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Regulatory changes top list of 2009 challenges for hospice

PI activities, data collection, frequent surveys new for agencies

The year 2009 will represent a year of change for hospices with new conditions of participation, greater scrutiny of claims, and new requirements for data collection. What is not known is how the economy, along with sociological and political changes, will affect the industry.

Political changes and the new administration might signal a focus on uninsured and underinsured adults as well as children, says **Jonathan Keyserling, JD**, vice president of public policy and counsel for the National Hospice and Palliative Care Organization (NHPCO). If President-elect Obama is able to implement changes that affect coverage of Medicare and Medicaid patients, similar changes will be seen in the private sector, he predicts.

As health care reforms are evaluated, hospice can be used as an example of integrated care model, Keyserling says. "We have 30 years of experience of providing care coordinated among different providers," he adds.

Susan Levitt, executive director of CNS Home Health and Hospice in Carol Stream, IL, says, "I'm not sure that a new administration means many changes for hospice because there is so much competition for Medicare dollars to support new programs." The change that is definitely

EXECUTIVE SUMMARY

Hospice managers began to see requirements for data collection in 2008, but even more regulatory requirements will challenge hospices in following years.

- Conditions of participation now require performance improvement projects that document evaluation and improvement.
- Hospices will begin to see more regular compliance surveys.
- The anticipation of a hospice prospective payment system means managers and staff need to adjust to an environment that requires fiscal accountability and clinical documentation to support visits and services.

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coming is related to new regulations that hospice managers learned about in 2008, along with more regulatory changes that should follow quickly, she says.

"Hospice managers have not had to face significant regulatory changes in 20 years, and there are many organizations that are not ready for change," Levitt admits. "We saw a good example of how unprepared many hospices are in July 2008 when we had to begin submitting visit data." Hospices that are affiliated with a home health agency, or hospices with managers that have a home health background, fared better in July and will be able to prepare for changes more easily because of the constant changes home health has faced in recent years, she says.

"Hospice managers that had no experience with reporting visits had to find ways to create reports and collect data that had never been

collected," Levitt explains.

Meeting several requirements of the new conditions of participation (CoPs) will be a struggle for many hospices, she says. **(For more information, see "Hospice Conditions of Participation focus on quality, patients' rights," *Hospice Management Advisor*, July 2008, p. 73.)**

"Measuring quality in hospice care is important, but it differs from home health because the patient's outcome in hospice is always death," she says. The performance improvement requirement in the COPs has some hospice managers asking themselves what to evaluate and improve upon, Levitt says. Improving the quality of care will require hospice staff members to evaluate clinical issues such as pain control, as well as education and family support, she adds. **(For other changes that staff members face, see p. 3.)**

Hospice rate reform will be a priority for the Centers for Medicare & Medicaid Services (CMS) in upcoming years, and the Medicare Payment Advisory Committee (MedPAC) recommendations should be watched carefully, suggests Keyserling. CMS has begun and will continue efforts to collect data from hospices to develop a reformed payment system, he says. "I hope that as we move forward, CMS will wait until there is enough data to develop a fair payment system," Keyserling says. "To move forward without complete data would be irresponsible."

The economy and budget concerns will create intense pressure on all health care providers to protect their reimbursement, he says. Associations such as NHPCO are taking steps to monitor and take action when needed. In fact, NHPCO filed a lawsuit to block implementation of a CMS rule that would reduce the hospice wage index and cut payments to hospices. Although the lawsuit has been dismissed, NHPCO and member hospices are evaluating other options to protect reimbursement, he adds. **(See story about lawsuit on p. 3.)**

Another effect of the economy will be fundraising for hospices, says Levitt. While large donations and grants still might be available, her hospice is seeing a drop in memorial gifts, she says. "This may also be due to a shorter length of stay for patients as they are referred later to us, so that they don't develop the same relationship with us as families that we serve for longer periods of time," Levitt says.

The downside to lower levels of giving will be the expected increase in requests for charitable care, she notes. "Our charitable care is completely funded by donations; so, if we receive fewer

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gifts, we won't be able to support as many patients," Levitt explains. **(For more information about fundraising and donations, see "Tough economic times present challenge for hospice fundraisers," HMA, December 2008, p. 133.)**

A positive change in the health care industry will be the growth in palliative care programs, says Levitt.

