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# Hospital Home Health<sup>®</sup>

the monthly update for executives and health care professionals

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## What causes more than 40% of home care sentinel events? Answer: Fire

*Improve patient education and staff vigilance to ensure safety*

Your nurses teach patients how to administer their medications, check their blood sugars, use their oxygen, care for their wounds, and in general, take care of themselves as they deal with their illness or condition. Your nurses also review the safety of the home environment, but how well are they protecting your patients from the risks of fire?

According to the latest sentinel event statistics collected by the Joint Commission on the Accreditation of Healthcare Organizations, almost 43% of sentinel events reported by home care programs were for fire in the patient's home, says **Maryanne L. Popovich**, RN, MPH, executive director of the home care accreditation division of the Joint Commission. That statistic leads all other causes of home care sentinel events, with medication errors reported the second most frequently at 14.3%, and patient falls reported slightly more than 6% of the time, she adds.

"Overall, the number of fires in patients' homes that result in injury or death has decreased since we started collecting sentinel event data for home care in 1997, but the frequency points out the need for thorough assessments and patient education," Popovich explains. "In March 2001, we issued a sentinel event alert related to home fires, after studying the root causes of the events," she says.

Because the sentinel event reporting system requires a home care agency to report any serious injury or death that occurs in the patient's home while the patient is in the care of a home health agency, not all fires are directly related to the home care agency's actions, points out Popovich. This means that nonhome-health-related reasons such as faulty wiring, unsafe holiday decorations, and carelessness of a cognitively impaired patient operating a stove all can be reasons for the fires. "For this reason, it is very important that home care nurses include a thorough home safety evaluation for all patients," she adds. A home safety evaluation should include a process for testing smoke alarms and designing an evacuation plan if needed, Popovich suggests.

Home care nurses do change the patient's environment, bringing in equipment that may increase fire risks, so it is vital that the initial

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assessment include training specific to fire safety with items such as oxygen tanks, says **Karen Apkins**, RN, head nurse at Titusville (PA) Hospital Home Health.

"Some patients are more at risk for fires because they are using oxygen," she explains. While all home health patients get a thorough general safety assessment that includes looking for items such as frayed electrical cords, patients using oxygen get more thorough teaching that focuses on the dangers of open flames and oxygen. "In rural areas, we are dealing with kerosene heaters and wood stoves, so we make a point of explaining fire safety and oxygen. We also talk with patients about the dangers of smoking cigarettes and letting family members smoke in the house," Apkins says.

"Don't forget to talk about other open flames such as fireplaces, gas stoves, and candles when educating patients about fire safety," Popovich continues. "Even if your patient or the family

caregiver doesn't smoke, remember that visitors or other relatives may smoke," she says. "Be sure to talk to the patient and family caregiver about the dangers of smoking when oxygen is in use and point out that this applies to any visitor. In fact, it is a good idea to place a small placard on the tank, or other visible location, that reminds people not to smoke," Popovich suggests.

"Although we have written information about fire safety, with older patients and older family caregivers, it is better to present the information verbally," Apkins says. "Be sure that your general safety assessment also includes looking for fire extinguishers and clutter-free paths that will enable easy evacuation," she adds.

In addition to assessing the home environment for safety hazards, be sure you assess your patient and the family caregiver carefully, especially when oxygen is in the home, Popovich suggests. The best education program possible won't alleviate risk if the person in the home is unable to understand the risks, she adds.

Also, communicate with your physicians and vendors supplying oxygen, Popovich explains. "Poor communication between the home care staff, physicians, and vendors was listed as the root cause in over 50% of the sentinel events," she says. Home care nurses should communicate with physicians if patients are noncompliant with fire safety steps, and vendors should also be made aware of potential problems, Popovich adds.

"Don't forget that assessment of fire risk is ongoing because things in the home get moved around or more electrical extensions are added for extra equipment," Apkins says. Most importantly, document any suggestions you make to the patient and caregiver to decrease the risk of fire, she suggests.

If you notice a lack of smoke detectors, faulty wiring, or candles close to draperies, and you suggest adding the detectors, fixing the wires, or moving the candles, document and date your suggestions, Apkins stresses. "Although we are careful to document all clinical issues, we sometimes forget that documentation of nonclinical items is just as important. Our assessment of fire risk and suggestions for reduction of that risk are just as important to the welfare of our patients as anything we do."

