Above & Beyond
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Quality Measures for Palliative Care and End-of-Life Care Endorsed

To help advance the quality of care delivered to seriously ill patients and to those nearing the end of life, the National Quality Forum (NQF) has announced its endorsement of 14 quality measures addressing areas of concern in palliative and end-of-life care. The measures are designed to be applicable across a range of providers and clinical settings, including acute care facilities, intensive care units, and hospices.

"As the number of older adults in this country continues to grow, palliative and end-of-life care services are needed more than ever," says NQF president and CEO Janet Corrigan, PhD, MBA. "This set of measures will help promote the type of high-quality care older people and acutely ill patients deserve."

THE PERFORMANCE MEASURES ADDRESS CARE CONCERNS SUCH AS:

- Assessment and management of pain and other symptoms
- Patient- and family-centered care, with a focus on psychosocial needs and care transitions
- Patient, caregiver, and family experiences of care

Although the number of palliative and end-of-life care programs has increased rapidly in recent years, notes the NQF, their services remain underutilized. It is estimated, for example, that more than one million people in the United States die annually of chronic and debilitating illnesses without receiving the benefits hospice services could have provided them.

"Despite the evidence for and support around palliative and end-of-life care, these services are still underused," states the NQF. "Studies have found that palliative care programs across the trajectory of a patient's illness, including end-of-life care, can result in improved quality of care."

BENEFITS OF PALLIATIVE AND HOSPICE CARE INCLUDE:

- Higher patient satisfaction
- Improved communication
- Fewer emergency department visits
- Fewer admissions to acute care hospitals and intensive care units
- More referrals to hospice
- Reduced costs

"Measuring palliative and end-of-life care quality is relatively new territory," notes the report, and "it is critical that providers have the right measurement tools to help ensure patients receive safe, high-quality, and compassionate care."

The current project was undertaken by NQF at the request of the U.S. Department of Health and Human Services. A panel of health care stakeholders, which included providers, measurement experts, and consumer representatives, evaluated 22 measures against the NQF endorsement criteria, then selected 14 as suitable for accountability and quality improvement.

For more information, visit www.qualityforum.org.

In This Issue:

Home Health Clinicians 'Uniquely Qualified' to Address Patients' Fall Risks

Clinical pharmacist offers stepwise approach for home care patients

Despite the recent heightened awareness of the importance and effectiveness of fall prevention among the elderly, too many patients remain at preventable risk of falling. Because home health care professionals see patients in their home environments, they have an opportunity to address this issue not available to providers in other settings, according to an article published in Home Health Care Management & Practice.

"A fall is often a 'defining event' for a patient and their family," writes author Emily K. Flores, PharmD, BCPS, assistant professor, Department of Pharmacy Practice at the East Tennessee State University (ETSU) College of Pharmacy, Johnson City, TN. "A fall may cause significant injury, lead to long-term care placement, functional decline, or even death."

The article provides an update on risk factors for falling, reviews current guideline recommendations for fall prevention, and offers a stepwise approach to evaluating and modifying patients' risk factors.

"Home health clinicians are uniquely qualified to fully evaluate patient falls risk and carry out clinical interventions to reduce risk," states Flores, who is also clinical assistant professor with the ETSU Quillen College of Medicine's Department of Family Medicine.

"Evaluation of a patient's home environment can tell you much about medication use, as well as their ability to attain and maintain a normal life themselves," Flores adds. "The home environment is a great place to assess activities of daily living as well as instrumental activities of daily living and environmental factors."

A multifactorial fall risk assessment can be conducted by a single home health care provider, or components of the assessment can be done by members of a coordinated interdisciplinary team, notes Flores. "For example, the physician may conduct the physical examination and evaluate the disease states and disorders, a physical or occupational therapist may evaluate gait and balance and provide exercise education, a pharmacist may evaluate the medications, and a home health nurse may evaluate the home environment and provide follow-up and ongoing education."

Most falls result from interactions among the following long- and short-term patient-specific factors:

- The presence of diseases/disorders
- Medication use
- Precipitating factors in the patient's environment

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Fall Prevention: An Approach to Risk Assessment and Intervention

1. Screen all older patients at least annually, by asking:

- "Have you had two or more falls in the past 12 months?"
- "Was there a health care encounter due to an acute fall?"
- "Do you have difficulty with walking or balance?"

If "Yes" is answered to any of the above:

- Determine the frequency and circumstances of the falls.
- Obtain the relevant past medical history.
- Conduct a physical examination, along with cognitive and functional assessments.

2. Determine the falls risk by factoring in the following:

- Patient history of falls
- Medications
- Disease states/disorders
- Environmental hazards

3. Tailor interventions based on identified risks, targeting more than one risk factor.

Interventions found particularly effective include those targeting: environmental adaptation; balance, transfer, strength and gait training; medication reduction, particularly psychoactive medications; management of visual deficits, orthostatic hypotension, and other cardiovascular and medical problems.

4. Reassess periodically.

— Adapted from Flores EK, *Home Health Care Management & Practice*

Fall Risks

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DISEASE STATES AND DISORDERS

Diseases or disorders that can cause falls in older persons include:

- Arthritis
- Depressive symptoms
- Orthostatic (postural) hypotension
- Impaired cognition
- Impaired vision, gait, or balance
- Muscle weakness
- Foot problems

MEDICATIONS

Medication use in older patients is of concern for a number of reasons, and may put these patients at higher risk for impaired balance and falls. "Medications may directly or indirectly contribute to falls through adverse effects, drug interactions, and polypharmacy," points out Flores. "Getting a patient to less than four medications and minimizing all other extrinsic risk factors maximizes their fall risk reduction."

