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

MARCH 2008

VOL. 25, NO. 3 • (pages 25-36)

Know the disease, alter approach to care for multiple sclerosis patients

Waxing and waning symptoms make disease course unpredictable

An estimated 400,000 people in the United States are diagnosed with multiple sclerosis, an unpredictable neurological disease that can cause blurred vision, loss of balance, poor coordination, fatigue, and even paralysis and blindness. Because the typical patient is a woman between the ages of 20 and 50 when first diagnosed, she doesn't appear to be a likely home health patient, but experts interviewed by *Hospital Home Health* say that MS patients are not only likely patients, they also are patients who require a different approach in home health care.

"We know that about 25% of MS patients need long-term care services at some point of their life, with between 5% and 8% of those patients choosing nursing home care," says **Dorothy E. Northrop, MSW, ACSW**, vice president of research and clinical operations for the National Multiple Sclerosis Society in New York City. "Although we don't have statistics, I would guess that between 15% and 20% of patients are choosing home health care to provide assistance beyond what family members can provide," she says.

The type of assistance that MS patients require varies according to the type and stage of the disease, points out Northrop. (See pg. 27 for a **description of types of MS**.) Home health services may vary from personal assistance to therapy and nursing services, but even when more complex services are needed, the home health staff member needs to remember that MS patients have different psychosocial needs than a traditional home health patient, she adds. (For **information on MS patient guidelines for home health agencies**, see p. 28.)

"Most MS patients don't look ill and they don't want to be treated as disabled, so the caregiver may not realize that the patient requires assistance with something other than what the caregiver is providing," says **Kent Griswold, PhD**, president of Griswold Special Care in Erdenheim, PA. For example, a home health aide might be told to take care of the patient's needs, but if the patient is a woman with a family and children, taking care of the whole family's laundry as opposed to only the patient's laundry is meeting her needs, he points out. Providing care to

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an MS patient often means assisting with more than her immediate needs, he adds.

“MS patients want to maintain control of their lives as much as possible,” points out Northrop. For this reason, patients should be allowed to direct their own care as much as possible, she suggests. “Be sensitive to their feelings about loss of control of their bodies, loss of work life, and isolation from social outlets,” she says. “Approach development of their care plan in a collaborative manner.”

One way to demonstrate sensitivity is to avoid the word “care” as much as possible, says Northrop. “MS patients prefer to say they need assistance rather than care,” she adds.

Another way to show that you understand the disease is to admit that the patient is an expert on his or her particular condition and ask for input and ideas about the services needed, she says.

“MS patients don’t want to give up control over every part of their life,” points out Griswold. “They don’t want aides telling them what time to eat or what to do during the day,” he says. Aides who are preparing a meal, should not only ask the patient what he or she wants for lunch or dinner, but also ask if the patient would like to prepare it with the aide’s assistance, he suggests.

Empathy important for staff

Selecting staff members for the service line team for MS patients requires careful planning, says **Diane Walker**, RN, MS, general manager of Griswold Special Care. “You need someone who doesn’t see all home health patients as the same type of patient,” she says. MS has a unique effect on each patient, so the caregiver must be able to recognize that each MS patient has different needs and different symptoms, she adds.

“Most MS patients prefer a caregiver that is around their own age,” points out Griswold. There are a lot of social issues associated with MS that often isolate patients and the presence of someone to whom they can relate creates a better relationship, he says. “MS patients also don’t want someone wearing a uniform, which represents illness or disability,” he adds.

There is a wide range of symptoms that can affect patients, and home health staff members need to understand and recognize them in order to evaluate the patient’s condition, says Northrop. “One of the most difficult aspects of MS is the vacillation of the disease symptoms, especially fatigue,” she says. “A patient may feel fine in the morning but be exhausted in the afternoon,” she explains. The sudden fatigue may be easy to misunderstand as laziness or depression, but the caregiver needs to look at the whole picture rather than a single symptom at a particular moment in order to accurately assess the patient, she suggests.

