them on top of the featured person's favorite music, whether it's religious or secular," Weaver adds.

Sometimes the songs are sung by grandchildren or other family members.

Faith Hospice provides all patients with a CD player to have by the bedside, so patients can listen to their personal CDs, as well as to other music, while they are dying, says **Carol Bourland**, BS, manager of volunteer services for Faith Hospice.

The Faithful Presence Program is one of several programs the hospice provides to patients and families as part of their spiritual and emotional care, Bourland says.

The CDs have provided a great deal of comfort and solace to patients. Among the quotes the hospice has collected from patients were:

- "When night comes, and you settle down, and then it's just you and your thoughts, they're going to wander to those people that you've loved so much. And all you've got to do is just reach out and turn on your tape — and there they are, right there by your bedside."
- "I go to sleep with my tape almost every night. Just to think I can reach out, and touch a button, and hear my children's voices or my grandchildren, or my friends . . . I can just hear their voices. It's a comfort to me."
- "When I listen to that tape, I don't think about anything except what's on it. That's why I play it. Because I completely lose myself, and I just absorb it."

When the hospice made a CD for a patient who was nicknamed "Peewee," the staff brought the finished CD to his home, where he was surrounded by family, but had been unresponsive for a couple of days, Bourland recalls.

"He was restless, and we played the tape and saw him calming down," she says. "He tried to sing along with his favorite song, 'Amazing Grace.'"

## SOURCES

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## COMING IN FUTURE MONTHS

- Are your billing and clinical staff working against each other?
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Peewee had been a music director for a church in a small Texas town, and so music was very important to him, Bourland says.

"The family said, 'I believe the CD helped show him the way to heaven,'" she adds.

The idea of the Faithful Presence Program is to help patients and their families focus on the present and on the positives in their lives, while accepting the negatives from the past and future, Weaver and Bourland say.

"We knew this would be beneficial for hospice patients, but we didn't know what impact it would have on family members," Bourland notes. "We interviewed family members three months after the loved one's death, and the impact was incredible."

Family members said the CD helped them to have closure, and one woman said the CD helped her to teach her young daughter about death and dying, Bourland recalls.

"They played the CD at his funeral, and it brought them closer together as a family," Bourland adds.

Listening to a Faithful Presence CD might remind one of a National Public Radio feature segment. The voices are clear and the sound quality is sharp. The memories the family members relate can easily bring tears to eyes.

With two decades of experience in making the special CDs, Weaver has created an efficient model for their creation.

"The start-up cost is you have to have a good microphone and CD recorder and, hopefully, you'll have some gear that will delete noise from the initial recording, such as trucks outside or, especially if you're in a hospital, extraneous sounds," Weaver says.

The basic equipment could be purchased for less than $1,000, but there also is a need for editing, and that takes both time and money.

"Hospices can partner with area universities and get it edited and mixed to music by students, who will receive independent credit for their programs," Weaver says. "I've been passionate about this for 20 years, and even in the dark times when the funding was not there, I'd do it for free."

Family members, from babies to elderly spouses, contribute to the CD. Those who can speak are asked to tell stories about the hospice patient that highlights his or her unique qualities and character, commenting specifically on the person's inspiring qualities. They also are asked to express their love and gratitude directly to the dying loved one, cutting to the chase of what's important here and now.

These stories are recorded directly to a CD, and then they are edited and placed on a finished CD, with music added to the background. The music is what the patient or the patient's family says is important to the patient.

### Labor-intensive editing process

The editing process is labor-intensive, Weaver notes.

"We get the raw material on the hard drive and then go through it, and it's very systematic: we're looking for verbal content that falls into three categories of vignettes, positive qualities, and saying, 'I love you,'" Weaver says. "Everybody has to say, 'I love you,' or they don't get out of the room."

The editor will identify the first and last word of each segment that will be included on the finished CD, and then these are pulled by an audio technician to record on the finished CD.

"We identify the good segments and themes, and the technicians pull it together," Weaver says.

For example, a local television station has donated some editing time, Weaver adds.

"We take it to sound experts, who spend an hour and a half on it, and then it's a finished product," Bourland says.

"We are very persnickety about what gets on the final product," Weaver says. "We take the CD and pull out the nuggets, good segments, and arrange them on the person's favorite music."

The hospice does have to worry about using copyrighted material, but most artists when contacted will provide permission to use their music

for free, since the CD is given as a gift to patients and families, Bourland says.

Families and patients who've received the CDs say they help them stop focusing on fear of the future, Weaver says.

"They focus on the positive contributions and experiences they've had in the past," Weaver explains. "It's a dramatic shift, and they tend to live more in the present and take each day as a gift, detaching themselves from negative memories." ■

## CE *questions*

21. What is the biggest challenge for home health agency managers with the new instructions for the Home Health Advance Beneficiary Notice (HHABN), according to Rachel Hammon, RN, BSN?
A. Making sure that you don't issue too many HHABNs.
B. Verifying receipt of the HHABNs.
C. Applying the instructions to different scenarios within the specific agency.
D. Finding the appropriate form.

22. What is one of the reasons that employees are reluctant to accept new technology in a home health agency, according to Dale Reis, RN, BSN?
A. They will be replaced by a computer.
B. No training will be offered.
C. Their salaries will be cut.
D. Their workload will increase.

23. What is one part of your staff that you need to remember when planning training sessions because you will need to be flexible to meet their needs, according to Leslie Halchak, RN?
A. therapists
B. nurses
C. billing personnel
D. PRN staff

24. Optima Health's asthma disease management program resulted in a 20% decrease in emergency department visits.
A. True
B. False

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

## 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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■