Research has shown that the following medications increase the risk of falling:

- Psychoactive medications
- Long-acting benzodiazepines
- Sedative-hypnotics
- Medications with anticholinergic properties

ENVIRONMENTAL FACTORS

Modifiable environmental factors found to increase the risk of falling include poor lighting, loose carpets, lack of bathroom safety equipment, suboptimal footwear, and obstacles. Some patients limit their activities of daily living and mobility because of a fear of falling due to risk factors that are often modifiable, notes Flores.

"In summary, current clinical guidelines recommend that clinicians screen patients at risk due to age and then initiate strategies that combine interventions targeting more than one risk factor for falls," writes Flores. "Screening patients for falls risk and implementing prevention strategies is an integral part of improving care for older patients living in the community."

Source: "Falls Risk Assessment and Modification," Home Health Care Management & Practice; *ePub ahead of print, April 3, 2012; DOI: 10.1177/1084822312441797. Flores EK; Department of Pharmacy Practice, Bill Gatton College of Pharmacy, East Tennessee State University, Johnson City, Tennessee.*

Home Health Nurses Can Play Important Role in Managing Bipolar and Other Psychiatric Disorders

One of the most challenging psychiatric diagnoses in home care is bipolar disorder, a lifelong disease with huge burdens for the patients and their families who must live with it. Although this disorder receives little attention in home care research, it is important — and possible — for it to be understood and addressed, according to an article published in *Home Healthcare Nurse.*

"A comprehensive and holistic approach is necessary when providing care and direction to those with mental health problems," write the authors. "The psychiatric home care nurse guides the patient/caregiver through assessments, education, counseling, and therapeutic approaches using psychiatric and medical knowledge/interventions."

Medicare criteria for psychiatric nursing services include:

- Axis I psychiatric diagnosis
- Physician referral
- Psychiatrically homebound status
- A need for the skills of a psychiatric nurse

Psychiatric home care has been covered by Medicare for many years, yet there are no published data from the Centers for Medicare & Medicaid regarding which diagnoses are most frequently addressed or how many patients receive psychiatric care at home, according to the authors.

Further, OASIS-C, the assessment tool that Medicare requires be completed for every patient admitted to home care services, includes screening and assessment requirements only for depression. Yet the abundance of information and research on depression indicates the role that home health care nurses can play in the management of all psychiatric disorders.

The only study examining the management of psychiatric diagnoses other than depression — and including bipolar disorder — in the home health setting was published more than 10 years ago, note the authors. Of the 80 patients studied, 48 (60%) were stable at discharge and had met the goals established in their plans of care.

The home health interventions in this study include:

- Medication teaching and management
- Psychoeducation about the illness
- Strategies for staying well
- Individual and family counseling

"Short- and long-term goals can be achieved when loved ones and family are included," comment the authors. "The mental health patient…can be managed cost-effectively and in the home through persistence, hard work, and caring."

To assist in the home management of bipolar disorder, the authors provide tables and sidebars that include: a description of bipolar disorder; a summary of commonly prescribed "atypical" (as opposed to "conventional" or "first-generation") antipsychotic medications used in elderly patients; and the Young Mania Rating Scale, a measure of the severity of the behaviors exhibited during the manic phase of bipolar disease.

Source: "Managing Patients with Bipolar Disorder at Home: A Family Affair and a Psychiatric Challenge in Home Health Care," Home Healthcare Nurse; *May 2012; 30(5):280-291. Carson VB and Yambor SL; Department of Nursing, Towson University, Towson, Maryland; and Mental Health Services, First Choice Home Health of Ohio, Cleveland.*

Relationships Between Caregivers and Hospice Patients Found to Vary Among Racial/Ethnic Groups

As the overall number of patients enrolling in hospice care continues to increase annually, the proportions of hospice users among ethnic and racial minorities remains low. An understanding of the caregiver relationships found among different racial/ethnic groups may help providers to better explain the benefits of hospice care, according to a report published in the *American Journal of Hospice & Palliative Medicine.*

Investigators examined the characteristics of 22,936 patients (White, 80.6%; African American, 9.6%; Hispanic, 9.3%; Asian American/Pacific Islander, 0.5%) enrolled at a hospice in the central part of Florida from 2002 to 2006. Overall findings:

- Hospitals were the most common referral sources across all groups, followed by primary care physicians. Whites were referred from long-term care facilities about twice as frequently as all other groups.
- Length of stay did not differ significantly across the groups.
- While the total number of hospice users increased from 3622 to 6124 over the four-year period, proportions by race/ethnicity varied only minimally.

Different caregiver relationships were found among the four groups:

- Spouse caregivers were most common among Whites and Asians/Pacific Islanders (35.1% and 36.2%, respectively). For these two groups, the second most common caregivers were daughters for Whites (27.1%), and sons for Asians/Pacific Islanders (24.8%).
- Daughters were most often the caregivers for Hispanics (32.6%), followed by spouses (30.2%).
- Caregivers for African Americans were most frequently listed as "other" than spouse or adult child (40.9%), followed by daughters (27.1%).

"Caregiver relationships are a key finding in this study, since many hospice organizations require patients to have a caregiver," comment the authors. They suggest that referring physicians and hospices make careful identification of patients' caregivers and ensure that discussions of hospice referral are culturally specific and scheduled to give working-age caregivers adequate time to consider and understand their recommendations.

Source: "Hospice Use Among African Americans, Asians, Hispanics, and Whites: Implications for Practice," American Journal of Hospice and Palliative Medicine; *March 2012; 29(2):116-121. Carrion IV, Park NS, Lee BS; School of Social Work, University of South Florida, Tampa.*