"We have a palliative care program that is separate from our hospice program, but benefits both our hospice and home health program," she says.

Hospices ideally are positioned to provide palliative care services to patients that are diagnosed with a potentially life-threatening condition but still are seeking curative treatment,

Levitt says. "It is necessary to set the program up separately, with its own staff and medical director, and to bill through the home health program, but hospice managers have the experience with palliative care to develop and oversee it," she says.

Hospices that don't have an affiliation with a home health agency easily can partner with an existing home health agency to handle billing, suggests Levitt. "I certainly don't recommend that anyone start up a home health agency now," she emphasizes.

The key to surviving the challenges of 2009 and the following few years will be flexibility, says Levitt. "We have to learn to adapt, and we have to learn managerial skills that we haven't needed before and that we didn't learn in nursing school," she says. ■

Behavioral changes might be biggest challenge in '09

Fiscal responsibility, more scrutiny to affect

Change is never easy, but the toughest type of change is behavior or culture change within a hospice, says **Susan Levitt**, executive director of CNS Home Health and Hospice in Carol

Court dismisses lawsuit against CMS

NHPCO evaluates other options

The lawsuit filed by the National Hospice and Palliative Care Organization (NHPCO) to block implementation of part of a final Medicare rule designed to phase out the budget neutrality adjustment factor (BNAF) has been dismissed.

The U.S. District Court for the District of Columbia dismissed the lawsuit on procedural grounds without examining the substantive merits of NHPCO's claims. The final rule was promulgated by the Centers for Medicare & Medicaid Services (CMS), and the lawsuit was filed against CMS and the Department of Health and Human Services (HHS). **(See "Hospice organization files suit to stop CMS rule," *Hospice Management Advisor*,**

October 2008, p. 117; and "Medicare proposal to reduce hospice wage index equals rate cut," *HMA*, August 2008, p. 85.)

The ruling was based on the court's view that, before it addresses the merits of the arguments presented in NHPCO's lawsuit, CMS first should be given the opportunity to consider those claims in an administrative appeal by affected hospices.

"While we had hoped that the court would be able to make a decision to settle the suit now, we do understand that the court must allow the government the appropriate process for the case," noted **Jonathan Keyserling**, JD, executive director of the Alliance for Care at the End of Life and vice president of public policy and counsel for NHPCO. "However, NHPCO and the Alliance for Care at the End of Life will continue to aggressively work to stop what are essentially cuts to hospice's reimbursement rates. This includes ongoing efforts to rally Congressional support for hospice." ■

Stream, IL. As hospices face more regulation, fiscal responsibility will become an important part of every staff member's mindset, she says.

"Hospice staffs are made up of devoted, caring people who are passionate about the value of hospice," Levitt says. "Now, we have to tell these staff members that they can't make a visit just because it feels right."

Making those "Kumbaya" visits, as Levitt calls them, might be good for the family and might make staff members feel like they are doing a good thing, but with the Centers for Medicare & Medicaid Services (CMS) collecting data, implementation of a hospice prospective payment system (PPS) based on data and standardized care might not be far behind. "We won't have the luxury of making visits without a reasonable clinical reason for the visit," she explains.

PPS: At least 2 years away?

It took several years to develop home health PPS, but it won't take as long to develop and implement hospice PPS because lessons learned in home health can be applied, she says. "I hope that hospice PPS is at least two years away because hospices will need that length of time to change the culture of their agencies," says Levitt. "Staff members and managers will need to change the way they approach their jobs."

Because hospice managers do not typically have an operational background, it is important that they begin now to learn more about the financial side of hospice and about performance improvement, she suggests. "Performance improvement activities have not been a focus for most hospices, so I think that designating a staff person as your performance improvement coordinator is important," says Levitt. "If the hospice can afford it, an individual who focuses on performance improvement will be able to become an expert in the process and ensure that projects comply with the CoPs [Conditions of Participation]."

