

HOSPICE Management ADVISOR

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Hospice status survives and advances in Medicare reform legislation

New law will offer some immediate benefits

While the debate over Medicare reform swirled around how to provide relief to senior citizens burdened by the high cost of prescription drugs, care for the dying was quietly improved. Once the massive Medicare reform bill was signed into law Dec. 8, hospices became the recipients of changes that industry experts say will help increase access to hospice care.

President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 amid ceremony and fanfare to showcase Medicare's new prescription drug benefit, and to hold up the sweeping change as a feather in his administration's cap. For hospices, though, there was celebration of the fact that Medicare left the hospice benefit largely intact and preserved its status. That means access to hospice services will not be negatively affected by other changes in the Medicare program.

The latest Medicare legislation includes a managed care program, as well as changes to traditional Medicare. Just as hospice care was treated under previous and current Medicare managed care programs, the Medicare Hospice Benefit will continue to be treated as a "carve out." Under traditional Medicare, the hospice benefit remains a distinct service.

"It's a step in the right direction," says Naomi Naierman, MPA, president and chief executive officer of the American Hospice Foundation in Washington, DC.

These industry-supported measures ensure hospice access for Medicare beneficiaries regardless of the Medicare program they select, says Jon Keyserling, vice president of public policy for the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA.

Unlike the drug benefit, which doesn't take effect until 2006, provisions aimed at strengthening the services hospices provide to dying Americans and their families became effective when Bush signed the legislation into

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law. Under the provisions, Medicare-certified hospices will be allowed to contract with other Medicare-certified hospices for core services. According to the NHPKO, this will help hospices provide core services when faced with situations such as unexpected periods of high patient census or staffing shortages. This new provision was included to address two potential service gaps: care for the traveling patient and care requiring specialized nursing services.

Provisions enhance flexibility

The NHPKO-supported provision allows hospices to contract for highly specialized nursing services, such as infusion therapy specialists, giving hospices flexibility to meet the unique care needs of hospice patients.

Under old Medicare regulations, traveling hospice patients — such as those who live with out-of-state family members for a portion of

their illness — would have to be discharged from their current hospice and then admitted to the hospice in the area they are visiting. When the patient returns home, he or she would have to be discharged from the hospice in the out-of-state location and be readmitted to the original hospice.

Now, the hospice simply contracts with a hospice at the patient's destination, avoiding the need to temporarily discharge the patient and preventing loss of control over the care the patient receives.

Hospices also can contract staff to provide specialized nursing services, but this comes with a catch: Hospices will have to prove that employing a nurse for these services is not cost-effective. Specifically, hospices will have to show the specialized service is not one routinely provided by the hospice.

These provisions follow a temporary measure issued by the Centers for Medicare & Medicaid Services (CMS) in September 2002, which allowed hospices to contract for core nursing services rather than hire a nurse to provide services. The move was made to address the nursing shortage that still afflicts all of health care.

Red tape aplenty

However, CMS' sympathy for the plight of hospices doesn't come without its share of red tape. To qualify for the exemption to the core services provision, a hospice is required to provide written notification to its state survey agency when the nursing shortage has become so severe that the hospice is unable to hire its own nurses. In addition, the hospice must estimate the number of nurses it will need to employ under contract. This notification should do the following:

- Give an estimate of the number of patients that the hospice has not been able to admit during the past three months due to the nursing shortage and the current and desired patient/nurse ratio for the agency.
- Provide evidence that the hospice has made a good-faith effort to hire and retain nurses, including:
 - copies of advertisements in local newspapers that demonstrate recruitment efforts;
 - copies of reports of telephone contacts with potential hires, professional schools and organizations, recruiting services, etc.;
 - evidence that the hospice's salary and benefits are competitive for the area;

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Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

— evidence of any other recruiting activities (e.g., recruiting efforts at health fairs, educational institutions, health care facilities, and contacts with nurses at other providers in the area);

— an ongoing self-analysis of the hospice's trends in hiring and retaining qualified staff.

- Demonstrate that it has a training program in place to ensure contracted staff are trained in the hospice philosophy and the provision of palliative care prior to patient contact.

- Provide assurance that contracted staff are providing care that is consistent with the hospice philosophy and the patient's plan of care.

- Show that contracted nurses are used to supplement the hospice nurses employed directly. Contracted nurses should not be used solely to provide the continuous nursing level of care or on-call service.