The most challenging symptoms to manage are changes in the patient’s cognitive abilities, says Northrop. Cognitive changes may be subtle so patients and caregivers may not recognize them as part of the disease process or may attribute them to depression. Short-term memory loss and ability to organize and follow through on plans create additional stress for patients coping with

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S.A., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are \$83 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

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

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

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other symptoms. Caregivers can help patients by writing, or reminding patients to write instructions, to-do lists, and notes that will help them stay organized and on track, she adds.

When most MS patients seek home health assistance, they may not require much more than help with activities of daily living, says Northrop. The disease's progression, however, may make the need for more complex care necessary over the years, she adds. "It is important that there be a multidisciplinary team for MS patients because they may require occupational therapy, physical therapy, speech therapy, and nursing care at different times," she explains.

Because most MS patients are not elderly, they or their spouses are working, so about 65% have private insurance, points out Northrop. About 25% of patients have Medicare as a result of being covered by Social Security Disability and the remainder have Medicaid coverage or are uninsured. In addition to insurance coverage, families

may pay out of their own pockets for additional services, she says.

One way that home health agencies can help MS patients and their families is to identify other community resources, suggests Northrop. "Several of our local chapters have programs that offer intermittent help to families in times of need and they also maintain their own lists of community resources."

Making sure that staff members are educated and equipped to meet the needs of MS patients is a valid way to increase admissions and create a niche in the marketplace. The key to successfully providing services to MS patients is to learn about the disease and listen to the patient, says Northrop. "The goal should be to help patients be as independent and as well as they can be." ■

MS cases vary from patient to patient

Multiple sclerosis (MS) is thought to be an autoimmune disease that affects the central nervous system (CNS). Surrounding and protecting the nerve fibers of the CNS is a fatty tissue called myelin, which helps nerve fibers conduct electrical impulses.

In MS, myelin is lost in multiple areas, leaving scar tissue called sclerosis. These damaged areas are also known as plaques or lesions. Sometimes the nerve fiber itself is damaged or broken.

Myelin not only protects nerve fibers, but also makes their job possible. When myelin or the nerve fiber is destroyed or damaged, the ability of the nerves to conduct electrical impulses to and from the brain is disrupted, and this produces the various symptoms of MS.

People with MS can expect one of four clinical courses of disease, each of which might be mild, moderate, or severe.

Relapsing-Remitting Characteristics: People with this type of MS experience clearly defined flare-ups (also called relapses, attacks, or exacerbations). These are episodes of acute worsening of neurologic function. They are followed by partial or complete recovery periods (remissions) free of disease progression.

Frequency: Most common form of MS at time of initial diagnosis. Approximately 85%.

SOURCES/RESOURCES

For more information about multiple sclerosis patients and home health, contact:

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- **Dorothy E. Northrop**, MSW, ACSW, vice president of research and clinical operations, National Multiple Sclerosis Society, 733 Third Avenue, 3rd Floor, New York, NY 10017. Phone: (212) 476-0454. E-mail: dorothy.northrop@nmss.org.

To download a copy of the National Multiple Sclerosis Society's *Guidelines and Recommendations for Home Care Providers and Personal Care Assistants*, go to www.nmss.org. Select "For Professionals" on top navigational bar, then choose "PRC Publications" on left navigational bar. Scroll down page to the guidelines.

The National Multiple Sclerosis Society also offers telephone and e-mail consultation for home health and other health care providers who have questions related to care for their patients. The e-mail address is HealthProf_info@nmss.org. Toll-free phone number for consultation is (866) 678-7328.

Primary-Progressive Characteristics: People with this type of MS experience a slow but nearly continuous worsening of their disease from the onset, with no distinct relapses or remissions.

However, there are variations in rates of progression over time, occasional plateaus, and temporary minor improvements.

Frequency: Relatively rare. Approximately 10%.

Secondary-Progressive Characteristics: People with this type of MS experience an initial period of relapsing-remitting MS, followed by a steadily worsening disease course with or without occasional flare-ups, minor recoveries (remissions), or plateaus.