Staff members and managers also will have to be ready for more oversight by CMS, says **Jonathan Keyserling**, JD, vice president of public policy and counsel for the National Hospice and Palliative Care Organization. "The Office of the Inspector General has found that in some states hospices go 10-14 years without a survey," he says. "This is too long a period of time, even for the most responsible providers." Regardless of

how well a hospice is run, there is always room for improvement, he says. "Even the best practices need tuning up periodically," Keyserling says. ■

Hospice community to provide input on reform

President-elect Obama has indicated that health care reform will be a top priority in his administration. Former Sen. Tom Daschle, (D-SD) who has accepted Obama's offer to serve as Health and Human Services Secretary, is the leader of the Transition's Health Policy Team. Daschle is asking Americans to help with reform efforts by sharing their health care experiences and concerns.

Recommendations that the transition team will provide to the new administration will include some of the information provided by the American public. National Hospice and Palliative Care Organization (NHPCO) and the National Hospice Foundation (NHF) are encouraging hospice supporters to participate to help the administration better understand what is important regarding end-of-life care.

"The need for people to tell their stories is one that we've longed championed as part of our grass-roots advocacy work in the hospice community," said **J. Donald Schumacher**, president/CEO of NHPCO. "There is no better way to understand the health care needs of our nation than by hearing the stories from concerned citizens."

While details of Obama's health care proposals won't be known right away, Daschle initiated the information-gathering process. The strategy began with an invitation for people across the nation to hold what are being thought of as "house parties" from Dec. 15-31, 2008, with the intention of sharing concerns and experiences. Information gathered from these informal gatherings then can be posted on the web site, change.gov. At press time, NPHCO's Caring Connections and the NHF were scheduled to host a discussion for staff, families, and organization supporters at their offices in Alexandria, VA, in December. Additional information about the Obama-Biden transition team's approach to health policy is available at change.gov/healthcare. ■

Volunteers preserve memories for families

Storykeepers record patient stories for posterity

Asking hospice patients to share and record their stories not only provides enjoyment to the patients as they recall important moments in their lives, but it also gives families a lasting memory of their loved ones. More than 300 hospices, nursing homes, and assisted living facilities have found that Project Storykeeper, a program offered through the International Association of StoryKeepers, is not only a good way to help families, but also a way to attract new volunteers.

Volunteers attend training sessions that teach them how to talk with patients to get them to share stories, how to introduce the idea of recording or writing down the stories, and how to listen during the storytelling, says **Mary Lorenz**, volunteer coordinator at Mount Graham Hospice in Safford, AZ. "The training to become a certified storykeeper is about 15 hours, and we offer it on a monthly basis for new volunteers," she explains.

Training is a combination of CD classes and online support, says **Dennis Stack**, founder of Project Storykeeper. Prices for the training programs start at \$79. Kits that contain booklets that contain "starter" questions are \$29, with discounts for multiple orders. The kits contain materials for writing notes as well as CDs onto which audio recordings can be copied.

"People don't have to use our kits, but the training is necessary because there is a progression of questions that prompt people to remember moments in their lives," he says.

Audio recordings are used rather than video recordings because patients are more comfortable with them, says Lorenz. Digital recorders are purchased by the hospice for use by the volunteers, she says. Costs for digital recorders start at \$40, so it is not an expensive part of the program, she says. "Usually, on the first visit, the volunteer talks with the patient and family member and explains that he or she can provide this service to preserve part of the family history," Lorenz says. This is a volunteer activity for which the hospice does not charge, she says.

Although family members are eager to have the stories recorded, patients often express the opinion that "no one wants to hear my stories." Volunteers respond to this statement by saying that they want

to hear them and if the patient doesn't want them shared immediately, the CDs will be held by the hospice until after the patient's death, she explains.

A storykeeper volunteer visits the patient multiple times, once a week, until the patient loses interest in the project, is physically unable to continue, or dies, says **Carolyn Cruson**, BSW, social worker and volunteer coordinator at Hospice of Missoula (MT). "The length of the volunteer's visit and how long the project continues is left up to the patient," she points out. "Most patients enjoy telling their stories, which family members may have heard multiple times, to a new audience."

New stories are disclosed

Because volunteers are taught how to listen and interject questions that tie stories together to present a picture of the patient's life, family members often learn more about the patient than they ever knew, Cruson says. "The questions are designed to provoke memories that patient's might not have discussed with anyone before," she adds.

