

HOSPICE Management ADVISOR™

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Nonprofit hospices can learn valuable lessons from for-profits

For-profit hospices provide clues to financial stability

Any perception of how hospices are faring these days depends on whom you ask. Someone who works at a small hospice may say his or her hospice is having a tougher time than a large hospice is. Staffers at rural hospices may say they're hoeing a tougher row than their metropolitan counterparts.

But there is one segment of the hospice population that seems more optimistic than the rest of the industry: for-profit hospices.

According to *Health Care Strategic Management*, a monthly newsletter for hospitals and health care systems, the hospice business is attracting investor-owned companies who are either buying or opening hospices at a record pace.

Health Care Strategic Management cited the acquisition frenzy of Dallas-based Odyssey Healthcare Inc. Odyssey operates 65 Medicare-certified locations in 30 states, with 14 more locations under development.

According to *Investor's Business Daily*, Odyssey's fundamental rank is the highest of 19 stocks in the medical-nursing home group, due in large part to its growth strategy. During the second quarter of 2002, Odyssey spent about \$11 million to acquire five hospices. These purchases were financed entirely by Odyssey's 2001 initial public offering of common stock. Seven more hospices were acquired in 2002 for \$9 million. Last year, Odyssey bought seven more hospices, spending nearly \$20 million, the newsletter reported.

The company's chief executive officer, **Richard Burnham**, told *Investor's Business Daily* that Odyssey plans to accelerate its schedule for the launching of new programs.

It seems three factors are giving rise to for-profit hospices' enthusiasm:

- the relatively low start-up costs for hospice;
- an aging U.S. population;
- favorable Medicare rates.

While at least two of those three points are worthy of debate, the

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fact remains that for-profit hospices are succeeding under the same rules and regulations that nonprofit hospices must follow.

"We've known for some time that for-profits are more efficient," says **Stephen Conner**, PhD, vice president of international development and children at the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA.

For-profit hospices are faring better than nonprofits in a few telling categories. For one thing, for-profits serve proportionately more patients than nonprofits do. For-profit organizations account for about a quarter of the hospices in business today and serve 35% of the people who choose hospice care, according to NHPCO figures. Nonprofit organizations make up 72% of hospices and serve 65% of all hospice patients.

For-profit hospices also are averaging longer lengths of service compared to nonprofits. According to Connor, for-profit hospices average about five days more service per patient than nonprofit

hospices. That's about \$118 in additional revenue per day, per patient. Depending on a hospice's average daily census, the lost revenue can easily equal 10% of a hospice's revenue.

For-profit hospices generally show a year-end profit or at least break even, while nonprofit hospice costs run an average of 10% to 20% above reimbursement revenue.

With for-profit hospices performing financially better than nonprofits, can nonprofits learn something from for-profit providers? Yes, says **David English**, chief executive officer of The Hospices of the National Capitol Region in Washington, DC. "It's a comparison that many nonprofit hospices can learn from," English adds.

Note the differences

That comparison begins with an acknowledgement of the differences between the two types of hospices. For one thing, for-profit hospices strive to maximize profit, while nonprofits endeavor to maximize their resources. That doesn't mean for-profit providers cut corners and sacrifice quality to increase their margin, nor does it imply nonprofits are fiscally irresponsible.

To be fair, there are well-known examples of high-quality, financially successful for-profit providers. Quality and profit do not have to be opposed to one another, says **Mark Cohen**, vice president of public relations and communications for Miami-based Vitas, a for-profit company with 29 hospices in eight states.

Another significant difference can be found in administration. For-profit companies operate their hospices from central locations. Nonprofit organizations are run locally, each provider having its own administration.

Yet, both hospice types are similar in a number of ways. Most importantly, both adhere to the same federal regulations. Certification as a Medicare hospice provider doesn't depend on a hospice's status. All Medicare-certified hospices must provide a basic level of care and receive the same per diem payment.

For-profit and nonprofit hospices face the same market pressures that affect length of service, rising labor costs, expensive high-tech palliative care, and, ultimately, the bottom line.