Frequency: 50% of people with relapsing-remitting MS developed this form of the disease within 10 years of their initial diagnosis, before introduction of “disease-modifying” drugs. Long-term data are not yet available to demonstrate if this is significantly delayed by treatment.

Progressive-Relapsing Characteristics: People with this type of MS experience a steadily worsening disease from the onset but also have clear acute relapses (attacks or exacerbations), with or without recovery. In contrast to relapsing-remitting MS, the periods between relapses are characterized by continuing disease progression.

Frequency: Relatively rare. Approximately 5%.

Reference

1. National Multiple Sclerosis Society, *What is Multiple Sclerosis*. www.nmss.org. ■

Various symptoms of multiple sclerosis

The unpredictable nature of multiple sclerosis (MS) presents challenges for both caregivers and patients who may wake in the morning with no symptoms and then find themselves fatigued and experiencing pain or cognitive problems in the afternoon. The best way for home health providers to help MS patients is to be aware of the variety of symptoms and understand that some affect some patients more than others, says **Kent Griswold**, PhD, president of Griswold Special Care in Erdenheim, PA.

Some of the more common symptoms are:

- **Loss of sensitivity or numbness**

“MS patients may lose their ‘ouch’ factor,” says **Dorothy E. Northrop**, MSW, ACSW, vice president of research and clinical operations for the National Multiple Sclerosis Society in New York, NY. The lack of sensation, especially in the lower extremities, makes it important for the patient and the home health staff member to be extra vigilant and look for cuts, infected insect bites, or other injuries. “The lack of sensation means that patients may not know they hurt themselves even if they need medical attention,” she explains.

- **Depression and other emotional changes**

The frustration and anger that a patient feels as a result of the unpredictable nature of MS often leads to depression, say Northrop. “About 50% of MS patients are diagnosed with clinical depression at some point in their disease,” she adds. Home health workers should not, however, automatically assume that a patient’s demeanor, fatigue, or lack of focus is related to depression because these changes can be part of the disease itself, she cautions.

- **Fatigue**

“MS patients may have a limited quantity of energy,” says **Diane Walker**, RN, MS, general manager of Griswold Special Care. “A home health worker should let the patient pick and choose which activities he or she wants to do,” she suggests. For example, the home health aide may focus on laundry and washing dishes so the patient has energy to focus on her children, she explains. Because an MS patient does not know from day to day what her energy level might be, an aide should not assume that she needs to assist the patient with the same activities each time, she adds. “What would you like me to assist you with today?” is a question that should be asked each visit, she says.

- **Pain**

“Physical therapists can offer helpful techniques with range of motion exercises and the use of heat or cold to treat pain,” says Walker. If the patient is taking pain medication, home health staff members need to be aware that the medication may exacerbate cognitive problems so a task that is easy to accomplish one day may be impossible the next, she adds.

- **Difficulty walking**

Gait problems are common in MS patients within 15 years of their diagnosis. The problems may be caused by the disease’s damage to nerve pathways, which hampers coordination, or by

fatigue. Physical therapists can often improve gait with exercise or assistive devices or medication may improve coordination. ■

Select deemed status survey to save time

Joint Commission option eliminates need for survey

No home health manager looks forward to any type of survey but agencies that elect to undergo a deemed status survey by The Joint Commission can take care of two surveys in one visit.

The deemed status survey option not only serves as The Joint Commission accreditation survey, but also replaces the state Medicare survey, according to **Debra Zak**, PhD, RN, executive director of the Home Care Accreditation Program. "The deemed status survey determines compliance with federal conditions of participation [CoP] requirements and conditions of coverage and evaluates compliance with The Joint Commission's standards," she says.

Although the survey is not a state licensure survey, The Joint Commission is recognized in 24 states for renewal of licenses, says Zak. "Our survey is not recognized by states for the initial license," she adds.