Stack says, "Simple, nonpersonal questions help patients start talking about their early childhood, then progress through the rest of their life with stories about special events, achievements, and family members. We try to connect the dots between the stories that family members may have heard throughout the years."

Even when families believe that they know a lot about their family history, a storykeeper volunteer can add to their knowledge, says Lorenz. "We have a lot of Latter Day Saints in our area, and they are very active in genealogical research and family history," she says. "Our project has helped them fill in gaps by finding out about the family member's first date or first meeting with their spouse." These and other memories might stay hidden until the volunteer prompts the patient with careful listening and nonjudgmental questions, she adds.

Volunteers for the storykeeper program can come from veteran volunteers already working with your hospice or from volunteers recruited specifically for the program, says Cruson. "They have to be comfortable listening to people's stories, have a natural curiosity about people, and be able to ask questions that coax details of the stories," she explains. The storykeeper position also attracts some volunteers who might not normally think about volunteering for a hospice,

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For information about Project Storykeeper training, supplies, and services, go to the International Association of StoryKeepers web site at www.prostorykeepers.com. Click on the "volunteer" button at the bottom of the page.

Cruson adds. "Recording the stories gives them something to do that is positive and doesn't focus on death, so they are more comfortable," she explains.

Lorenz says, "I would recommend that all hospices make this type of program part of their service." Patients benefit by talking about important details of their lives, and family members learn more about the patient, she says. "I can't tell you how many times a family member has described the patient as a quiet, serious person, and then the patient tells us stories about themselves that show a fun-loving, adventurous young person. It's an important part of that family's history that would be lost without the storykeeper volunteer." ■

Accusations of theft by employees increase

Proper hiring, supervision reduces risk to agency

"Hospice nurse arrested for theft." . . .
"Family accuses hospice nurse of stealing from patient."

All hospice managers cringe when they see the increasing number of headlines that proclaim hospice nurses or aides as guilty of stealing from patients. Are these headlines aberrations, or is there a real, growing trend in the industry?

"The risk of theft by employees has always been a problem in home health care," admits **Elizabeth E. Hogue**, Esq., a Burtonsville, MD-based attorney. The increase in news coverage of this potential problem is a reflection of the increased awareness of the industry, she explains. "When I started my law practice 30 years ago, I would tell people I worked with home health agencies, and they would ask what a home health agency was," she says. "Now, I mention home health, and most people say that their father, mother, or friend had a home health nurse."

An increased awareness of the industry as well as an increased willingness to press charges probably are more to blame for the headlines than an increasing number of employees who steal, suggests Hogue. While some patients might have been reluctant to report employees in the past, because they did not want to cause trouble for someone they considered part of the family, others did not report for fear of retribution by the accused employee, she says. Today, family members and patients might not see the same person day after day, and they also realize the agency can stop scheduling the accused employee at their home.

"The first step to take when an allegation of theft is made is to remove the employee from the home," points out Hogue. This is not only done to preserve the trust between the patient and the agency and to protect the agency, but also to protect the employee, she says. "Remember that

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The increased publicity of theft by health care employees in the home is more a reflection of the general public's awareness of such care than an increasing number of employees with criminal intent, according to experts interviewed by *Hospice Management Advisor*. Even so, agency managers should review the steps they take to reduce the risk of employee theft and preserve their reputation in the community.

- Establish guidelines related to accepting gifts from patients or their families.
- Be thorough in reference and background checks during the hiring process.
- Investigate all allegations of theft immediately, and remove the employee from that patient's home.
- Encourage families to file police reports if they feel strongly that a theft occurred.

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your employees have rights, and it is important to investigate the allegation fairly," Hogue adds. "In many cases, the home health employee is not the only other person coming into the home." Family members, church volunteers, friends, durable medical equipment employees, and even Meals-on-Wheels volunteers may come in and out of the home on a regular basis, she points out.

"Document all of your conversations," Hogue emphasizes. Ask what is missing, when and where it was last seen, and who else has been in the home, she suggests. Talk to as many family members as possible, and ask if they have looked for the item or if someone else might have moved it.

If your investigation cannot prove the employee's guilt or innocence, be sure to tell the patient and family that they can file a police report if they wish, stresses Hogue.

