Hospice and CommunityCare INSURANCE SERVICES℠
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Update

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Important news about insurance and risk management for hospice and community service organizations.

IN THIS ISSUE:

We welcome your comments and questions.

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International and National Patient Safety Initiatives

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Patient safety has been increasingly in the spotlight in recent years. In late 2004, the first meeting of the World Alliance for Patient Safety was held in Washington, DC. This meeting brought together heads of agencies, health policy-makers, patient groups and the World Health Organization for the purpose of advancing patient safety and the goals established, [1] "First do no harm" and [2] reduce adverse health and social consequences of unsafe health care. [http://www.who.int/patientsafety/worldalliance/en/]

This was the forerunner of many collaborative efforts on the international, as well as the national front. Leaders in patient safety initiatives include the World Health Organization [WHO], Department of Defense (DoD) Patient Safety Program, Agency for Healthcare Research and Quality (AHRQ], as well as the Joint Commission for Accreditation of Healthcare Organizations [JCAHO]. In 2005, the World Health Organization (WHO) designated the Joint Commission on Accreditation of Healthcare Organizations and Joint Commission International as its Collaborating Centre on Patient Safety.

High5s Initiatives

The World Health Organization brings together international representation through the Commonwealth Fund [Australia, Canada, New Zealand, the United Kingdom, United States of America, Germany and the Netherlands]. This group is part of the WHO World Alliance for Patient Safety and together these nations have streamlined their patient safety focus to 5 key initiatives. These initiatives, the High5s, and solutions are focused on preventing avoidable catastrophic adverse events [defined as death or serious injury]. The High5s initiatives are:

- Prevention of patient care hand-over errors
- Prevention of wrong site / wrong procedure / wrong person surgical errors
- Prevention of continuity of medication errors
- Prevention of high concentration drug errors
- Promotion of effective hand hygiene practices

[http://www.who.int/gpsc/elements/en/index.html]

Other Global Patient Safety Challenge initiatives are focused on:

- Blood collection, processing, antisepsis safety
- Injection and immunization safety
- Safe clinical procedures [specifically in the surgical setting]
- Safe water and sanitation in health care
- Hand hygiene

[http://www.who.int/gpsc/elements/en/index.html]

Hand hygiene is a key element in patient safety and can be found in many initiatives. Proper handwashing is essential to providing safe care and is believed to be the first line of defense in preventing the spread of organisms and infections.

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International and National Patient Safety Initiatives

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National Center for Patient Safety [NCPS]

This Center, established by the Veteran's Health Administration [VA] came about as a result of this health care setting's concerns regarding patient care quality and safety. This center looks at the human, as well as biomedical factors that impact patient safety. The NCPS provides resources to health care providers for their use in improving patient care and safety. Some of these resources include a Patient Safety Curriculum, correct surgical intervention strategies, medication safety [High Alert Medications] tools, falls [Focus on Falls] prevention education, root cause analysis tools and other related education and program resources. These assist the health care provider in developing, implementing and monitoring the effectiveness of its comprehensive patient safety program. The primary initiatives of this center are the creation and applications of knowledge, development of a patient safety culture and increasing pubic awareness of the importance of patient safety initiatives. [http://www.npsf.org/html/psofficer.html]

TeamSTEPPS

The Department of Defense (DoD) Patient Safety Program works with the Agency for Healthcare Research and Quality (AHRQ) to focus on improving patient safety through the development of a team approach to care. This program, titled TeamSTEPPS, operates on the premise that by establishing an evidenced-based teamwork system to improve patient safety, better outcomes and results can be achieved. TeamSTEPPS also provides resources and training materials to integrate these principles within the health care provider's organization. This curriculum, a multimedia resource, provides training focused on optimizing care outcomes and patient safety and includes CDs, DVD, pocket guide and presentation materials. [http://www.ahrq.gov/qual/teamstepps/]

JCAHO National Patient Safety Goals

As part of its organizational initiative, the Joint Commission International Center for Patient Safety (ICPS) was established as a combined initiative of the Joint Commission and Joint Commission Resources (JCR). The mission of the center is: To continuously improve patient safety in all health care settings. [www.jcipatientsafety.org]