Home health agencies must meet the criteria of both The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) to be eligible for a deemed status survey. The Joint Commission requires that an agency have served 10 patients with seven active at the time of survey. CMS requires at least one therapeutic service or home health aide service be provided in addition to skilled nursing services.

Because CMS has fewer requirements for a hospice survey than The Joint Commission, agencies must meet Joint Commission requirements for eligibility, says Zak. The Joint Commission requires that a hospice have served 10 patients with two active patients at the time of the survey. CMS has no patient volume requirement.

A significant change to The Joint Commission's general eligibility requirements is the elimination of the need to have four months' data on compliance, says Zak. "Now, every organization is expected to be compliant at the time of the survey," she explains.

Agencies that are already accredited by The Joint Commission can request a deemed status survey be conducted at the same time as their accreditation survey when it is scheduled or, if an agency is a year or more away from the regular survey, an agency can request a Medicare CoP survey prior to the accreditation survey, says Zak. "Agencies cannot request a Medicare-only survey for an initial survey," she adds.

Even if an agency is Joint Commission accredited and Medicare certified, it cannot be automatically given deemed status, says Zak. "Deemed status is an option and must be selected by the agency," she adds.

Following the survey, an organization has a 10-day period to explain reasons that a document could not be produced or respond to other items on the report. If an organization has a standard out of compliance, there is a 45-day period to submit evidence that the organization is in compliance, says Zak. "Standard-level deficiencies must be corrected before Joint Commission can recommend accreditation to CMS," she points out.

One area that poses problems for many agencies is the CMS requirement that a professional advisory committee be in place, says Zak. "This is a CMS requirement not a Joint Commission requirement but CMS does not bend on compliance with it," she adds.

In addition to cutting one extra survey out of your busy schedule, Zak points out that CMS is overburdened and cannot always perform surveys in a timely manner. Agencies also have the ability to talk one-on-one with trained professionals to discuss best practices that can help with challenges that are faced by the organization, she adds.

[Editor's note: To apply for a deemed status survey, contact Jasmina Juric, business development specialist, at (630) 792-5251 to request an application. An online application can be accessed at www.jointcommission.org/Hctoolkit.] ■

Community-based CMs help clients navigate health care

Closer relationships mean more effective care plans

Faced with a complex, difficult-to-negotiate health care system, multiple providers, and

myriad treatment options, many health care consumers are looking for somewhere to turn, and that means opportunities for case managers, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM.

“Consumers pay for tutors for their children. They pay for legal advice and financial advice. Why wouldn’t they be willing to pay for an independent professional case manager to be their advocate as they visit the doctor, to help them understand their treatment options and their medication and to help sort out the confusion” says Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company.

Mullahy frequently hears case managers say they are discouraged by increasing paperwork that takes them away from direct patient contact. But while they are not satisfied with their jobs, they don’t want to leave the field.

Community-based case management gives independent case managers the satisfaction of developing long-term relationships with their patients and allows them to balance their home life and their professional life, she says.

Getting back to the patients

“The process of case management works so well but you can’t do effective case management when you have a caseload of 100 patients. Case management is so individualized and involves so many components. The best way is to put case managers in the community. When you can see a person in his own environment and develop a personal relationship with him, you can be a better advocate,” she says.

Her words are echoed by **Susan Moore**, RN, PN, a Chicago-based case manager who specializes in oncology and contracts with cancer patients and their families to support them through diagnosis, treatment, and survivorship.

“Meeting with people helps develop a closer relationship. The people I see personally think of me as a nurse case manager, advocate, and a friend. Those I work with by telephone see me as a nurse case manager and a resource, but the personal contact is lacking,” she says.

When Mullahy speaks at health care seminars and forums, she asks the nurses if they have patients who are readmitted to the hospital or visit the emergency department over and over again because of something that happens after discharge.

Regardless of the setting in which the nurses work, the answer is always “yes.”

Discharge plan problems rampant

Patients are getting out of the hospital quicker and sicker but hospital discharge planners don’t have the time to make sure that the discharge plan that looks great on paper really works, Mullahy says.