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To see a copy of the latest sentinel event statistics from the Joint Commission, go to: [www.jcaho.org](http://www.jcaho.org). Click on sentinel event statistics under the "Latest From JCAHO" heading, then choose sentinel event statistics.

To see a copy of the March 2001 Sentinel Event Alert related to home care fires, go to [www.jcaho.org](http://www.jcaho.org), choose search, and enter "Sentinel Event Alert, March 17, 2001." ] ■

## Small steps and realistic goals control diabetes

*Don't overwhelm patients with lofty expectations*

**H**elping your diabetic patient stabilize blood sugar levels and improve control of the disease doesn't necessarily mean new medications, significant weight loss, or a major change in their lifestyle, according to experts interviewed by *Hospital Home Health*.

Don't present your patient with a lengthy list of dos and don'ts, most of which will be ignored because the patient thinks that there is no way he or she can do what is needed, says **Janine M. Vogel**, RN, CDE, a diabetes educator for Lake Regional Health System in Osage Beach, MO.

"It is like making your New Year's resolutions. If your list is too ambitious and too long, you'll end up not keeping any of them," she points out.

The first step to helping a patient set his or her goals is to talk with them, Vogel says. "Find out what kind of person the patient is."

Some patients, especially older patients, will have the attitude that amputation is inevitable so why bother changing the way they live, she says.

"Find out what the person knows about diabetes, monitoring blood sugar, medication, nutrition, and control of diabetes," she recommends. After you have a good idea of the patient's attitude toward the disease and the level of knowledge the patient possesses, then you can begin to set goals, Vogel adds.

Keep the goals realistic and make sure the

patient has the resources to meet them, Vogel says.

"For example, can the patient afford test strips or is there running water in the home for hand washing?" she asks. This is an important step because if the patient is noncompliant because there is no one to pick up supplies for him, you don't want to just write him off, Vogel adds.

Be sure to address stress as a factor that affects diabetic control, she continues. "I have patients who will be controlling their blood sugar levels with no problems until their children come to visit," she says.

The stress of some family dynamics or just the disruption of a comfortable routine not only affect a patient's diet, exercise, and schedule for testing, but the stress itself affects blood sugar levels, Vogel adds. "Build stress management techniques into your teaching so patients can learn to recognize and handle their stressful situations."

While losing weight is a great benefit to overweight diabetic patients, it may only take as little as 5% to 10% of weight loss to make a difference in the ability to control blood glucose levels, says **Joy Pape**, RN, BSN, CDE, president of Enjoy Life Health Consulting in Columbia, MO.

"Reducing calorie intake by decreasing starchy foods and increasing protein doesn't have to mean a giving up all foods a patient enjoys so the diet is easier to maintain," she says.

Patients also need to increase their activity level, Pape adds. "Home care patients with some mobility can do little things like walking to the kitchen for a glass of water or just walking around a chair or dining room table," she says.

Some patients turn to herbs to help themselves lose weight or to control their blood sugar, Vogel explains. "While herbs and complementary therapies can be beneficial, it's important for the home care nurse to find out if the patient is using an alternative therapy. One study showed that 60% of 2,000 diabetic patients interviewed were using alternative therapies but less than 2% shared the information with their physician because they didn't think the physician would agree with use of the therapy or herb," she says.

This can be dangerous for patients who choose herbs that interact with medications they are currently taking, Vogel adds.

"Chromium picolinate is the most dangerous for diabetics even though [some believe] that the supplement can be used to control diabetes and help with weight loss. This supplement works by

lowering blood sugar levels and that is very dangerous for patients who are already taking insulin," she adds. **(For more information about herbs and supplements, see *Hospital Home Health*, October 2002, p. 114.)**

Don't forget that insulin is the best way to control diabetes; and although it is often viewed as a last resort, home care nurses should present the possibility of insulin in a positive light, says Vogel. "Patients who are prescribed insulin after a period of trying to control the diabetes with lifestyle, diet, and exercise changes often feel as if they've failed," she explains.

"This can lead to a pattern of noncompliance during which patients forget to get prescriptions filled or lose syringes," she says.