- Show that the hospice is expected to continue its recruitment efforts during the period when it is contracting nurses.

Nurse practitioners not employed by a hospice will now be allowed to continue following their patients who elect hospice care. This provision addresses the disruption in the continuity of care when a patient elects hospice and must give up the staff that has cared for him or her for the majority of the patient's illness. Also, the inability to continue the patient/nurse relationship has been a barrier for many people who would benefit from hospice care.

Under the old rules, physicians were the only exception to the requirement that patients, upon entering hospice care, give up services not related to hospice care. This change closes the gap that can occur when nurse practitioners play a role more prominent than a physician.

"In rural settings, a nurse practitioner is often the only caregiver for miles around," says Keyserling. "Now the disincentive of losing a caregiver is no longer there."

Nurse practitioners, like a patient's physicians, are allowed to continue providing visits and assist patient management. The nurse practitioner, however, cannot certify that a patient is hospice-eligible, and payment for nurse practitioner services is separate from the hospice per diem.

Another change is that Medicare will now allow for a one-time hospice consultation service for terminally ill Medicare beneficiaries beginning in January 2005. The service, which must be provided by a physician who is either the hospice medical director or an employee of a hospice program, would involve an evaluation of the individual's pain and symptom management needs, counseling regarding end-of-life issues and options for obtaining care, and advising the individual regarding advance care planning.

"It provides a knowledgeable source to a patient so the patient can make an informed decision," Keyserling says.

The education consultation provision provides hospices with another opportunity to reach out to patients, and it also becomes a source of revenue, albeit a modest one. How the visit will be coded using CPT codes for

Part B services is yet to be determined, but it will likely come out of the evaluation and management section of the coding manual.

"It gives patients a chance to consult with a hospice physician without having to commit to electing the hospice benefit," says Naierman. "Any opportunity to reach out and talk to people about hospice will inevitably increase access to hospice."

CMS will establish three rural demonstration sites that will provide hospice care in residential facilities of 20 beds or fewer for beneficiaries who are unable to receive hospice care in their home. The demonstration sites will provide care inside the facility and not in the community. This demonstration project will be conducted over a period of not more than five years.

The provision calling for demonstration projects does not have money attached to it, but it grants a waiver to participants for the 80/20 Rule, which requires inpatient care not to exceed 20% of the care the hospice provides. In at least one of the sites, an inpatient facility will act as a central site for care, allowing patients in remote areas who are without caregivers to be cared for in a hospice setting. **(For more analysis of the impact of Medicare reform in the coming year on home health agencies, see article on p. 23.)** ■

Nurse practitioners not employed by a hospice will now be allowed to continue following their patients who elect hospice care. This change closes the gap that can occur when nurse practitioners play a role more prominent than a physician.

National study provides great marketing data

Study in JAMA shows you have what they want

By **Eric Resultan**

Editor, *Hospice Management Advisor*

Left to die in nursing homes and hospitals, terminal patients and their families are largely underserved. Hospices, on the other hand, provide a variety of services that meet the needs of the terminally ill and their families. That, in a few words, is what a recent study published in the *Journal of the American Medical Association (JAMA)* found.

Specifically, researchers concluded that dying Americans receive inadequate pain management, little emotional support, and poor communication from their physicians. Hospice care at home provides greater levels of satisfaction and fewer problems with pain management, the study concludes.

The national study by researchers from Brown University was published in the Jan. 7 issue of *JAMA* (2004; 291:88-93).

From an academic perspective, the results suggest that people dying in institutions would be better served by hospices where specialized end-of-life care services can be provided. For hospice leaders, the findings of the *JAMA* study are no real surprise. Step back, though, and look at the study outside of its academic perspective. Think of it as marketing research that points out the market advantage that hospices have over the competition. First, let's look at the study itself and what it tells us about hospice, its competitors, and consumer demands.

Study findings

Key findings from the report include:

- One in four people who died did not receive enough pain medication. This was 1.6 times more likely to be a concern in a nursing home than in hospice at home.
- One in two patients did not receive enough emotional support. This was 1.3 times more likely to be the case in an institution than in hospice.

- Twenty-one percent of respondents complained that the dying person was not always treated with respect. Compared with hospice, this proportion was 2.6 times higher in a nursing home and 3 times higher in a hospital.

- One in four respondents expressed concern over physician communication and treatment decisions.

- One in three respondents said family members did not receive enough emotional support.