The Joint Commission focused on patient safety as part of the accreditation process. The sentinel event reporting and root cause analysis process provided data relative to safety issues within the health care setting. These reports and findings became part of the foundation for the development of national patient safety goals. The Joint Commission's National Patient Safety Goals are revised each year. The 2007 Patient Safety Goals have just gone into effect and the proposed 2008 Patient Safety Goals are currently under review. The 2007 and 2008 goals add new areas of patient safety emphasis. In 2007, community-based providers, home health, hospice and private duty were impacted with revisions in only two of the National Patient Safety Goals. These were focused on medications provided at time of discharge or transfer to and from the organization [Goal 8B] and home fires associated with long-term oxygen therapy [Goal 15, 15B].

Patient Safety goals for 2008, currently under field review that would affect community based care providers, include additional requirements for one existing goal and two new proposed goals. Goal 3, Improve the safety of using medications, has new requirements related to anticoagulation therapy and details the process, procedures and protocols for safe anticoagulation therapy within the community based care setting. Proposed Goal 18, Health Care Worker Fatigue, focuses on the potential impact on patient safety and the potential for patient harm resulting from health care worker fatigue. This proposed goal includes requirements related to scheduling, task differentiation and annual training on worker fatigue. Goal 19, Catheter Misconnections, addresses the potential harm resulting from catheter and tubing misconnections and strives to prevent these care errors. This goal would require a risk assessment, procedure development and education to address the process of tubing disconnects and reconnects in order to decrease this preventable care delivery error. [www.jcaho.org]

It will be important to follow the progress and implementation and evaluation of these goals as they are further integrated into the provider settings. These goals are similar to other international and national patient safety directives for health care provider organizations.

Fire Safety

One patient safety goal with increased emphasis in 2007, is that of fire safety and patient care delivery. This increased focus is due in part to the high percentage of the sentinel events related to fires being reported by home care providers [over 40%] to the Joint Commission. Key risk factors identified for potential fire within the home include individuals living alone, those with cognitive impairments, lack of or non-functional smoke detectors and smoking in the presence of oxygen. In addition, during the winter months, there is the tendency to use space heaters, fireplaces and other means of heating the home, which also leads to an increased risk for home fires to occur.

Assess and Address Risk

In order to determine the risk factors present, it is important to conduct a risk assessment and follow up this risk assessment, with actions aimed at prevention, education and ongoing monitoring as needed. The best time to begin to address this patient safety concern is at the time of

admission. During the admission process, a home safety assessment should be completed, with ongoing reassessments regularly included as part of the care delivery process. In addition to the assessment, education relative to general, as well as specific findings is also an important safety strategy. An assessment of the care setting alone is only one component of the risk assessment process. The patient and/or family caregiver should also be assessed for understanding, capability, ability, compliance and follow up to safety suggestions made.

In homes where oxygen is not present, there are basic fire prevention guidelines that should be followed. Sample fire prevention and home safety education tools would include the following key hints for fire prevention and fire safety.

Fire Prevention

1. Do not smoke in bed, on the sofa or when lying down.
2. Stomp out lit cigarettes or cigars and throw out smoking tobacco into a large, heavy metal or glass ashtray.
3. Dampen cigarette butts and ashes and throw them into metal or sealed glass containers.
4. Close the bedroom door when you go to sleep. This will slow a fire from coming into your room.
5. Do not allow trash cans to overflow. Empty trash cans when full.
6. Throw away newspapers and other paper products every day. Do not allow them to accumulate into a stack.
7. Do not leave the kitchen with food cooking on the stove.
8. Turn handles of hot foods towards the center of the stovetop.
9. Keep stove tops clear of clutter.
10. Keep matches and lighters out of the reach of children.
11. Have a multipurpose fire extinguisher [ABC extinguisher-with the UL label] in your kitchen and in other hazardous areas, such as the garage. Make certain the fire extinguisher remains functional.
12. Place smoke and fire detectors on each floor of your home [Entrance to bedroom, bottom and top of stairwells].
13. Test and clean smoke and fire detectors every month and change the battery twice a year [when daylight saving time goes into effect and upon return to standard time].
14. Store combustibles in a metal cabinet or metal container away from heat or flames.
15. Do not store gasoline or other flammable liquids.
16. Have your furnace inspected and cleaned by a professional each year.
17. If using a fireplace or wood / coal burning stove, have the chimney inspected and cleaned by a professional every year.
18. Be alert for natural or propane gas leaks. Do not turn on lights or use an open flame, if gas is smelled.