Home care nurses can help patients deal with their reluctance to take insulin by introducing the idea of insulin long before it is prescribed, Vogel suggests.

"Explain that diabetes is a progressive disease to your new diabetic patients. Be sure to say that while they may not be on insulin right now, they will probably need it at some time in the future,"

she recommends. By talking about insulin early on in patients' education, the home care nurse can prepare them emotionally so that they won't feel like failures, she adds.

"The main idea to communicate to patients is that they can make a difference in the progress and control of their disease," Pape stresses. "It's important that home care nurses stay on top of information about diabetes so they can share with their patients."

"If the nurse can offer practical, realistic advice on how they can manage diabetes on a day-to-day basis, patients will meet their goals and enjoy good outcomes," she adds.

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## HIPAA

## Q & A

*[Editor's note: This column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Hospital Home Health, Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com]*

**Question:** Does the HIPAA security rule specify how a risk analysis must be conducted?

**Answer:** "The security rule requires all covered entities to perform an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of EPHI in its possession," says **Robert W. Markette Jr.**, an Indianapolis attorney.

"The rule does not specify how a covered entity should perform this assessment," he adds. "Frankly, even computer security experts don't all use the same methods," Markette admits.

The goal of a risk analysis is to identify potential risks and their likelihood of occurring, he explains.

"A risk assessment can be performed by hiring outside consultants or can be performed by the home health staff," Markette says.

"Home health agencies will need to use their own judgment when deciding whether to handle the risk assessment on their own or to hire outside consultants," he says. The decision may depend on the agency's individual staff resources and expertise, Markette adds.

**Question:** How should passwords be chosen to ensure security?

**Answer:** "There are a few rules of thumb for choosing passwords," says Markette. "First, do not use words from the dictionary or obvious words such as relatives' names or pets' names," he emphasizes.

"Do not use your birth date or a relatives' birth date," he says. Birth dates and names are easily learned and are often the first things a hacker will choose when guessing a password, he explains.

"Generally, a password should be a combination of letters, numbers, and perhaps, even other ASCII characters," Markette suggests.

"Of course, this is a two-edged sword," he points out. The more complicated the password, the more difficult it is for a hacker to guess; but it also is more difficult for an employee to remember, Markette explains.

Complicated passwords are of absolutely no

value for security purposes if the employee writes on a Post-it note that is stuck to the computer screen, he says.

There are a couple of ways you can come up with difficult-to-guess but easy-to-remember passwords, Markette continues.

"You can combine somebody's initials with the last four digits of another person's phone number, or take the first letter from each word in an easily remembered phrase and combine it in some way with a birth date or phone number," he suggests.

For example: The phrase "hasta la vista baby" combined with the last four digits of a phone number could become any of the following:

- alvb5543;
- a5l5v4b3;
- 5543alvb;
- 5a5l4v3b.

"None of these passwords are easily guessed, but for the employee they should be simpler to remember than trgh678# or some other randomly generated password" he explains.

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## Impact of new legislation continues for home health

*Background checks, homebound evaluated by HR 1*

*[Editor's note: This is the second of a two-part article that looks at the challenges faced by home health managers. In the first article, challenges were identified and the impact of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (HR 1) was discussed. This month's article looks at demonstration projects included in HR 1 that affect the home health industry.]*

In addition to the reduction of the marketbasket update, extension of the rural add-on, and elimination of the home health copayment, HR 1 also calls for demonstration projects that will affect home health hiring practices, definition of homebound patients, and collaboration with adult day care, says **Ann B. Howard**, director of federal policy for the American Association for Homecare in Alexandria, VA. New procedures and programs include:

- **Employee background checks**

One 10-state pilot project that will run for three years requires a criminal background check on home health employees, Howard points out. In addition to state licensure checks and confirmation of previous employment, home health managers would need to check state and federal databases for criminal backgrounds as well as the Office of Inspector General and General Services Administration web sites to see if potential employees have been excluded from Medicare program participation, she adds.

This project is an important one to watch because there are a number of concerns for home health, she says. "Not only will this requirement add to the expense of hiring new employees but it adds time to

the hiring process," Howard explains.

Because criminal background checks can take time, home health managers are concerned that their agencies will have to operate short-staffed for longer periods of time, even when a qualified candidate is available, she adds.