- Respondents whose loved ones received hospice in a home setting were the most satisfied. More than 70% rated hospice care as excellent. Fewer than 50% gave that grade to nursing homes or home health services.

The study stated that "high-quality end-of-life care results when health care professionals (1) ensure desired physical comfort and emotional support, (2) promote shared decision making, (3) treat the dying person with respect, (4) provide information and emotional support to family members, and (5) coordinate care across settings."

According to the National Hospice and Palliative Care Organization in Alexandria, VA, "These characteristics of quality end-of-life care are integral to the interdisciplinary hospice philosophy of care."

"The results of this survey attest to the continued need to improve the quality of care for seriously ill and dying persons," says the study's lead author, **Joan M. Teno**, MD, professor of community health and medicine at Brown.

You have what consumers want

There it is. The very things that are hallmarks of hospice care are the same things that consumers told researchers they felt contributed to a high-quality end-of-life experience. In other words, the five points listed above are distinct market advantages hospices have over their competitors.

Health care organizations, hospices included, are no different from any other business in a free-market economic system. You must develop a marketing plan that provides a competitive advantage. So what is a competitive advantage? It is anything that makes you better than your competitor. For example, McDonald's has a competitive advantage over most other fast-food chains because they have more restaurants than the competition. Delta Airlines has more non-stop flights to New York City from most major cities than other carriers. The Mayo Clinic has a

brand recognition that is synonymous with quality health care.

Given this principle, hospices have the following market advantages over hospitals and nursing homes:

- **Providing physical and emotional support.**

Pain management, counseling, and spiritual care are services that have defined hospice, yet local and national efforts have yet to successfully market this point to a degree that has changed consumers' habits. Hospitals and nursing homes, on the hand, have a great deal of negative baggage attached to caring for the terminally ill.

So, this market advantage actually presents two opportunities: one, promote the benefits of palliative care; and two, seize upon consumer dissatisfaction with other care options.

- **Promoting shared decision-making.**

For many patients, losing control is a real issue. From the time they are diagnosed with terminal illness, there is a sense that treatment decisions are made for them. Choosing to die rather than continuing with futile treatment is often the single choice they get to make during the curative phase of their illness.

A greater role in treatment decisions

Time and again, consumers tell the health care community they want more options and the power to choose the kind of care they receive. For instance, women revolutionized how they gave birth a generation ago. Their desire to have their spouses in the delivery room and better prenatal care gave rise to birthing centers and women's health centers.

Consumers are now telling the health care industry that they want to play a greater role in treatment decisions when they are diagnosed with a potentially life-limiting illness. For hospice, this means getting more involved in the disease process sooner and showing consumers they do have a choice. Hospices also must do a better job communicating to consumers just how prominent a role they play in their hospice care and how hospice workers help communicate treatment options.

- **Respecting the patient.**

The fact that consumers feel slighted by physicians and nurses in non-hospice settings speaks volumes. It shouts loudly at hospices to take advantage of consumer dissatisfaction. It does not mean denigrating other health care professionals,

but hospices, especially those that gather patient/family satisfaction data, can market their success in this arena.

For example, a public campaign can make use of testimonials in which family members of hospice patients share their positive experience or how the patient's quality of life improved when they were taken from an institutional setting and allowed to return home to die.

- **Supporting family members.**

It can be said that hospice care is as much caring for the family as it is for the patient. The issues of family and patient are so intertwined that it would be ineffective to treat one without considering the other. Bereavement programs are also a unique benefit that can only be found in hospice.

On the other hand, a consistent complaint of families whose loved one is in a hospital or nursing home is the unresponsiveness of physicians and nurses when they have concerns or a need for information.

Hospices must promote the following services to show how they support family members:

- bereavement care;
- spiritual care for both patient and family;
- identification and connection to community services to assist caregivers;
- 24-hour on-call nursing services to assist caregivers in emergencies;
- coordination of care across health care settings.

Clear up misunderstandings about hospice

One the biggest hurdles hospices face is a lack of understanding. People have long misunderstood what hospice care entails, such as believing it's a place where people go to die, where doctors and nurse practice euthanasia, where you only go when you have no other options or when you've lost hope, and so on.

First, hospices must do a better job of communicating what their services entail and debunking myths about hospice. Make sure consumers in your area understand that hospice tries to serve patients where they feel most comfortable, which for most people is at home, among family and friends. Yet people need to know that hospice care is available to them no matter where they reside, and that hospices are capable of coordinating their care even though they are a nursing home patient or in an intensive care unit bed.