Whether they file a report or not, be sure not to send that employee back to the home, even if the family requests the nurse or aide, she says. "People will ask for the nurse again, because they found the item they thought was taken," she says. "You don't want to put your employee back into a situation in which the family didn't trust him or her," she explains.

Be careful, too, about the way your agency gift policy is written, suggests Hogue. "Patients and family members want to give gifts to employees, but other family members may not realize it was given as a gift," she points out. **(See tips on how to set up policy on p. 8.)**

Hire carefully

Of course, the best way to reduce the risk of allegations of theft is to be careful about who you hire, says **Greg Solecki**, vice president of Henry

Ford Home Health Care in Detroit. Although interviews do confirm that the potential employee has the skills and experience, most of the time spent in an interview is to discover what type of person the potential employee is, he explains.

"We engage the applicant in a conversation, and then listen to what we can learn when they are comfortable," Solecki says.

Applicants prepare for standard questions such as goals and previous work experience, but interviewers can get a sense of the applicant's opinions, philosophies, and ethics in a conversation, he adds. **(For more about hiring and supervision to reduce risk, see p. 8.)**

Make welcome call to patients

Supervision of the employee and communication with the patient also can help reduce complaints about employees, or will let the agency know early if there is a potential problem, says Solecki. "Within the first 24 hours of admission, we make a welcome call to the patient and encourage them to call us if they have any questions or concerns," he says. Another call is made seven to 10 days into the episode of care to see how the agency staff members are doing and identify any patient needs that are not being met.

"The patient feels comfortable talking to us, and this is how we identify problems," he says.

While Solecki can count on one hand the number of times that a patient has accused an employee of theft during his 20 years at Henry Ford, other issues, such as missed visits, can be discovered with these calls. The key is to set up a line of communication outside the employee in the home to reassure the patient that there is someone else with whom he or she can talk, he adds.

Although employee theft may be rare in your agency, be aware that it does happen, says Hogue. While your investigation may not uncover any wrongdoing, and the patients might decide that they just misplaced the items, theft by hospice employees does happen. The employees are not always smart about hiding their theft either.

"My favorite story is of the home health employee who worked for a family that repeatedly reported missing items but the agency, and the family could never substantiate the allegations," she recalls. "About a year later, the employee held a garage sale to prepare for a move, and the items she was accused of taking were included in the sale." ■

Limits, disclosure avoid misunderstandings

Employees should never accept cash

Hospice nurses, aides, and therapists do a wonderful job caring for their patients, so it is natural that the patients and families want to thank them with gifts. Unfortunately, the size and type of gift can put the employee and agency into the uncomfortable position of being accused of theft if strict guidelines are not developed and followed.

"I believe that the best policy is that no employee can accept a gift worth more than \$25," says **Elizabeth E. Hogue**, Esq., a Burtonsville, MD-based attorney. Even with the dollar limit, make sure that employees immediately report the gift to their supervisor and document when it was given, she suggests. By insisting on full disclosure by the employee and placing limits on the value of the gift, the agency and the employee are protected, she says.

There are times that a patient may give away an item that another family member believes should stay in the family, because it is an heirloom or part of the family history. Other times, family members just don't realize the patient gave the item away, says Hogue. In either case, once a family member contacts the agency about the "missing" item, offer to return it, she says. "You can say that you knew the gift had been given and that the employee reported the gift immediately, but you understand that the patient may have given away something the family wanted to keep," she says.

In most cases, once the family realizes that the item was given as a gift, they no longer ask for its return, she adds.

Cash is also not appropriate, says Hogue. "Policies need to state that employees can never accept cash," she says. Although grateful families may want to give cash bonuses at holidays or at the end of service, employees should make it clear that they appreciate the gesture but agency policy does not allow them to accept it, she says.

To make sure that all employees are familiar with the policy, be sure that you have them sign a document that they've received and understand the agency gifts policy, says Hogue. "This ensures that employees do know the policy and cannot claim otherwise." ■

Background checks, references are important

Gather info when former employers won't share

Checking a potential employee's background is harder than ever, with previous employers reluctant to give much information about the employee beyond the dates they worked at the organization.

"Even when a former employer indicates whether or not the employee would be rehired, the information is not definitive," says **Elizabeth E. Hogue**, Esq., a Burtonsville, MD-based attorney. While background checks with local police might identify some problems, the only reliable check is a national check through the FBI, and that check takes months, she adds.