“Sometimes the patients are being treated by multiple physicians and they don’t know which practice to call when they have symptoms. They call and get voice mail and the problem isn’t corrected so they go to the hospital and are treated by yet another doctor,” she says.

Chronically ill or catastrophically ill patients may be receiving telephone calls from a case manager, a disease manager, a health coach, and a discharge planner, but they don’t talk to each other and none of them know what’s going on in the home or what issues or obstacles to adherence the patient may be facing.

“The health care system is broken. The process of case management is a wonderful process and it’s not broken. What is broken is where and how case managers are being used,” she says.

Mullahy recalls the words of a patient in the hospital coronary care unit where she started her nursing career.

“I was telling him how he needed to make lifestyle changes, to pace himself better, and to consider another job. He said, ‘You have no idea what my life is like,’ and he was right. You can’t possibly know what an individual’s life is like and help him or her make lifestyle changes until you have a relationship with them,” she says.

Case managers can’t determine whether their discharge plan will work unless they know what is going on in the home. Is it in a trailer park or the inner city; is it crowded and dirty? All of those factors can affect the discharge plan and the patient’s ability to adhere to the treatment plan, she says.

“I remain convinced that the best way to do case management is on site,” she says.

The on-site model

The model is already working with geriatric case managers who help manage the care of elderly patients whose children are living in other parts of the country, Mullahy says. Many geriatric case managers are social workers but there are

many elderly people with complex conditions who could benefit from the help of a nurse case manager, she adds.

"You can't work with elderly Medicare patients over the telephone. You have to see them up close and personal to determine what is wrong. Some have dementia. Some have personal problems. Many have hearing problems. You can't work with them telephonically and you can't expect them all to use a web site to obtain the answers to the questions they may have or get the reassurance they need," she says.

Some insurance companies are beginning to provide face-to-face interventions for their high-risk clients. For instance, WellPoint locates community resource centers in areas where there is a large population of members in its publicly financed insurance programs in order to better serve its members by building a relationship.

"We realized that we couldn't adequately serve members' complex medical and social needs with just a toll-free number. With people whose needs are so complex and far-reaching, it takes a personal relationship to make a difference," says **Nancy Atkins**, MSN, RNC, NP, vice president of state-sponsored business for WellPoint.

But the elderly and other publicly funded clients are not the only people who could benefit from an independent, community-based case manager, Mullahy adds.

People who are catastrophically ill, people who are newly diagnosed with cancer, those with life-changing illnesses such as congestive heart failure or end-stage renal disease, parents of children with multiple handicaps or chronic illnesses could all benefit from someone who could help them understand their condition, evaluate treatment options, and help them comply with the treatment plan, she says.

"The goal would be to empower patients and families to become their own case managers. Some people may need only a few weeks of help until they understand what's going on. Others may need case management for several months," she says.

In addition to patients and family members, sources of referrals for community-based case managers may be treating physicians, Mullahy points out.

"As the trend toward giving physicians pay-for-performance incentives continues, some physicians are hiring case managers to help them improve the outcomes for complex patients. There is more recognition that complex patients

need a different kind of intervention," she says.

Sources of referrals could include physicians who have difficult-to-manage patients, financial advisors who work with trust funds on behalf of individuals who suffered birth injuries or life-altering injuries from accidents, employers that offer health savings accounts, or self-insured employer groups not large enough for a managed care case management program.

"There's a push toward consumer-driven health plans and consumers assuming control of their health care but the system we have is not one that works for the average person. Of equal concern, the system is difficult even for those of us who have worked in the midst of it for all our professional lives. Patients and their families need someone to advocate for them and to help them through the health care maze and the community-based care managers can be that caring professional," Mullahy says.

(For more information, contact **Catherine M. Mullahy**, Mullahy and Associates, Huntingdon, NY. E-mail: cmullahy@mullahyassociates.com. Web site: www.mullahyassociates.com.) ■

Six Sigma projects add efficiency to discharges

Hospital system improves patient throughput

Six Sigma projects at Sharp HealthCare hospitals have dramatically shortened the time that elapses between the time that discharge orders are written and the time the patient leaves the acute care setting.