It is important to remember that all these factors are market advantages only if consumers believe them to be so. If a physician practice's marketing plan relies on the marketing advantage of having the "best doctors," the advantage is lost if the market itself doesn't recognize this point.

In many ways, hospices are in a situation in which they must drive demand. Until consumer habits change and hospice care is a commonly known health care option, this will remain true. So, it is incumbent upon hospices to not only communicate these market advantages, but to explain why these elements should be seen as qualities missing from health care in the area.

Also, developing a strategy that will bring market advantages is only as good as the advantages themselves. In other words, if a factor ceases being a market advantage, then you've lost ground to your competition. Failing to communicate your advantages to consumers in the face of competition only buys your competitors time to retool their product and position themselves to seize upon what was once yours. ■

Palliative consultations improve outcomes — study

'Broad impact' on patient care possible

Palliative care consultations can lead to improved patient outcomes, including relief of dyspnea, anxiety, and sleeplessness, and may reduce the number of times patients must seek primary or urgent care, according to a new study.

The study, conducted by researchers at the University of California-San Francisco and published in the *Archives of Internal Medicine*, tracked seriously ill UCSF outpatients whose primary care physicians requested palliative care consultations for patients with cancer, advanced congestive heart failure, or chronic obstructive pulmonary disease, and who had a one- to five-year prognosis. The study was conducted as part of the Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care program, through the Department of Medicine and the Institute for Health and Aging at UCSF.

"We saw improvements despite the fact recommendations from the palliative care team were

only partly adopted by the patients' physicians," says study co-author **Michael Rabow**, MD, associate professor of clinical medicine at UCSF.

"More widespread support for, and adoption of, palliative care principles — especially pain management and treatment for depression — has the potential to yield broader impact on patient care.

Palliative care aims to relieve suffering and to support the best possible quality of life for patients with advanced, chronic, or life-threatening illnesses and their families. It focuses on treating pain, symptoms, and stress, providing support for daily living, helping patients and families make difficult medical decisions, and ensuring patient and family wishes for care are followed.

UCSF was recently awarded a \$700,000 grant from the Robert Wood Johnson Foundation to become one of six Palliative Care Leadership Centers. The aim of the Palliative Care Leadership Center Initiative is to increase the availability of palliative care in hospitals throughout the nation by bringing institutions to learn from exemplary palliative care programs in settings similar to their own. The UCSF Comfort Care Consultation Service and Suites specializes in palliative care within an academic teaching hospital setting and provides multidisciplinary palliative care consultations as well as operating an acute inpatient palliative care unit within the hospital. ■



Providers have recourse when MCOs don't pay

Don't be afraid to challenge claims denials

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

Home care providers and patients remain concerned about the decisions that managed care organizations (MCOs) and other payers make about whether to pay for care. Both groups often perceive that the true decision-makers about treatment may be payers, not providers.

This perception has resulted in a number of lawsuits against payers related to payment denials.

One of the defenses claimed by some payers has been that providers and patients are not allowed to sue them for these complaints because their claims are pre-empted by the Employee Retirement Income Security Act (ERISA), a federal law that governs employee benefit plans.

Specifically, payers argue that the claims of providers and payers are matters of state law.

Consequently, some payers have argued that the federal statute that governs ERISA controls the outcome of such claims even though the statutes may be silent on issues related to these claims and precludes providers and patients from suing payers.

In the case *In Home Health Inc. v. Prudential Insurance Co.* (CA 8 No. 95-3974, Dec. 2, 1996), a home care provider claimed that Prudential, as the third-party administrator for a group health plan, negligently misrepresented a patients' coverage status.

Specifically, In Home Health claimed that Prudential falsely informed the provider that a patient covered by one of the employee benefit plans it administered had not reached the plan's \$1 million lifetime maximum benefit limit. In reliance on this information, the agency provided services to the patient worth \$40,000.

Retrospective denials not uncommon

This is a familiar dilemma for providers. Staff members routinely verify the eligibility of patients for services under benefit plans. In response, it is common for payers to indicate that patients are eligible for services under particular benefit plans. Based upon this verification, providers routinely initiate and continue to provide needed services.

Subsequently, payers retrospectively may deny payment on the basis that patients, in fact, were ineligible for the benefits they claimed and that were verified by the payer. Providers, understandably, are extremely concerned about this type of retrospective denial because thousands of dollars may be lost despite precautions

taken by staff.