One advantage many for-profit hospices have over their nonprofit brethren is economies of scale—the ability to spread costs across a multi-hospice organization or larger volume of patients.

For example, Vitas has one administrative

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Editorial Questions

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

office serving hospices scattered across the country. Rather than having 29 separate administrative offices, each handling its own marketing, payroll, and human resources, the cost of one corporate office is spread across the entire organization.

According to Cohen, Vitas serves about 8,000 patients per day. That means the administrative cost per patient for Vitas is significantly lower than that for a local nonprofit that serves 500 patients per day.

Most hospices would have difficulty emulating this particular trait of for-profit hospices because few hospices are in the position to expand their coverage area or acquire hospice programs.

Better marketing

While this is a significant feature of large organizations like Vitas, it isn't the only characteristic that contributes to their success. For-profit hospices are better marketers, says English. While for-profits may enjoy greater financial resources to devote to marketing, their strategy cannot be dismissed.

Their marketing is more selective, English observes. Hospices as a whole strive to increase patient lengths of stay. Cancer patients generally inhibit a hospice's ability to break even because of the high cost associated with admission, coupled with a week-long stay that barely allows enough time for the hospice to recoup its up-front cost. The desired patient — from a financial perspective — is one whose illness lends itself to a longer hospice stay.

Selective marketing is a concept that English doesn't completely accept. "We have difficulty with selective marketing from a mission perspective," he says. But he says he believes that specific populations could be targeted as areas in which hospice can improve access.

Nursing homes are a good example. Skilled nursing, assisted living, and other residential facilities have long been underserved by most hospices. English has noticed how for-profit hospices have successfully reached out to this market segment, which carries a number of financial benefits:

- **Lower travel costs.** Rather than having a nurse spend hours on the road between visits, a hospice nurse has to travel to one location to see several patients.

- **Lower labor costs per patient.** With the ability to see more patients in a shorter amount of

time, the cost of a single nurse is spread across a higher number of patients.

- **Longer lengths of stay.** Most patients in this setting require less complicated care and suffer from non-cancer illnesses.

For-profit hospices, by virtue of their fiduciary responsibility to shareholders and investors, are better managers of costs. Of course, this can be construed as sinister or an example of misaligned incentives: In order to cut costs, one must sacrifice quality.

According to *Health Care Strategic Management*, VistaCare expects 30% to 35% growth in 2004. Its chief financial officer, **Mark Liebner**, told the newsletter: "Our profitability is largely dependent on our ability to manage costs of providing hospice services and to maintain a patient base with a sufficiently long length of stay to attain profitability. We are susceptible to situations, particularly because of our open-access philosophy, where we may be referred a disproportionate share of patients requiring more intensive and therefore more expensive care than other providers. Although Medicare and Medicaid currently provide for an annual adjustment of the various hospice payment rates based on the increase or decrease of the medical care expenditure category of the Consumer Price Index, these hospice care increases have historically been less than actual inflation. If these annual adjustments were eliminated or reduced, or if our costs of providing hospice services, over one-half of which consist of labor costs, increased more than the annual adjustment, our profitability could be negatively impacted. In addition, cost pressures resulting from shorter patient lengths of stay and the use of more expensive forms of palliative care, including drugs and drug delivery systems, could negatively impact our profitability."

Bottom-line pressures

What Liebner is saying is no different from what nonprofit hospices have said in the past. Medicare rates, lengths of stay, and complex patients in an open-access model are all pressures that affect a hospice's bottom line. The only difference between nonprofit and for-profit hospices is that one relies on charitable donations to make up a cost/revenue deficit, while the other suffers from disgruntled investors.

The wrinkle in Liebner's statement is his emphasis on managing cost. This is a concept with which both English and Cohen are comfortable.

In addition, both maintain that quality care can still be achieved in a cost-management environment.