The Six Sigma team at Sharp Chula Vista (CA) Medical Center shortened the time it takes for patients to be transferred to skilled nursing facilities after the discharge orders are written from a median of four hours to a median of 3.3 hours. Projects at Sharp Grossmont Hospital and Sharp Memorial Hospital shortened the median time between discharge orders and actual discharge from 2.2 hours to a median of about 1.5 hours.

The teams determined that using the median was a better measure than using averages because there are always outliers that unduly influence the average, says **Patricia Atkins**, MS, RN, CNS, director of Lean Six Sigma and a certified ASQ Six Sigma Black Belt.

"The case managers were involved in all

phases of the projects because they are involved with the patients from admission through the discharge process,” Atkins adds.

Sharp HealthCare’s case management department includes RN case managers and care coordinators, who are clinicians but who are not RNs. For instance, some are foreign-trained physicians who are not licensed to practice in this country; others are licensed vocational nurses.

Case managers are unit-based with an average caseload of one to 25 cases. Their primary responsibilities are utilization review and discharge planning.

The health system has a centralized Lean Six Sigma department that works on projects with the staff at each of the system’s four acute care hospitals.

Identifying projects

The hospitals identify potential projects proactively by reviewing performance indicators for key health care processes and reactively by reviewing customer complaints and quality variance reports in problem areas.

Each hospital submits proposed projects and the executive steering committee sets priorities for the health care system. Each Lean Six Sigma project is developed and carried out by a multidisciplinary team. The projects typically take four to six months, and often longer if they are complex, Atkins says.

The Lean Six Sigma projects at the different hospitals had similar high-level processes and goals but the strategies and tools were tailored to conform to the systems and structures at each individual hospital, she adds.

“We ran our projects concurrently with separate teams at each hospital and a project manager [that] collaborate to share the best practices we discover along the way with the teams at all the hospitals. This approach works best because there are different cultures and systems within the different entities,” Atkins reports.

Before beginning the discharge project at Sharp Chula Vista, the case management department went through the Team Resources Management (TRM) training to improve their teamwork skills.

The TRM program includes training on work distribution, conflict resolution, hand-off strategies, and communication improvement strategies, such as checking to make sure a message was received.

“The program was offered throughout Sharp HealthCare to give the staff the tools they need to

be effective in working with each other. The participants learned what their expectations are as a team member, within the hospital as a whole, and on the unit level. This training on working as a team creates a foundation to make it easier to change long-standing processes,” Atkins says.

When the staff at Chula Vista Medical Center reviewed discharge times, they determined that they had the most opportunity to affect the discharges to skilled nursing facilities, says **Cheri Graham-Clark**, RN, MSN, PHN, director of quality improvement and care management/patient safety officer.

The majority of patients are discharged to the 100-bed skilled nursing facility located on the hospital campus or one of six other facilities within 10 miles of the hospital in locations that are most convenient to the patients’ families.

Smoothing discharge to SNFs

The Chula Vista Six Sigma team started by looking at the time that elapsed from when the physician issued the discharge order until the patient actually left acute care.

“When we started the project, it was taking approximately 10 hours from the time the discharge orders were issued until the patient was transferred to a skilled nursing facility. Our goal was to get the time down to four hours,” Graham-Clark says.

The team reviewed patient records to find out the roadblocks to a speedy discharge and drilled down to determine what could be done to increase efficiency and decrease the delays.

“Many of the reasons for the delays were around standard work flow and teamwork issues. There was not a standard process for handling skilled nursing facility discharge forms, limited knowledge of what facilities could take what kind of patients, and gaps in communication between the case managers and other providers,” says **Jason Broad**, MBA, certified Six Sigma Black Belt.

The team determined that the case managers were spending a lot of time providing information to skilled nursing facilities that wasn’t necessary for the facility to make a decision as to whether it could provide appropriate care for a patient.