- **Payments linked to outcomes**

Another project that ultimately could affect a home health agency's bottom line is a three-state project that will look at linking outcomes to reimbursement, she continues. This project focuses on patients with chronic conditions and evaluates indicators that can be used to reimburse agencies with better outcomes at a higher rate, Howard says.

- **Redefinition of homebound status**

A three-state, two-year demonstration project will evaluate the impact on Medicare of further loosening the homebound definition for 15,000 younger beneficiaries who can leave their homes for visits to locations such as adult day care centers but still need help with activities of daily living, says **Seth Johnson**, director of public policy for the American Association for Homecare. **(For information on adult day care and home health working together, see *Hospital Home Health*, September 2003, p. 101).**

"If the definition is loosened, home health agencies and adult day care centers will benefit from affiliations and even joint ownership," he says.

If implemented, the new definition may result in increased numbers of patients eligible for home health services, Johnson adds.

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# End-of-life caregivers often don't get support

*Grief counseling should be available*

In teaching health care providers how to care for patients at the end of life, many institutions forget to teach the providers that they need to care for themselves as well.

Physicians, nurses, and other personnel who care for dying patients on a daily basis — who also must frequently cope with the death of a patient — need special support if they are going to continue to provide optimal care. Nursing homes, hospices, and hospitals are just beginning to provide the sorts of programs and education that these caregivers need, say advocates.

“Caregivers and staff often become like family,” says **Donalyn Gross**, PhD, LCSW, a clinical social worker who works with nursing homes to improve the care of and response to dying residents. “Sometimes, residents will tell the caregivers something that they would not tell their immediate family. And they also hear things from family members that they don’t want the resident to hear. They develop a relationship.”

When Gross began working in nursing homes as a teenager, she noticed that residents’ deaths were met with little ceremony. Often after a resident died following a long illness, the staff members simply would do what was necessary to take care of the body, then simply close the door and wait for representatives from the family or funeral home to arrive and do the rest.

Aside from the negative impact on residents’ families, this also had a detrimental effect on the caregivers, Gross contends. “The tended to shut down and feel as if they had to distance themselves from the people they cared for. They were also very uncomfortable with death and the process of dying, yet they saw it all the time.”

In Gross’ current practice, she encourages nursing homes and hospitals to establish support groups for people who care for dying patients and encourage open discussion and sharing of feelings of grief and uncertainty after a patient’s death. “It doesn’t have to be mandatory that people attend the groups, but it should be available,” she notes. “More people are recognizing that this is a need that caregivers have. I had a call recently from a nursing home director who said, ‘We’ve had a lot of deaths here recently. Can you come in here and

help get people to talk?’ They need to know that their feelings are normal, and it is OK to feel bad, and it is OK for them to cry.”

Gross also encourages facilities to hold some sort of ceremony for people who have died. At the nursing home where she currently works, a memorial service is held annually to honor the residents who have died over the past year.

“We invite the residents, family, staff . . . everybody. Everybody pitches in with the planning, and it is a wonderful thing. We play music, and we allow people to share their memories of the people who died.” The services give staff a chance to honor the residents they have come to know, and the residents’ family members are comforted by realizing their loved ones were cared for and really known by the people at the facility, she adds.

Although hospices often are an exception, many health care facilities fail to recognize that clinicians may grieve the loss of a patient or have difficulty dealing with patients’ deaths over time, agrees the Rev. **Martha Jacobs**, former chaplain with the New York United Hospital Medical Center, now the associate director of pastoral education and community-based programs with The Healthcare Chaplaincy, a nonprofit, multi-faith center dedicated to advancing pastoral care at health care sites throughout the New York City metro area. “Hospices do a better job with this, and they often offer support groups for their staff,” she notes. “But in hospitals, a lot of times the prevailing attitude seems to be that you shouldn’t have feelings, and if you do, you need to deal with them on your own time.”

Hospital staff often have problems coping with their feelings of grief over dying patients, particularly when a patient’s case has been very difficult, or when the patient is close to the caregiver’s own age, Jacobs says. “That challenges the chaplains a lot as well, when someone close to your own age dies. And if the providers have gone through a death in the family recently, that can be difficult as well. For example, a nurse whose mother has died may have a difficult time coping when faced with the children of a dying patient.”