Nonetheless, the position of many payers is that providers must bear the loss even though the payer acknowledges that it initially verified the eligibility of the patient. They often point out that they may lack accurate information for a variety of reasons. For instance, payers and administrators frequently claim that employers do not always inform them promptly when patients are no longer employed or are disenrolled for other reasons.

In Home Health was on the receiving end of a retrospective denial of this type. This provider decided that it would not sit still for this kind of treatment from Prudential and sued to collect the payments due for services that were provided.

During the trial, the judge dismissed the provider's complaint. Prudential claimed that ERISA pre-empted the provider's claim. The judge reasoned that, if the provider's claim was granted, the money paid to it would have an economic

impact on the plan by requiring payment of benefits beyond its coverage limits.

Appeals court reversed lower court's ruling

The appeals court, on the other hand, reversed the decision of the trial court and sent the case back to the lower court for further consideration. In doing so, the court first noted that the majority of appeals courts that have ruled on this issue have decided that ERISA does not pre-empt such claims.

The court also based its decision to reject Prudential's argument of pre-emption by ERISA on the fact that In Home Health's suit was that of an independent entity seeking damages for alleged misrepresentation, not plan benefits on behalf of a plan beneficiary. As such, any damages paid would come from Prudential as the third-party administrator, not the plan itself. The court further said that just because an ERISA plan is involved in a case, that does not automatically mean that the claims are pre-empted.

In addition, the court noted that the provider's claim of negligent misrepresentation would not

Payers retrospectively may deny payment on the basis that patients, in fact, were ineligible for the benefits they claimed and that were verified by the payer. Providers, understandably, are extremely concerned about this type of retrospective denial because thousands of dollars may be lost despite precautions taken by staff.

affect any provision of the ERISA plan involved, nor would it impose new administrative duties on Prudential. It also would not affect relationships between the primary parties to the ERISA plan or have any adverse economic impact on the ERISA plan itself.

The court also based its decision on the fact that the underlying legislative purpose of ERISA is to protect the interests of employees and their beneficiaries in employee benefits. If the court adopted Prudential's arguments, according to the judge, providers may be reluctant to render services unless beneficiaries pay in advance. Such a result clearly would defeat congressional intent.

ERISA pre-emption claims likely to be rejected

This last argument may point providers in the direction of future resolution of this issue of ERISA preemption. Specifically, courts likely are to continue to reject claims of pre-emption by payers in the future.

The ERISA statute was enacted by Congress long before the role of payers changed so dramatically. The court's analysis that the ERISA statute was never intended to address issues such as those raised by the provider in this case is very strong.

In short, providers do have recourse when MCOs and other payers fail to pay their claims. They should not hesitate to pursue their interests.

[Editor's note: 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.] ■

Limit nursing shifts to protect patients

Fatigue has impact for patients, workers

Nurses should be restricted from working more than 12 hours at a time or more than 60 hours per week to prevent "error-producing fatigue," an Institute of Medicine (IOM) panel recommended in a comprehensive review of the nursing work environment.

Health care should learn from other "safety-sensitive" industries such as aviation and nuclear energy to establish limits on nurse scheduling, the panel said. For example, hospitals should staff their intensive care units with one nurse for every two patients and should involve nurses in setting scheduling patterns, the panel said.

"We just have not paid attention to designing systems to make sure that errors don't reach the patient and instead have assumed that we are superhuman," says **Donald M. Steinwachs**, PhD, chair of the panel and chair of the department of health policy and management at the Bloomberg School of Public Health of Johns Hopkins University in Baltimore.

"This report addresses what a health care organization has to do in order to really tackle the issue of patient safety," he says.

The issues of shift work, mandatory overtime, and fatigue-related errors in health care have recently been receiving more attention. Four states — California, New Jersey, Maine, and Oregon — prohibit mandatory overtime for nurses. California has adopted minimum staffing levels. The National Institute of Occupational Safety and Health (NIOSH) recently announced a study of shift work and its impact on worker safety.

Recommendations from the IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, will be presented to Congress and shared with the Joint Commission on Accreditation of Health Care Organizations. But Steinwachs says the panel was speaking directly to hospitals with many of its major points.

"This report will provide [hospital CEOs] with a blueprint for how to address patient safety on the organizational level," he says, and notes that the panel recommended adding staffing information on federal hospital report cards.