The hospital invited all of the key stakeholders in the skilled nursing referral process to a meeting to brainstorm on what information case managers should provide when they refer patients. Participants included the hospital case managers, and case managers from the Sharp

skilled nursing facility and from others in the immediate area.

At the time, each of the skilled nursing facilities had different requirements for information they needed in order to decide if a patient was appropriate.

The Six Sigma team members worked with the skilled nursing facility to create standard expectations so that case managers could provide the same information for each referral.

By doing so, the team was able to reduce the information that the case managers were sending by 30%, Broad says.

This step saved the case managers 10-15 minutes or longer for each patient referred to a skilled nursing facility.

The team determined that case managers were spending a lot of time contacting facilities that could not provide services to a particular patient. The case managers on the team came up with a list of the types of patients who were difficult to place, such as those who needed wound vacs or ventilation equipment.

The team created a list of skilled nursing facilities throughout the county, contacted them, and found out which kinds of patients they could accept.

"This helped to narrow down the choices for patients and families and eliminated telephone calls to facilities that were not appropriate for a particular patient," Broad says.

The team tackled improving efficiency in the case managers' work stations using a Lean Six Sigma approach called "the 5S," a five-step methodology for improving the flow and organization in the workplace. The steps are: sort, straighten, shine, standardize, and sustain.

"The purpose of the 5S is to make the environment efficient so that workers have everything they need where they need it and when they need it and there is no wasted time looking for things," Atkins says.

The team looked at the design and placement of the workspace, the computer access, the efficiency of the work process, and the flow of information between the physicians, nurses, and the case managers.

At the time of the project, the case managers' work stations were located in a corner, where people had to seek them out.

"They were not in the natural flow of the physicians and nursing providers. Simply relocating the workstations so the case managers were visible and available to the physicians was

a key to improving communication," Atkins says.

Observing workflow

By observing the workflow on the unit, the team determined that the case managers were spending a lot of time walking out of their work area to the other end of the unit to the fax machine. Moving the fax machines to a more convenient location and, in one case, purchasing an additional fax machine for the unit saved time for the case managers.

When the Lean Six Sigma teams at Sharp Grossmont Hospital and Sharp Memorial Hospital looked at improving discharge times for routine discharge, they determined that the delays were occurring because the staff were often being reactive to the physician's discharge orders, rather than taking a proactive approach to discharges that were going to occur in the future.

"The treatment team wasn't systematically talking today about tomorrow's discharges. They were waiting until the physician actually wrote the orders. We wanted to develop a systematic way of keeping the team aware that a patient is probably going to go home the next day so they can be prepared," Atkins says.

Solutions to the project included creating an icon placed on the spine of the chart, notifying staff that a patient is likely to be discharged the next day, a discharge checklist inserted into the communication forms on each unit, and a standardized computerized screen for home care education.

"With this project, it was difficult to come up with a meaningful figure to measure because there are so many outliers whose discharge takes longer than average for so many reasons," Atkins says.

The team decided to measure median time from discharge order to the time the patient was out the door. The median dropped from 2.2 hours to 1.5 hours.

"It is really hard to change a median, so even though it seems like a small improvement, it is statistically significant," Atkins adds.

Instead of documenting probable discharges in the chart and raising the possibility that an insurance company could issue a denial, the team created an icon that anyone on the treatment team can place on the spine of the patient's chart if the patient is likely to be discharged the next day.

The icon is a sticker of a car, in keeping with the theme of the project: "Way to Go."

The car icon calls the treatment team's attention to the fact that the patient is expected to be dis-

charged and alerts them to make sure that all the patient's discharge needs are met.

"This is not like an actual discharge order but it encourages the team to start talking to the family, arranging transportation, setting up home health care or durable medical equipment deliveries, and taking care of other discharge needs," Atkins says.

The team created a discharge checklist to insert into each unit's communication form.

Since each department in both hospitals uses a different type of form to communicate between staff and has different information needs, the Lean Six Sigma team decided not to create a new form, Atkins says.