At her former hospital, Jacobs frequently tried to organize debriefing sessions for staff after the death of a patient — particularly if the patient’s care had been difficult or the patient had been in the hospital for a long period of time. “It’s essential that staff have that opportunity to vent their feelings and talk about them,” she notes. “If they are forced to keep bottling it up inside, they start to lose the ability to be sympathetic with the

patients and start to distance themselves. At that point, they will burn out very quickly.”

It may be necessary for the support group meetings or debriefing sessions to be held at an out-of-the-way place, Jacobs adds, because there still is sometimes a stigma associated with health care providers who need help. “I found this to be true during 9/11. The fire and police departments had support groups and sessions available for the people working at Ground Zero, but many people did not want to be seen leaving the site or be taken away from their duties.”

Health care providers are very accustomed to being the people whom others turn to for help, and it may be difficult to accept the idea that they need help, too.

“There is sometimes the idea that if you seek help to deal with these negative feelings of grief, then others will think you are burned out or you aren’t capable of doing that job any more,” Jacobs says. “In reality, I think the day you don’t have a problem with patients who die is the day that you need to stop.”

Facilities also need to provide education about the stages of dying and what might happen with patients when they are dying, Gross points out. This information is particularly necessary for staff who may help care for patients, but have little medical training themselves.

She holds training workshops for nursing home staff on understanding death and dying and covers both common clinical stages of dying and some of the physical manifestations that might occur. Gross also covers how to relate to and speak to patients who are dying and to their families. “Especially in a nursing home, the housekeepers and even the dietary staff will get to know a patient, and it is important — and they are so relieved to learn these things. “It helps them become more comfortable with the idea of death and dying and in knowing the things that will happen.”

As the staff become more comfortable with death and mortality, they are better able to bond with the residents and care for them, both before and when they die, she adds. “I’ve seen such a change in people. Where once they may have been very remote — when someone died, they just did their job and cleaned the body and shut the door and that was that. Now, some people will actually sit with someone who has died; they wait until the family comes in or the funeral director comes in.

“You can really see the change and that they are more comfortable with things. They talk about things more freely and are more comfortable with

the family and talking about that person than they were before,” Gross says.

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## Pain-relief measures take root nationwide

*Despite progress, much pain still poorly managed*

Attorneys general should play a role in advising state agencies and educating others about how laws and policies related to end-of-life care should be enforced, especially if they seem to be at odds with patient rights. The most salient example of this conflict has been the ongoing battle between end-of-life care advocates and law enforcement agencies.

Efforts to stem drug diversion, particularly for the drug OxyContin, have physicians fearing prosecution if they regularly prescribe opioids or if a terminally ill patient dies.

**Drew Edmondson**, attorney general for Oklahoma and outgoing president of the National Association of Attorneys General (NAAG), says his colleagues must use their positions to educate physicians, prosecutors, medical boards, and others about the intention behind federal and state anti-drug laws. “The NAAG should convene the parties and explain that the law is not intended to punish physicians who use these drugs appropriately,” he adds.

In the same year that Edmondson made improving end-of-life care a focus of his one-year term as NAAG president, there have been encouraging signs that honest physicians have little to fear, while those who fail to provide comfort through pain management drugs are at risk for criminal punishment or professional sanctions.

According to the *American Medical Association (AMA) News* in June, three studies concerning medical boards, prosecution, and pain treatment guidelines showed progress in differentiating criminal physicians from compliant ones. The studies were published in the Spring 2003 issue of the *Journal of Law, Medicine & Ethics*.

The first study was a survey of 38 medical boards, which found that boards were abandoning drug quantity as a marker of questionable practice and assessing instead whether a doctor properly evaluated a patient and followed the board's pain treatment guidelines. A second study of county prosecutors in Oregon, Maryland, Washington, and Connecticut found the likelihood of investigation or prosecution for prescribing medications for pain management extremely low. A third study said more boards had adopted pain management guidelines but recommended that they take further steps to train investigators about pain standards and circulate guidelines to physicians.