The next best way to evaluate potential employees is to put the onus on the applicant, points out **Greg Solecki**, vice president of Henry Ford Home Health Care in Detroit. "We ask for the name of a supervisor or manager who would be willing to talk with us, and we ask them to bring in copies of past performance evaluations," he says.

'Read between the lines'

When his staff talk with previous employers, they explain that they have a consent form from the applicant that gives the former employer permission to release information, explains Solecki. "Even with this consent, we have many employers who say they can only confirm dates of employment," he admits. The next step is to "read between the lines," he says. "We explain that they can never get into trouble for releasing positive information, especially with a consent form," he says. If the previous employer says they understand, but they still are not able to say anything, you can make an assumption that there may be something negative about the employee. In these cases, check other sources carefully, he suggests.

Also, trust your gut instinct, says Hogue. "A lot of home health managers and supervisors have been doing this a long time, and there are times that their radar tells them something is wrong," she says. "Trust these feelings, and if the person is already hired, add extra, unannounced supervisory visits."

Trusting instinct during the hiring process is important, says Solecki. "As an agency, we've made the decision that we'd rather work without a full

staff rather than fill positions with warm bodies. We want to make sure that the employees we send to patients' homes are the right employees for our agency." ■

Doctors' legal questions might result in patient pain

When treatment options dwindle or are exhausted, terminally ill patients often opt for pain management and comfort over life-extending therapies. However, researchers report that a lack of thorough understanding about the laws governing end-of-life care might leave providers with an ethical dilemma and cause some terminally ill patients considerable, unnecessary pain.

The report, appearing in a recent issue of *Mayo Clinic Proceedings*, concerns the legal and ethical issues involved with deactivating an implantable cardioverter-defibrillator (ICD) in patients who are terminally ill. The researchers were from University of Rochester Medical Center and Unity Health System, both in Rochester, NY, and Wake Forest University Baptist Medical Center in Winston-Salem, NC.

The legality of deactivating the ICD in terminally ill patients who request to stop receiving the therapy is not clearly written, the study shows, and might be causing doctors to subject dying patients to undue pain.

The results stem from a physician survey that collected information about doctors' knowledge and preferences regarding the medical, ethical, and legal issues involved in caring for terminally ill patients with an ICD. **Vinodh Jeevanantham**, MD, of Wake Forest Baptist, and colleagues identify a general lack of knowledge among physicians concerning ICD therapy in terminally ill patients that might result in extra suffering.

Terminally ill patients might be at increased risk of ICD shocks due to electrolyte disturbances, hypoxia, and heart failure. It is estimated that more than 3 million people in North America are eligible for an ICD. With a growing elderly population in the United States, clinicians are likely to care for an increasing number of elderly patients with ICDs.

The deactivation of an ICD, which might have been placed years before the onset of a terminal condition, might not be a clear-cut decision for patients, families, or physicians. Although physicians are aware that ICDs save lives by

delivering an electrical shock and that such shocks are associated with considerable pain, busy clinicians might not always reanalyze the risk-benefit ratio of ICD therapy when their patient experiences a terminal illness, the report states. In this situation, life-prolonging therapy might no longer be desired. Although guidelines for appropriate ICD use are readily available, a glaring deficiency exists regarding end-of-life care for patients with an ICD, according to the report.

Although voluntary refusal of treatment is a basic patient right, the study highlights a lack of clarity regarding the laws concerning ICD therapy in terminally ill patients. "While 64 of the physicians who participated in our survey had cared for terminally ill patients with an ICD, they were unaware of any guidelines regarding deactivation of the device in such patients," the authors wrote.

Although patients can better tolerate the shock from the ICD with time, they still might find an ICD firing frightening and painful, the researchers said. "Our study showed that only 51 clinicians thought that the shock therapy would be uncomfortable," they said. This finding highlights the importance of physician education regarding the ICD functioning, particularly regarding symptoms that result from shock therapy.

"With increased knowledge about managing the withdrawal of this potentially life-prolonging therapy, physicians are likely to become more skilled at caring for dying patients with an ICD," the authors said. ■

Terminal patients given OK to administer lethal drugs

Washington state voters recently approved a measure permitting terminally ill adults to request and self-administer lethal medications prescribed by a physician, according to the American Hospital Association (AHA).