Instead, they took whatever communication form each department used and inserted the items that need to be double-checked before discharge, such as durable medical equipment, home health services, transportation, and patient education.

Before the Lean Six Sigma initiative, the case managers, nurses, and physical therapists documented home care instructions on a different screen. The team created a centralized documentation screen so everyone on the team could communicate potential barriers to discharge and proactively work together to address those barriers.

(Editor's note: For more information, contact Patricia Atkins, e-mail: patricia.atkins@sharp.com.) ■

NEWS BRIEFS

CMS releases final HIPAA Security Educational Paper

The Centers for Medicare and Medicaid Services (CMS) has released the final paper in the HIPAA Security Educational Paper series. Entitled *Security Standards Implementation for the*

Small Provider, the paper is intended to assist small health care providers with HIPAA security rule compliance. In addition to an overview of the Security Rule standards as they apply to small organizations, the paper includes a table that describes each standard, an example of proper implementation, and questions that each organization should ask in order to evaluate compliance.

The other papers in the series include:

- Security 101 for Covered Entities;
- Security Standards Administrative Safeguards;
- Security Standards Physical Safeguards;
- Security Standards Technical Safeguards;
- Security Standards Organizational, Policies and Procedures, and Documentation Requirements;
- Basics of Risk Analysis and Risk Management;

To see a copy of the *Security Standards Implementation for the Small Provider* go to <http://www.cms.hhs.gov/EducationMaterials/Downloads/SmallProvider4final.pdf>. ■

Pathways explain fee for service

The Centers for Medicare and Medicaid Services (CMS) has published *Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals* as an educational tool for fee-for-service (FFS) health care staff who are unfamiliar with the Medicare Program, as well as for those professionals looking for easy access to the many resources on the CMS website. Using a "road trip" motif, the pathways lead users through nine sections of information covering the Medicare Program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items. The pathways can be accessed at <http://www.cms.hhs.gov/apps/training/guidedpathways/index.html>. ■

COMING IN FUTURE MONTHS

■ What bugs are hiding in your bag?

■ Future of home health: New business model ensures success

■ The importance of education in disease management

■ Telehealth for therapy? It can work

Home Health PPS fact sheet published

The Home Health Prospective Payment System Fact Sheet, which provides information about home health coverage and elements of the Home Health Prospective Payment System, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ■

Home care issues may play part in election

The American Association of Retired Persons has dubbed the 2008 election as "the 50-plus election," estimating that voters age 50-plus will turn out in even greater proportions than the 52% reported by exit polls during the 2006 elections.

According to a national telephone survey of 1,000 American adults, Americans age 55 and older are more likely (83%) to express support for candidates who support home care, compared to the 18 to 54 age group (76%). Approximately 69 million Americans are 55 or older.

The survey also showed an overwhelming majority (78%) of American voters say they would vote for congressional candidates who would strengthen Medicare coverage for power wheelchairs, oxygen devices, hospital beds, and other durable medical equipment and services used in the home. ■

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CNE questions

9. What percentage of multiple sclerosis patients are most likely to use home health care, according to **Dorothy E. Northrop**, MSW, ACSW, vice president of research and clinical operations for the National Multiple Sclerosis Society?
 - A. 5 to 10%
 - B. 15 to 20%
 - C. 25 to 30%
 - D. 30 to 40%

10. The most common type of multiple sclerosis is:
 - A. relapsing-remitting
 - B. primary-progressive
 - C. secondary-progressive
 - D. none of the above

11. **Debra Zak**, PhD, RN, says the deemed status survey option serves as The Joint Commission accreditation survey, and replaces the state Medicare survey.
 - A. True
 - B. False

12. **Catherine M. Mullahy**, RN, BS, CRRN, CCM, says the community-based case management model is already proving successful in the pediatric population.
 - A. True
 - B. False

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

On-line bonus book for *HHH* subscribers

Readers of *Hospital Health Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

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

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CNE 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. ■

CNE 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 **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. ■