"If someone says, 'We can't afford to do this,' You have to ask the question also, 'Can you afford not to do this?'" he says.

Long shifts similar to intoxication

"Prolonged wakefulness" can be as harmful as intoxication in its effect on work performance, according to studies cited by the panel.

Yet overtime and extended shifts are commonplace in nursing. The report cites 2001 surveys by the Washington, DC-based American Nurses Association (ANA) and the Aliso Viejo, CA-based

American Association of Critical Care Nurses, in which 60% of nurses reported being required to work mandatory overtime. Many nurses also take advantage of incentives to work voluntary overtime.

'After 12 hours, you commit more errors'

"We've got enough information to know that after 12 hours, we are putting patients at higher risk, and no nurse wants to do that," says **Ada Sue Hinshaw**, PhD, RN, vice chair of the IOM panel and dean of the School of Nursing at the University of Michigan in Ann Arbor. "We didn't address the issue of whether it's voluntary overtime or mandatory overtime because either way the effects are the same. After 12 hours, you commit more errors."

In other industries, studies have shown that errors increase after nine hours, double after 12 hours, and triple after 16 hours, the report said.

The report lends credibility to concerns nurses have raised, says **Cheryl Peterson**, RN, a senior policy fellow at the ANA.

"Nurses have been talking about issues of mandatory overtime, or feeling tired and overworked, for many years," she says. "Our hope is that it creates as much of a momentum for change as we saw from the 1999 [IOM patient safety] report, *To Err Is Human*."

The ANA also will need to educate members about fatigue and voluntary overtime, she says. "We ultimately must put patient safety first," she says.

NIOSH study will examine impact of fatigue

More information will soon be available on the impact of sleep, fatigue, and work schedules on worker safety. Researchers from NIOSH have proposed to survey 1,000 nurses from 10 hospitals. The nurses will keep a sleep and activity diary and an overtime diary. They also will complete questionnaires that ask about cardiovascular, musculoskeletal, and gastrointestinal symptoms, lifestyle issues, their workplace safety climate, and other risk factors. Researchers also will review work schedules from the hospitals.

"We need nurses in the workplace to be alert and healthy and optimally functioning," says **Claire Caruso**, PhD, RN, a research health scientist at NIOSH in Cincinnati who is heading the study.

"We don't know much about how [nurses'] work schedules affect their alertness and their

health. Patterns of work schedules can vary tremendously," she explains.

How can you address work scheduling in the midst of a nursing shortage? The panel concluded that a poor work environment contributes to turnover — and thus to staffing problems and shortages.

Hospitals need fundamental changes in their culture, giving nurses a greater voice in hospital leadership, involving front-line nurses in decision making, and promoting a "culture of safety," the IOM panel said.

They also advised hospitals to spend more money on education and training and to rely less on contract or agency nurses.

Some duties, such as transporting patients or retrieving medications, could be shifted to other workers to allow nurses to spend more time on clinical tasks, the panel said.

"If we could build a stronger, more productive work environment, it would not only [improve] patient safety, it could quite possibly be a substantial savings," Hinshaw says. "Cutting turnover alone would make a big difference.

"Most of the work environment and culture of safety recommendations essentially assume that every person in the organization will be responsible for and on the alert for safety issues," she says.

Supporting front-line care providers

"A great deal of the care for patients will be decentralized to the front-line staff who care for patients. While we need strong leadership, particularly nursing leadership, at every level of the organization, we need it to be patient-centered and supportive of the front-line individuals so they can make quick decisions."

That sort of environment can be found today in magnet hospitals, where turnover is low and some hospitals actually have a waiting list for nursing applicants, Hinshaw says.

New nurses will be looking for that kind of environment, Hinshaw says, noting that the American Association of Colleges of Nursing has developed a brochure on characteristics of a good working environment.

The panel urged hospitals not to take a "piece-meal" approach to the recommendations on the work environment, stating that "none of these recommendations is 'less important.'"

(Editor's note: A copy of the IOM report can be found at www.nap.edu/books/0309090679/html/.) ■

Pain cases settled: Nursing home fined

Undertreatment of 'severe and constant pain'

In a case watched closely as a harbinger of what can happen when a health care provider undertreats pain, two doctors and two health care facilities reached settlements just before the case was scheduled for trial.