Fire Evacuation Hints

1. Establish a fire exit route from the home if a fire should occur.
2. Determine alternative exit routes based upon the location of the fire within the home.
3. Set a safe meeting place outside the home.
4. Establish an offsite communication plan.
5. Assign someone to assist the disabled, elderly and children to exit the home.
6. Place a sign on the bedroom windows of those requiring help to exit the home.
7. Have each person within the home practice opening the exit windows.
8. For upper floors, install chain drop down ladders and practice their use.
9. Conduct a fire evacuation drill, from the home, at least twice a year.

Should a Fire Occur:

1. Remain calm.
2. Feel doors for heat before opening them.
3. Do not open a hot door.
4. Stay low when exiting the area; such as crawling along the floor to decrease smoke inhalation.
5. If unable to exit, place wet towels below the doors to stop smoke from entering the room.
6. Do not take time to call the fire department from the home when there are flames or smoke in the house.
7. Follow the offsite communication plan [such as the use of a neighbor's phone].
8. Carry out the evacuation/exit plan as practiced.
9. Do not go back into the home once you have exited.

Excerpted From: Gingerich, BS. , [2002]. *SAFETY MANUAL for the HOME CARE ORGANIZATION*. 4th Edition. Advantage Publications. York PA.

Oxygen Use Safety

In addressing fire safety within the care setting, another primary area of attention is oxygen use safety. This includes the posting of no smoking/no open flames notices on the door of the patient's room, or any room where the oxygen equipment is present. Examples of do and do not hints for safe use of oxygen guidelines, include:

- **Do not** allow anyone to smoke within 12 feet of oxygen or oxygen tubing, even when oxygen is turned off.
- **Do not** use oxygen within 12 feet of an open pilot light [stove, dryer].
- **Do** use the portable liquid oxygen unit only in its upright position.
- **Do** place an Oxygen In Use sign at all entrances to the home.
- **Do** keep the telephone number and inform the electric company, if an oxygen concentrator is in use, in case of electric outage.
- **Do not** change or adjust the amount of oxygen without contacting your physician.
- **Do** clean the equipment, as instructed, regularly. [Gingerich.2002]

Summary

In addition to assessing and reducing risks within the patient's care setting, providers are challenged to be aware of national and international patient safety initiatives that relate to health care. It is also important to be aware of the many resources available without charge to assist the provider in developing and implementing its organization wide safety program. Through the use of resources and staff initiatives, organizations will better identify and address risks associated with care delivery and as a result, be better prepared to reduce risks and increase patient care quality and safety.

To contact the author, please visit our web site at www.hccis.com, and click on the "Contact Us" icon.

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Gingerich, BS., DO Ondeck.[2002]. *Clinical Pathways for the Multidisciplinary Home Care Team.* 2nd Edition. Aspen Publishers: New York NY.

TeamSTEPPS: Strategies and Tools to Enhance Performance and Patient Safety. October 2006. Agency for Healthcare Research and Quality, Rockville, MD.

www.ahrq.gov- Agency for Healthcare Research and Quality

www.jcaho.org- Joint Commission on Accreditation of Health Care Organizations

www.jcipatientsafety.org- Joint Commission International Center for Patient Safety

www.npsf.org- National Patient Safety Foundation

www.who.int- World Health Organization

Patient Safety and Risk Reduction in the Private Duty Care Setting

Barth Holohan, MSW, MBA, President Continuum

In private duty home care, the ultimate goal is maintaining patient satisfaction. Because the consumer selects the private duty company from a wide range of choices, it is inherent in the company's business model to keep clients, their families and those referring to the company happy with the service. Maintaining patient satisfaction includes emphasizing patient safety. That emphasis also includes risk reduction, as this is essential to the process.