When the AMA last published its annual state-by-state review of pain policies, it found encouraging data. State regulators, according to the AMA, are taking unprecedented steps to help physicians provide relief to cancer patients and others suffering from chronic pain. However, **Aaron M. Gilson**, PhD, AMA's pain policy expert, says despite the availability of many pharmacologic and nonpharmacologic approaches to the treatment of pain, pain remains inadequately managed, due in part to concerns about addiction and legal sanctions.

The AMA's annual report in 2001 found a steady adoption of state pain policies that ease constraints surrounding the use of opioid analgesics for the treatment of pain. These policies were developed by medical regulators and can result in more pain patients receiving appropriate treatments, says Gilson, chief policy researcher and assistant director of the Pain & Policy Studies Group at the University of Wisconsin in Madison.

### ***State medical boards: Pain is undertreated***

In 1998, the Federation of State Medical Boards developed model guidelines that encourage the use of controlled substances for pain therapy and give physicians guidance in the use of controlled substances. The guidelines also recognize that pain is undertreated, partially due to physician concern regarding investigation by state regulatory agencies and medical boards. "This is unprecedented policy development," Gilson explains. "Not only did it come from a national regulatory organization, but it also represents input from a multidisciplinary panel of experts from medicine and from medical regulation." The policy was disseminated to medical boards in each state.

The report found that state policies addressing the appropriate use of controlled substances for pain management increased from six in 1989 to

more than 80 in 2001; some states have more than one policy. In addition, the report suggested that 22 states have developed policies addressing the use of controlled substances for pain that are based on the model guidelines. Twelve states adopted the policy in its entirety. "Most states now have some type of policy relating to pain management," Gilson stresses.

Still, the AMA says some state policies, especially those not based on the model guidelines, contain language that has the potential to impede the use of opioid analgesics and restrict patient access to adequate pain management. "Considering the increased collaboration between medical regulators, drug regulators, and the health care community, I am hopeful that these policies translate into more appropriate pain management for patients and lessened concerns about unwarranted discipline of physicians," Gilson adds.

In 2003, there were a number of other developments in pain management at the state level. In Florida, proposed prescription tracking legislation failed to pass in the final moments of the state's legislative session. Many complained that tracking systems would have a chilling effect on physician prescribing patterns. Rather than risk investigation and discipline as a result of one interpretation of prescribing habits tracked on a system, physicians may not prescribe opioids at all, critics say.

The bill would have created a program to track prescriptions for Schedule II, III, and IV medications, which include many pain and psychiatric drugs. Supporters say a tracking program would prevent prescription drug overdose deaths.

Purdue Pharma, the Connecticut-based manufacturer of OxyContin, pledged \$2 million toward financing a tracking program last year as part of an agreement with the Florida attorney general's office to end an investigation into the company's marketing practices. This is the second year that Florida legislators have considered and declined to pass legislation on the program.

In Virginia, the state received \$180,000 from the U.S. Department of Justice to fund a prescription-tracking program approved by the state legislature last year. The two-year pilot program will focus on counties in southwest Virginia, where prescription drug abuse has become a major problem in recent years. The program will allow police to access a database containing information about prescriptions for Schedule II drugs, such as OxyContin, methadone, and Percocet.

Virginia Attorney General **Jerry Kilgore** favors

the tracking system, saying the database will be useful in curbing abuse of OxyContin.

The database is expected to be operational by late summer or early fall, according to **Robert Nebiker** of the state's Department of Health Professions, which will oversee the program's operation. It will be accessible only by law enforcement officers who have an active investigation into a patient or doctor.

The law creating the pilot program makes unauthorized release of database information a misdemeanor.

U.S. Rep. **Frank R. Wolf** (R-VA) has asked the U.S. Department of Health and Human Services to restrict OxyContin prescriptions to patients with severe pain. Wolf also has requested that Health and Human Services Secretary Tommy G. Thompson take steps to warn the public about the dangers of OxyContin abuse.

His letter to the agency cites a link between OxyContin and overdose deaths and robberies in his home state and argues that "[t]he drug should not be marketed to treat moderate pain."

Wolf chairs the House Appropriations subcommittee, which oversees the Commerce, Justice, and State departments and related agencies. ■

## LegalEase

*Understanding Laws, Rules, Regulations*

### Ethics of discontinuing home health services

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

Over time, patients who initially are appropriate for home health services may no longer meet the care criteria from agency staff. For example, the clinical condition of patients may become so complex that they cannot be treated properly at home. Likewise, the availability of reliable primary caregivers may change. The patient's spouse may become too ill to participate in care. Case managers/discharge planners may recommend nursing home placement for patients they may flatly reject.