There were financial settlements with all the parties, says **Kathryn Tucker**, JD, director of legal affairs with the Compassion in Dying Federation in Seattle, an advocacy group that supported the plaintiff. She says this case should have set off alarm bells across the country. "There will be serious consequences legally and financially if you don't provide good pain management. Historically, there hasn't been accountability, but clearly that has changed."

The suit was filed against providers at Mt. Diablo Hospital Medical Center in Concord, CA; Bayberry Care Center, the nursing home where the patient was transferred for long-term care and where he died; and three physicians. The defendants did not return phone calls seeking comment. The plaintiffs settled for confidential amounts with Mt. Diablo Hospital; the hospital physician, Fred Von Steiff, MD; and Eugene Whitney, MD, the nursing home physician. Mt. Diablo acknowledged that it has implemented continuing medical education (CME) regarding pain and palliative care as a result of the suit. Whitney agreed to take 16 hours of CME in pain and palliative care.

Bayberry Care Center paid \$80,000 and agreed to provide 16 hours of CME in pain and palliative care to its staff, to be completed by June 30, 2005. "That reflects a significant commitment from that facility, considering its status and its financial situation," Tucker says.

Medical board, payer also take action

Another significant development was that the Medical Board of California filed formal charges against Whitney through the attorney general's office. A hearing is pending. Also, the state's Department of Health Services, acting on behalf of the federal Center for Medicare & Medicaid Services (CMS), issued a Class A Notice of Deficiency to Bayberry Care Center, finding numerous violations of code provisions pertaining

to pain and symptom management. The Medical Board's action and the sanctions by the third-party payer up the ante beyond previous pain management cases.

"The filing of formal charges against Dr. Eugene Whitney by the Medical Board of California reflects a significant and positive change," Tucker says. "The Medical Board's willingness to take action in an undertreated pain case will hopefully serve as an example to other medical boards considering such complaints. The settlement by all four defendants prior to trial sends the message that abandoning a dying patient carries a great risk."

The case is similar to a case from two years ago in which a California doctor was ordered to pay \$1.5 million because he undertreated a dying man's pain. The hospital's records proved to be the doctor's undoing because they showed the man was in terrible pain and that the doctor must have known about it.

In the current case, an 85-year-old man dying of lung cancer was denied adequate pain management despite his advance directive calling for all possible pain relief and his frequent reports to the nursing staff that his pain was intolerable. The lawsuit filed in the Superior Court of California, County of Contra Costa, was an action for elder abuse because state law does not allow recovery for pain and suffering after the patient dies. The family also alleged intentional infliction of emotional distress, fraud, unfair business practices, and other statutory violations.

Patient's wishes not heeded

The complaint claimed that "from Jan. 18, 2001, through the day of his death on Feb. 12, 2001, Lester Tomlinson's severe and constant pain was callously ignored, never effectively treated, and allowed to progress by defendants without any intervention which would comply with modern concepts of pain management. Tomlinson, who had gone to the effort of clearly expressing his wishes to live his last days with maximum control of his pain, nevertheless spent the last month of his life in agony, confusion, and indignity."

Nurses at the hospital and the nursing home assessed Tomlinson's pain level regularly, but then he did not receive adequate medications, the complaint says. While Tomlinson was often unable to rate his pain either because he was hard of hearing or because of confusion, he did rate his pain on many occasions, and the pain level was

almost always high. He frequently reported pain levels up to 9, and his initial assessment on admission indicated that he frequently experienced pain he rated as 10. The lawsuit alleges he sometimes received no medication or at other times wholly inadequate medication, despite his family members' pleas for better pain management.

Tucker says the main difference between the earlier pain management case in California and this one is in the depth of accountability. "In Tomlinson, three different complaints were filed — one with the Medical Board of California, one with CMS and the state Department of Health Services, and the tort suit. In each of those complaints, accountability was realized," she says. "In the Bergman case, we had fairly similar facts, but the Medical Board declined to take action," Tucker continues. "With Bergman, the defendant was not willing to enter into settlement discussions, so the case went to trial, and there was as a meaningful verdict against the doctor. In the Tomlinson case, all of the defendants were highly motivated to settle before trial."

California poses bigger hurdle than most

Tucker cautions against assuming that these pain management cases are a California phenomenon. The successful resolution of these claims in California should be seen as a signal that such actions can be expected across the country, she says. In California, it is particularly difficult to prevail in court action for failure to treat pain in a dying patient, she says. A case alleging pain and suffering for a patient who died cannot be brought as a medical negligence claim because the state has a "no survival" rule for malpractice law. That is why cases are framed as elder abuse, which permits a claim without a survivor.