Patient satisfaction starts initially in the actual hiring process in a private duty home care company. The onus of quality standards falls on the business to create a system that integrates patient safety and satisfaction in each and every possible juncture from screening, to orientation, to hiring, to on-the-job supervision and training. This quality standard continues and is incorporated into the learning process throughout the employee's career with the company.

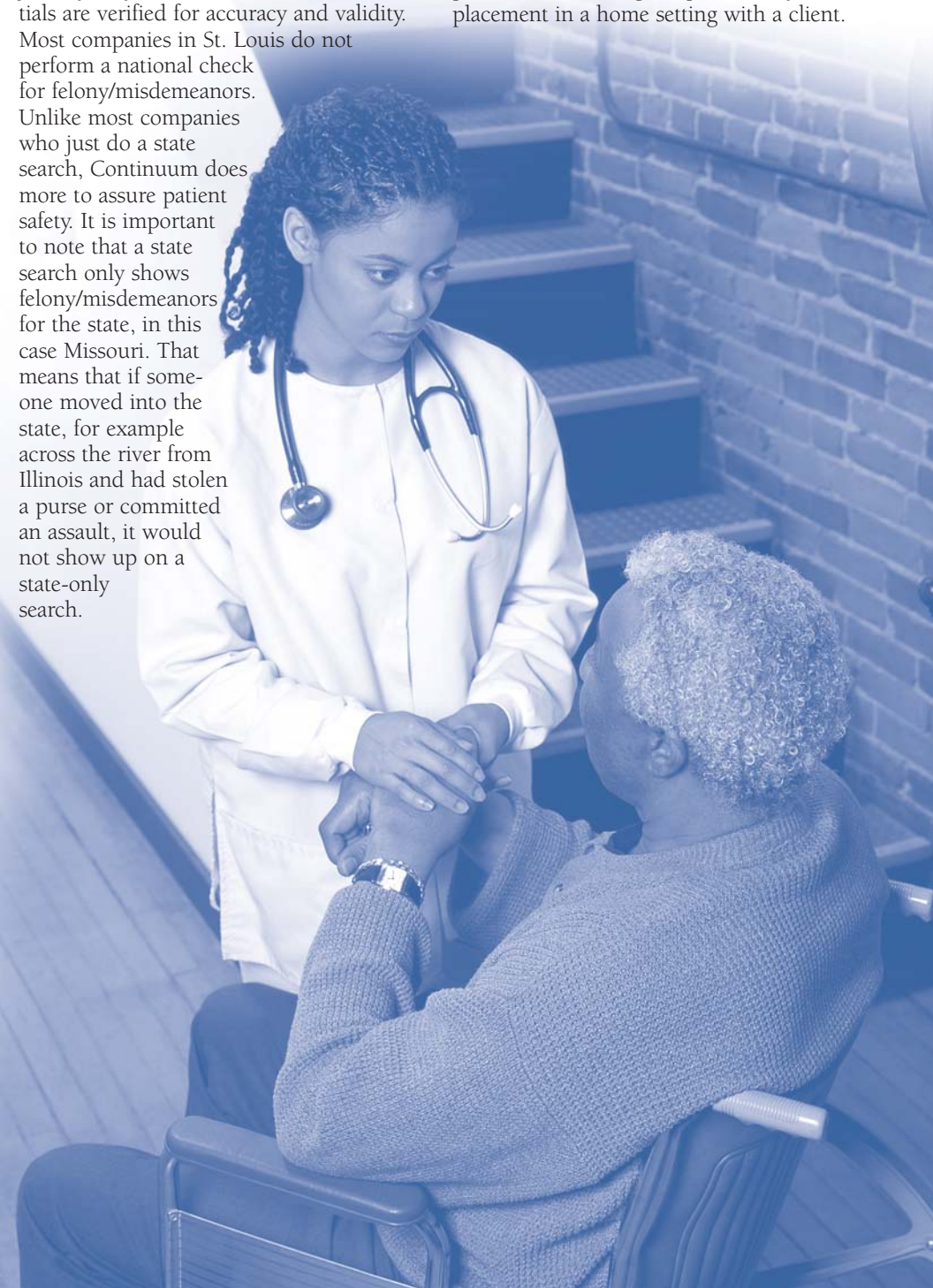
When a private duty company works in a hospice setting, several skills that may not be required in other emotionally less demanding and overtly medical environments are called forth. In staffing hospice patients, from a private duty perspective, it is important to use in-home caregivers who are trained in what hospice is and does, as well as staff that are comfortable with the dying process and the needs that may arise from the patient, the family, involved friends and community resources.