Under the measure, approved by 59% of voters, a physician with primary responsibility for the patient's care must determine that the patient has an incurable disease expected to cause death within six months, that the request is voluntary, and that the patient is competent and making an informed decision, the AHA said. A second physician would have to confirm that information, according to the AHA. The measure does not require a health care provider or facility to provide a prescription for

lethal medication, it said.

Leo Greenawalt, president of the Washington State Hospital Association, was quoted by the AHA as saying Washington hospitals are working to improve end-of-life care and access to palliative care. The recently passed initiative makes this work even more important, he said. The state association also is renewing efforts to get residents to discuss their end-of-life wishes with their families and put their wishes in writing, Greenawalt added. ■

Patient-controlled pain med can increase risk of errors

Intravenous patient-controlled analgesia (PCA) allows patients to control their own pain medication, but a new study published in the December 2008 issue of *The Joint Commission Journal on Quality and Patient Safety* shows that errors related to this practice are four times more likely to result in patient harm than errors that occur with other medications.

The study of more than 9,500 PCA errors over five years showed that patient harm occurred in 6.5% of incidents, compared to 1.5% for general medication errors. The PCA errors examined also were more severe —harming patients and requiring clinical interventions in response to the error — than other types of medication errors. Most errors involved the wrong dosage or the wrong drug caused by human factors, equipment, or communication breakdowns. The PCA errors examined also were more severe — harming patients and requiring clinical interventions in response to the error — than other types of medication errors. Harm associated with PCA errors can include respiration suppression, inadequate pain relief, and patient death.

“PCA orders must be written, reviewed and then accurately programmed into sophisticated delivery devices for patients to be pain-free,” said the study’s lead author **Rodney W. Hicks**, PhD, MSN, MPA, endowed chair for patient safety, University Medical Center Health System, and professor, Anita Thigpen Perry School of Nursing, Texas Tech University Health Sciences Center, both in Lubbock, TX. “Such complexity makes PCA an error-prone process,” he said. “Health care organizations should now plan to make the process safer.”

Data for the study came from voluntary reports to the United States Pharmacopoeia’s (USP) MEDMARX Program, and shows that more than 60% of

the hospitals anonymously reporting medication errors through MEDMARX had at least one PCA error.

To reduce PCA errors, Hicks and the co-authors recommend three strategies:

- **Use bar codes and an electronic medication administration record to reduce errors that involve the wrong medication.** Independent double-checks of the PCA orders, the product, and the PCA device settings should be standard practice, the study advises.

- **Ask pharmacists to design easily understood and standardized forms for PCA, and ensure that prescribers use only these standardized forms.** These actions would address communication problems that lead to errors and bring regional standardization to the PCA process.

- **Simplify the technical equipment used in PCA.** The study shows that the PCA process is heavily dependent on the ability of caregivers to execute sequential tasks successfully, so easy-to-follow setup instructions for equipment could reduce errors. ■

Number of patients grows by 3.8%

Hospices serve 1.4 million people

Recently released data reflecting 2007 usage of hospice indicates that 38.8% of all deaths in the United States were under the care of hospice, up from 35% the previous year. The report issued by the National Hospice and Palliative Care Organization shows that 1.4 million people with a life-limiting illness received care from the nation’s 4,700 hospice providers.

The top five diagnoses among hospice patients show the continued trend of fewer cancer patients among those served. Noncancer diagnoses accounted for 58.7% of patients in 2007, which is an increase over the 2006 rate of 55.9% of patients with noncancer diagnoses. The top five diagnoses seen in hospice for 2007 are as follows:

- cancer, 41.3%;
- heart disease, 11.8%;
- debility unspecified, 11.2%;
- dementia, includes Alzheimer’s, 10.1%;
- lung disease, 7.9%.

Other statistics included in the report:

- average length of service increased to 67.4

days (from 59.8 days in 2006);

- 30.8% of those served by hospice died or were discharged in seven days or less;
- 13.1% of those served died or were discharged in 180 days or more. ■

Advanced certification created for social workers

Credential focuses on palliative and hospice care

The National Association of Social Workers (NASW) and the National Hospice and Palliative Care Organization (NHPCO) have created the advanced certified hospice and palliative social worker credential (ACHP-SW).