But an elder abuse claim requires a much stronger showing of departure from the standard of care. The plaintiff must show recklessness instead of simple negligence. In most other states, the same set of facts could be used to file a medical negligence claim, which is comparatively easier to prove, Tucker says. "In negligence, you only have to show that the treatment deviated from the standard of care. In recklessness you have to prove a much greater departure from that standard," she says. "Your expert has to go a much greater distance to say this was further out of bounds. So it's harder to prove these cases in California than it is in any other state. If it can be proved here, it can be proved anywhere." ■

Coming year colored by Medicare reform package

Regulatory, staffing, financial issues key for HHAs

[Editor's note: With passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (HR 1) in the last days of November 2003, many of the issues that home health administration managers will be related to this legislation. This article introduces a few of the key issues addressed by this new legislation.]

If you are a fan of roller coasters, then home health is the industry for you. Most experts agree that home health managers have experienced a lot of ups and downs, and unexpected bumps and turns, during the past several years. The good news is that many of these experts expect 2004 to be a little calmer.

When asked to pull out their crystal ball and share some of their predictions for the home health industry in 2004, key leaders identified some of the major challenges that home health managers can expect in the coming year.

"I think that we'll continue to deal with the same issues we faced during the past years, but I also think that the pace of changes will slow down and give us a chance to catch our breath, and refine the processes we've put into place," says **Greg Solecki**, vice president of Henry Ford Health Care in Detroit. "Although we will have to continue to address the regulatory issues we've been facing, I don't anticipate a great number of new regulations, primarily because 2004 is an election year," he explains.

"Congress will be distracted by the elections in 2004, and although refinements will continue to be made to the Medicare bill passed in late November 2003, I don't anticipate introduction of new legislation that will relate to home health," says **Ann B. Howard**, director of federal policy for the American Association for Homecare in Alexandria, VA. The most immediate financial repercussion of HR 1 is the reduction of the market basket update by 0.8% for each year for three years beginning in April 2004.

"The reduction of the market basket update does mean that home health agencies will continue to pay rising costs for items such as salaries, liability insurance, and travel expenses without reimbursement that reflects these increasing costs," says **Joel Mills**, president and chief executive officer of

Advanced Home Care in Greensboro, NC, and chairman of the board of directors for American Association for Homecare. "This means that we will have to continue to look for ways to improve efficiency within our agencies," he says.

Not all bad for home health

The good news that comes with HR 1 is a one-year extension of a 5% rural add-on, says Mills. "This is positive news for rural home health agencies that must address greater travel costs than urban agencies," he explains. "Another positive aspect of the legislation is the elimination of the requirement to collect OASIS data on non-Medicare and non-Medicaid patients," he says. "The elimination of this requirement for private-pay and managed care patients will help us by reducing some of the paperwork we have for some of our patients," he explains.

Another positive aspect of HR 1 is the fact that there is no copay for home health patients, points out **Seth Johnson**, director of public policy for the American Association for Homecare. "The elimination of copayments from the legislation is the result of an amazing grass-roots effort by the home health industry," he says. "The collection of a copayment would have created a tremendous administrative burden on home health agencies and would have placed an unrealistic financial burden on many home health patients," he says. "Because home health receives patients after they've already paid copayments on hospital and physician visits, even a small home health copayment might have been too much for some elderly patients," he adds. For this reason, many home health experts believe that a copayment would have reduced the number of patients able to benefit from home health, he explains.

New COPs welcomed

"We were very happy with the draft of the new Conditions of Participation for Medicare that were posted about two years ago, and we hope that the new conditions will come out in Spring of 2004," says **Val Dalton**, CHCE, vice president of Borgess Visiting Nurse Association and Hospice in Kalamazoo, MI, and president of the Michigan Home Health Association.

Quality and outcomes measurement will continue to be an important issue for home health, but the industry does need to find ways to be

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more efficient in gathering and reporting information, Dalton says.

While all agencies will be focusing on outcomes, some will also become more selective about the patients for which they market, suggests Johnson. "Rather than the friendly competition we traditionally have seen in home health, I believe we will see agencies becoming more competitive and going after patients who are more profitable to their agency," he says. For this reason, the home health industry may start to see more agencies specializing in care of certain types of patients based upon an expertise the agency possesses, as well as a higher profit margin for that particular disease state, he adds. ■

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