However, under these circumstances, staff may

have concerns about terminating services that they express in terms of ethics. They may acknowledge that it is legal to terminate services but say they are not certain that discontinuation is ethical. As a result, it is important to address ethical concerns about termination of services.

One of the most common dilemmas faced by home care staff occurs when patients refuse transfer to a nursing home. A careful review of this issue from an ethical point of view should include examination of three principles: autonomy, justice, and beneficence/nonbeneficence

#### 1. Autonomy.

The term generally means patients can make choices and act upon them.<sup>1</sup> The primary mechanism to ensure patients' autonomy in home care is through the process of informed consent. Patients are given information about treatment alternatives upon which they base their choices. This principle requires health care providers to honor patients' choices, including decisions to refuse treatment. Bioethicists recognize the right of patients to refuse treatment in the form of nursing home placement.

Patients have an absolute right to stay at home, and staff must honor their choices to be ethical. But does the patient's decision to refuse treatment mean staff should continue to arrange for and/or provide care in inappropriate settings? Must staff help patients refuse treatment by continuing to provide care at home? The principles of justice and beneficence/nonbeneficence may provide some insight into the answer.

#### 2. Justice.

This term means every patient receives his or her due. Individuals are entitled to justice. According to the principle of so-called distributive justice, justice also must be applied on a communitywide basis.<sup>1</sup> So a key question is: What is just in the case of patients who refuse nursing home placement for both individuals and the community? Patients who are inappropriate for home care often gobble up agency resources. When patients who need continuous care receive only intermittent services, staff almost always end up trying to take up the slack by going well beyond the proverbial extra mile. Although ethical issues are sometimes characterized as matters of patients' rights, it is important to recognize that ethical principles apply to everyone involved in the care of patients — including staff.

Do staff receive their just due when asked to care for patients who are inappropriate for home care and perhaps at great risk of injury as a result? In terms of distributive justice, is it fair to other patients to lavish attention on patients who are

inappropriate for home care, so that others may not receive adequate attention?

When viewed from this perspective, staff may conclude that it is not just to continue to arrange for or provide services to patients who refuse nursing home care. Another dimension of justice also is relevant. Justice implies that patients are entitled to their due in the sense of appropriate care. When agencies assist patients who remain at an inappropriate level of care, and patients are denied justice in this form, they may not be acting in a manner consistent with ethical principles.

### 3. Beneficence/nonbeneficence.

These principles must also be examined in view of this dilemma. Beneficence means staff members act to do good for patients. Nonbeneficence is a more passive principle that basically requires staff to do no harm.<sup>1</sup>

What action should agencies take when patients refuse treatment in the form of nursing home placement? Both justice and beneficence may dictate that patients take action to secure appropriate treatment in a nursing home. Thus, although home care practitioners tend to conclude that "some care is better than no care," this mindset may be ethically unsound.

The principle of nonbeneficence may dictate discontinuation of home health services in order to avoid enabling patients to remain in inappropriate settings.

Consideration of ethical issues always involves balancing ethical principles of various participants' points of view.

Certainly there are no easy answers to ethical questions in home care. Providers, however, must be careful to engage in ethical decision making, as opposed to operating from their "guts," when a situation just feels wrong.

When providers engage in a process of ethical decision making, they may conclude that they are acting ethically when refusing to arrange for or discontinuing services to patients who are no longer appropriate for home care.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Phone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue@comcast.net.]

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# NEWS BRIEFS

## New tool evaluates care options for seniors

*Web site educates and empowers caregivers*

Those who work with senior citizens have a new tool to help them advise their clients on appropriate care or living decisions.

CarePlanner is a web site and on-line tool to help people make decisions about care for the elderly or disabled, based on their situation and preferences.

The purpose of the tool is to educate and empower caregivers to make appropriate decisions, including keeping seniors at home if possible, says **Meghan Coulehan**, MPH, research project director for CarePlanner at Clinical Tools Inc., a health care management company that developed CarePlanner through a grant from the Centers for Medicare & Medicaid Services.