As with any quality program, the actual hiring process is the place to first introduce expected quality standards and a starting point for patient safety and satisfaction. At Continuum, a St. Louis based home care company that provides care for those who have needs in any stage of life, each potential caregiver is first interviewed for personality and caring experience. From the initial contact with Continuum through to the signing of the employment contract and placement on the job, there are many screenings and checks through which the applicant must pass.

Before hiring, checks are performed on driving records, credit, felony/misdemeanors in any county in which they've lived in the US, sex offender checks, and references/employment verification. Applicants may claim to be a Certified Nursing Assistant [CNA] or Certified Medical Technician [CMT], while others just say they are a nurse's aide. All credentials are verified for accuracy and validity. Most companies in St. Louis do not perform a national check for felony/misdemeanors. Unlike most companies who just do a state search, Continuum does more to assure patient safety. It is important to note that a state search only shows felony/misdemeanors for the state, in this case Missouri. That means that if someone moved into the state, for example across the river from Illinois and had stolen a purse or committed an assault, it would not show up on a state-only search.

Baseline Training

Every single person who is hired to work for Continuum receives baseline training. All training is completed with a satisfactory skills assessment check completed on each caregiver prior to any placement in a home setting with a client.



Patient Safety and Risk Reduction

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Continuum's goal is to provide care in keeping with training and competency of each individual staff person.

Training includes but is not limited to:

- ❑ Company mission
- ❑ Disaster procedures
- ❑ Confidentiality
- ❑ Emergency procedures
- ❑ Incident reporting
- ❑ General safety
- ❑ Lifting and transferring
- ❑ Orientation to home safety
- ❑ Walking and ambulation
- ❑ Patient safety
- ❑ Identifying abuse/ neglect
- ❑ Realignment and positioning
- ❑ Changing bed linens of a bedridden client
- ❑ Information on disease control
- ❑ The company's policy against restraints
- ❑ Dealing with dementias
- ❑ Working with other care teams
- ❑ Giving bed baths
- ❑ Orientation to the specifics of working with Continuum and our care teams

Skills Assessment

Each applicant then completes a one-page self skills assessment where they check off items they feel competent and capable of doing. Both this self assessment and the final skills assessment checklist are tied into the scheduling software package, so the caregiver is only matched with clients who are appropriate for his or her level of care and credentials.

This careful screening and hiring process provides assurance that the right caregiver will be placed on the job. However, more training and quality checks are completed after the caregiver is hired, including random drug screenings.

Assuring Safety and Reducing Risks

To assure safety and reduced risks in the home, a home assessment is always completed by a social worker or nurse prior to caregiver placement. Sometimes with hospice clients, there is more involvement because of the increased clinical needs. In addition to the client and family contact information, Continuum makes certain they have all the contact information for the hospice company, the primary physician and physician assigned for hospice care, community resources and any others involved in the care, and family members, all in addition to the designated social worker and nurse contacts who are coordinating the hospice care.

Hospice training in palliative care and how one provides care in that setting is an important part of the ongoing continuing education for Continuum staff. What constitutes an emergency and when to summon help are discussed and reinforced on an ongoing basis through in-services as well as through the company's monthly employee newsletter. Continuum also trains on the patient compliance (or non-compliance) process and steps to take in those situations.

An extra step to personalized ongoing training and quality care assurance is Continuum's insistence upon the introduction of the caregiver to the client. The caregiver is also familiarized with the care plan, so when the caregiver goes into the home setting they know what they are to do and who assumes what role. For Continuum, the client-specific training comes in on a case by case basis, with the supervisor introducing the caregiver and walking him or her through the specific needs of the client. Caregiver documentation completed during a shift is collected from the home and reviewed by the assigned Case Manager (social worker or nurse) to monitor changes and assure ongoing quality care.