This is the first national credential in hospice and palliative care tailored to capture the specialized knowledge, skills, and abilities of professional social workers in hospice and palliative care settings. Developed by NASW and NHPCO, it became available from NASW on Nov. 1.

"Many of the professions that comprise the interdisciplinary team in hospice and palliative care offer advanced certifications and credentials," Elizabeth Clark, MD, NASW executive director, said. "There has been no other certification available exclusively for social workers in this domain. Social workers in hospice and palliative care deserve recognition for the unique skills and abilities they bring to the field."

J. Donald Schumacher, NHPCO president and CEO, said, "In developing this new credential, NHPCO and NASW worked closely together to ensure that social workers who earn the ACHP-SW demonstrate the highest levels of expertise and accomplishment in the field. Social workers who earn this credential will show both the professional community and members of the public that they have achieved the highest standards of excellence in end-of-life care."

To secure the ACHP-SW, a social worker must be a member of NASW's and NHPCO's National Council of Hospice and Palliative Professionals

(NCHPP). NCHPP is the individual membership category of NHPCO. NCHPP exists to support the individual discipline and the team concept. Social workers who are employed by an organizational provider member of NHPCO can join NCHPP for free. For others, annual membership rates are \$79 for students, \$149 for social workers with organizations that are not eligible for NHPCO membership, and \$249 for social workers that are employed by organizations that are eligible for NHPCO membership but do not belong.

More information on the ACHP-SW credential is available from the NASW. Go to the NASW web site at www.socialworkers.org. On the right side of the page, select "continuing education and credentials," then scroll down to "Advanced Certified Hospice and Palliative Social Worker (ACHP-SW)." Readers also may call NASW at (202) 408-8600, ext. 447. ■

Woman who launched first hospice dies

Florence Wald, a former Yale nursing dean whose interest in compassionate care led her to launch the first U.S. hospice program, has died, according to the Associated Press (AP). She was 91.

She died Nov. 8 of natural causes, and a hospice volunteer was by her side to the end, according to AP.

When Wald was dean of the Yale University School of Nursing in the 1960s, she updated its curriculum to include a stronger focus on comfort for the dying and their families, AP said.

Wald's passion for hospice began when she heard a lecture by the founder of St. Christopher's Hospice in London, the story said. She later left Yale to study at that center, according to AP.

She returned to organize Connecticut Hospice in 1974 in Branford, which AP says is widely accepted to be the first U.S. hospice program. Her husband and children also became heavily involved in the hospice movement, according to

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the AP. One daughter, quoted in the article, is a nurse and trained hospice worker.

Wald's recent work included efforts to bring more hospice care to U.S. prisons and train inmates as hospice volunteers. ■

Hospital discharges to post-acute care on rise

The annual number of patients discharged from U.S. community hospitals to home health care rose 53% between 1997 and 2006, while the number discharged to long-term care and other facilities rose 30%, according to a new report from the Agency for Healthcare Research and Quality (AHRQ).

According to AHRQ, the increases in part reflect the rising number of hospital patients who are acutely ill. Total annual discharges from community hospitals rose 14% over the period, while Medicaid discharges grew 36%, uninsured discharges grew 34% and Medicare discharges grew 17%. The data are from the 2006 Nationwide Inpatient Sample, part of AHRQ's Healthcare Cost and Utilization Project.

To see the report, go to www.hcup-us.ahrq.gov/reports/factsandfigures/HAR_2006.pdf. ■

Medicare issues home health PPS notice

The Centers for Medicare & Medicaid Services (CMS) issued a notice to update the Home Health Prospective Payment System (HH PPS) for calendar year 2009.

Medicare payments to home health agencies will increase by an estimated additional \$30 million next year as a result of a 2.9% increase in the annual market basket calculation of the cost of goods and services included in providing services under the HH PPS. The update also accounts for a 2.75% reduction to the HH PPS rates (the second year of a four-year, phased-in reduction) to account for the changes in case-mix that are unrelated to patients' health status, and an updated 2009 wage index.

A copy of the notice (CMS-1555-N) is available on the CMS web site at www.cms.hhs.gov/center/hha.asp. ■

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