The CarePlanner asks users a series of questions about the senior's age, gender, current living environment, and state of residence. It includes questions about financial issues, health status, treatments, ability to carry out activities of daily living, personal preferences (such as doing their own cooking or sharing a bedroom), and the availability and health of any caregivers.

Based on the selections, the CarePlanner creates advice reports analyzing the senior's potential for successfully living in each of seven living and care options: hospice, home care, retirement community, continuing care community, personal care home, assisted-living facility, and nursing home.

The tool includes links to other agencies and organizations that can help in implementing the plan.

"It doesn't tell people what the best option might be. It gives them recommendations for successful placement," Coulehan says.

The CarePlanner aims to educate seniors, their families, and caregivers about community-based and home-based health care options, with an emphasis on options that provide care at home, she adds.

"Most people don't know about all the resources that are available. If Mom falls and breaks her hip, the family thinks the only option is to put her in a nursing home," Coulehan says.

The tool is designed for seniors, physically disabled people with a chronic illness who need supportive services, and their caregivers, case managers, social workers, and families. The care planning process tends to be overwhelming, Coulehan comments.

"A lot of times, people become caregivers because of a sudden event. They know nothing about caregiving options or making arrangements, and it's dumped on them all at once," she adds.

For more information, see the CarePlanner web site at [www.careplanner.org](http://www.careplanner.org). ▼

## JCAHO modifies patient safety goals

An important part of any accreditation survey by the Joint Commission on the Accreditation of Healthcare Organizations is the review of a home health agency's compliance with the National Patient Safety Goals. **(For information on patient safety goals, see *Hospital Home Health*, January 2004, p. 4.)**

Some of the safety goals were designed more for acute care settings than for home care, so the Joint Commission has modified the goals to better reflect home care practice.

The modifications for the home care patient safety goals are effective immediately.

The modifications are:

- Goal #4, which relates to elimination of wrong-site, wrong-patient, wrong-procedure surgery, has been removed from the home care goals.
- The wording of Goal #3 (improving the safety of high-alert medications), Goal #5 (improving the safety of using infusion pumps), and Goal #6 (improving the effectiveness of clinical alarm systems) have been modified

slightly to reflect home care services.

The modifications are the first of a two-phase plan for the Home Care Accreditation Program.

The second phase includes the review of available sentinel event data and determination of the feasibility of identifying new program-specific evidence or experienced-based requirements for 2005. Any changes to accreditation requirements made during 2004 will be implemented Jan. 1, 2005.

# SARS

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To view the 2004 National Patient Safety Goals for Home Care on-line, go to: [www.jcaho.org/accredited+organizations/home+care/standards/revisions/04\\_hc\\_npsg.htm](http://www.jcaho.org/accredited+organizations/home+care/standards/revisions/04_hc_npsg.htm). ■

## CE questions

*Editor's note: Last month's CE questions were numbered incorrectly. The numbering should have been 13, 14, 15, 16. This month's questions resume the correct pattern.*

For more information on the CE program, contact customer service at (800) 688-2421.

17. What type of home care patients are most at risk for fire in the home, according to Karen Apkins, RN, head nurse at Titusville Hospital Home Health?
- patients who live in rural areas
  - patients with fireplaces
  - patients who use oxygen
  - patients with a family caregiver
18. How much weight loss is necessary to improve control of diabetes in most patients, according to Joy Pape, RN, BSN, CDE, president of Enjoy Life Health Consulting in Columbia, MO?
- 5% to 10%
  - 15% to 18%
  - 20% to 23%
  - 25%
19. According to Robert W. Markette Jr., why are complicated passwords a problem for home health agency staff?
- It makes it difficult to share passwords.
  - They require too many characters.
  - Staff can't remember them.
  - They require too much time to input.
20. When considering the ethics of discontinuing service when a patient is no longer appropriate for home health, Elizabeth Hogue, Esq., recommends examination of three principles: autonomy, justice, and?
- legality
  - beneficence/nonbeneficence
  - severity of patient's condition
  - none of the above

**Answer Key:** 17. C; 18. A; 19. C; 20. B

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## CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

- Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
- Describe how the issues affect nurses, patients, and the home care industry in general.
- Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■