Medication reconciliation as well as storage and tracking are important safety checks for hospice clients. Even though hospice or the hospice nurse administers medications, sometimes there is self-administration in place (where the patient pushes a button to release medication, up to a certain level). This is where extra coordination with hospice comes in. Continuum takes clinical direction from hospice, but Continuum's nurse is usually the clinical liaison between the hospice nurse and the client's paraprofessional staff. They always have hospice supervise all medications. For any clinical oversight at all, Continuum takes direction from hospice. Continuum's staff records status, condition, and medications as a part of their in-home record keeping duties. They are in the home to provide respite care for the family or to provide round the clock care to allow hospice care in the home.

Continuum's care role in earlier stages of hospice care is usually to provide cooking, cleaning, errand running, and non-personal care services. As the client progresses through the dying process, the care needs become more intense, and care moves into more personal care, such as incontinency care, bed baths, and/or rotating the patient in bed to decrease the possibility of bed sores. In addition, Continuum's staff increases its support to the family.

Job descriptions are reviewed at hire, annually when evaluations are performed, and throughout the year if any changes are made. For hospice care, special training for handling or dealing with any materials deemed to be hazardous is also performed. Care continuity and essential communications for care team changes are a cornerstone to patient safety and satisfaction.

In short, assuring client safety and reduction of risks associated with hospice care is the same as assuring client safety and patient satisfaction for all Continuum clients. Continuum takes the care and its caregivers' role in that care seriously, and has created a system that helps eliminate risks.

Barth Holohan, MSW, MBA *is the founder and president of Continuum, which provides Care Managed Home Care, Nursing, Retirement Community Supportive Services, Personal Emergency Medical Response Systems, and Care Planning and Management. His company is headquartered in St. Louis, Missouri. He is a national expert on elder care and the home care industry. He holds a Masters of Social Work with a concentration in gerontology and a Masters in Business from Washington University in St. Louis. He also received a nursing home administrator's license. In addition to serving on many boards, Barth is a member of the NASW and the National Private Duty Association.*

Physician Credentialing

Betty Norman, BSN, MBA

Credentialing is the process of obtaining information, verifying the information, and evaluating physician applicants who want to obtain or renew their privileges at a given healthcare entity. The process should include verification of licensure, education, medical training, certification (if applicable), malpractice history and professional experience.

What is credentialing?

Credentialing starts with a completed application, which is the first step: obtaining the information. That information then needs to be verified. For certain items verification should be obtained from the "primary source" or originator of the credentials to determine if it is real, current and complete. For example, a physician license would be verified by contacting the state medical board it was issued by and asking them to verify that the license is current, and if any actions such as suspensions or restrictions have been issued by them against the individual. Obtaining a photocopy of the license directly from the physician is not adequate. Methods of primary source verification include direct correspondence, telephone verification, internet verification, and reports from credentials verification organizations.

The process of primary source verification can be done within the organization or externally. Many state medical boards provide primary source verification for education and training, as well as license. The American Medical Association (AMA) also offers a profile service for initial and reappointment credentialing.

If an outside agency is utilized, it should be by a certified credentials verification organization (CVO). There are numerous CVOs available if you are unable to allocate internal resources for this function. Most of these CVOs are set up to assure compliance with JCAHO and NCQA (National Committee for Quality Assurance) standards.

The final step is a review of the verified information to identify any potential concerns such as missing or inaccurate information, unexplained gaps in time, inadequate references, or significant medical malpractice history. The information can be reviewed by a designated Credentials Committee set up specifically for physician review, or by key individuals within the organization who may be responsible for physician oversight. This might include the Medical Director, Executive Director and Board Member.

Professional and accrediting organization standards

There is no single prescribed method for performing credentialing and privileging. Most accrediting bodies, and some state licensing authorities, have developed standards in this area, however. The Joint Commission for Accreditation of Healthcare Organizations' (JCAHO) standards for Home Care and Hospice organizations state that "when current licensure, certification, or registration are required by law or regulation to practice a profession,

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What should a complete physician file include?

Physician files should be at least as complete as those files kept on the organization's employees, even if the physicians are contracted to provide service. Each file should include at a minimum:

- A completed application
- Attestation questions related to:
  - Challenges to any licensure or registration
  - Relinquishment of license or registration
  - Termination of medical staff membership
  - Limitation, reduction or loss of clinical privileges
  - Health status
  - Criminal history
- Current license*
- Current CDS and/or DEA registration*
- Evidence of relevant training, experience and competence*
- Professional experience and affiliations*
- Current Certificate of Insurance (COI)*
- Malpractice/Claims History, if applicable*
- Applicable board certification information*
- Professional recommendations

**** Requires primary source verification***

Physician Credentialing

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the organization **verifies those credentials with the primary source** at the time of hire and upon expiration of the credentials" (HR.1.20).

The National Hospice and Palliative Care Organization (NHPCO) addresses the need to identify and maintain "an appropriate number of qualified interdisciplinary healthcare professionals and volunteers to meet the unique needs of its patients and families." They provide a practice example that states: "The hospice maintains accurate, up-to-date personnel records to support proof of current licensure, certification or other required credentials." This standard would apply to employed or contracted physicians.

The American Academy of Hospice & Palliative Medicine (AAHPM) has a position statement entitled "Statement on Credentialing in Hospice/Palliative Medicine." The Guiding Principles state that an organization should "ensure that physicians.....have appropriate education or experience." They also indicate that "The privileges to offer additional procedures performed on patients with life limiting illnesses should be granted only to those physicians who specifically request them and can demonstrate the appropriate training and skills." This would include invasive procedures such as thoracentesis or paracentesis.

> ...the most important reason for credentialing of professional healthcare providers is to assure quality patient care.

Why should we credential physicians?

The most obvious reason for physician credentialing is to assure that a physician applying for privileges at your organization has the appropriate education and experience to work with your given patient population. A second reason is to assure that the information provided on the application is complete and accurate. This should be as true for physicians who are employed or contracted by your organization as it would be for any employee. But the most important reason for credentialing of professional healthcare providers is to assure quality patient care. If done correctly and comprehensively, credentialing ensures that patients receive quality medical care from qualified practitioners.

In many states, a claim of negligent credentialing can be asserted against a healthcare organization that does not properly credential a physician. Claimants bring this type of action alleging they have been harmed by a practitioner who they claim was not qualified to perform the services. This type of suit is premised on the fact that the health care organization should have discovered that the physician was not qualified during the credentialing and privileging process.

What needs to be done on an ongoing basis?

Credentialing should not be a static process. Administrative policy should indicate the required frequency for re-credentialing of physicians, generally every two to three years. During that time, however, a diary should be set up to assure that the organization maintains current information regarding licensure, certification, DEA registration, and malpractice insurance coverage.

Re-credentialing offers an opportunity to evaluate a physician's practice within your organization over time. As with any professional employee, it would not be appropriate to hire or contract with someone to provide medical services and then not monitor their performance. An important component of any re-credentialing process is ongoing quality assurance and peer review activities.

In summary, negligent or inadequate credentialing is a significant risk exposure. It is important that all healthcare organizations establish a consistent process for credentials verification of all professional staff, including physicians.

To contact the author, please visit our web site at www.hccis.com and click on the "Contact Us" icon.

Performance Improvement/Peer Review

Many small hospice and home care organizations struggle with what to include in their physician review process. It is important to establish a process for ongoing physician review that is overseen by another physician, i.e. a peer. The Performance Improvement staff can participate in data collection, but the actual review should be done by a physician.

Cases should be reviewed for practitioner specific data. Some issues that might be included in this review are:

- Clinical and technical skills
- Coordination of care, treatment and services, and referral as necessary
- Use of medications or invasive procedures
- Any significant departure from established patterns of clinical practice
- Accurate, timely and legible completion of medical records
- Communication/education of patient and families
- Patient/family satisfaction

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We are making improvements to the look and utility of our web site, www.hccis.com, which should be finished in April. We are sure that you will not only find new, helpful information, but you will also find it easier to navigate. We have also provided a search function so that you can find specific information on your topic of interest.

As always, the current and all past issues of our newsletters can be found on line. We are now also offering an opportunity to sign up for an e-newsletter option.

We hope you will take advantage of all the resources available to you on line.

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