"[Nonprofit hospices] need to have a better sense of how our money is spent," English says. "We want our employees to be passionate about whatever role they play, we ask them to strive to be the best in the world at what they do, and we want them to be good stewards of our resources."

Vitas is an open-access hospice that emphasizes quality care regardless of patient circumstances. Cohen emphasizes that Vitas does not manage cost by denying access to patients who require expensive treatment, such as cancer patients who need palliative chemotherapy.

To manage costs and achieve a better understanding of its business as a whole, Vitas invested in information technology. The company developed proprietary software, Vitas Exchange, that allows it to collect data on costs, patient care, referrals, records, and other areas that are useful in decision-making. In the end, Vitas is able to cite data that show how quality is improved by using a particular therapy, even when that therapy is less expensive than another. The availability of data allows Vitas to abandon the practice of relying on anecdotal evidence to promote itself.

"We tell our representatives not to talk about hospice anecdotally, but to show real data," Cohen says. ■

some knowledge of how money is being spent is foolhardy and will likely lead to financial heartburn, or worse.

If you wouldn't run your family finances in a cavalier manner, then why would you run a hospice that way?

The point is this: Hospices must take as much care in managing their costs as they do in caring for their patients. Cost and quality are not mutually exclusive.

"We have to be good stewards of our resources," says **David English**, chief executive officer of The Hospices of the National Capital Region in Washington, DC.

From a strategic standpoint, health care businesses generally have three ways to improve their bottom line: raise prices, increase patient volume, or lower costs. For hospices, raising price is not an option, but patient volume and cost management are amenable to change. Cost is the area over which providers have the most control. The best way to manage costs is to identify processes and to improve on them rather than simply cutting positions or programs to reduce costs.

Here are some steps to follow as you try to improve your organization's cost management and cost accounting:

- **Management must commit to better cost control.**

Before activities-based cost (ABC) accounting can be implemented, there must be management commitment to the process. This must occur at the highest level of the organization. Without leadership buy-in, it will be difficult to justify the time spent scrutinizing activities. Further, it will be difficult to make the changes that ABC will reveal to be necessary.

- **Identify activities and resources.**

Determine what is involved in a process. For example, a home visit encompasses a number of activities and resources, such as nursing, travel, and medical equipment. In general, you'll need to identify resources—the pool of costs that make up activities. This requires going back to staff or department heads and conducting interviews to find out how employees fill their days.

Follow these guidelines when identifying resources:

- Focus on the most expensive products. Trace these expensive products and service lines to diagnoses or episodes of care.

- Focus on resources that have significantly varied rates of consumption by product and product type. For example, therapy is a resource

Hospice Trends

Controlling costs without violating hospice tenets

Here's how to get a handle on your costs

By **Eric Resultan**

Editor, *Hospice Management Advisor*

Our households are prime examples of non-profit organizations. Right? Bear with me here for a minute. We raise money through revenue from work in hopes of earning enough to cover our costs. Surplus — if there is any — is reinvested in family programs, such as savings, clothing, cars, etc. Operating this venture without

that varies from one diagnosis to the next or from one episode of care to the next.

— Focus on resources that have demand patterns that don't correlate to traditional allocation measures, such as direct labor, documentation, and billing. In other words, examine resources needed to treat a diagnosis or episode of care that are not traditionally measured by current cost-accounting methods.

There are lots of ways to get this information. The most effective, you may find, is simply to ask your staff. Identifying costs enables you to compile an activity dictionary, an organization-wide document that defines each activity. People in different positions often perform similar activities and refer to them by different names. The dictionary ensures that when you assign costs to these activities, everyone in the organization will have a clear understanding of what these costs represent.

- **Assign costs.**

This is a simple concept with complex hurdles. Much of the cost information you'll need can be found in employees' salaries and benefits. Beyond that, you'll need to determine other cost items, such as medical equipment, drugs, office space, and whatever other costs your organization incurs. Each of these costs will play a role in one or all of the various processes a provider performs. The complexity of the exercise lies in segmenting these costs, such as determining how much of a nurse's salary and benefits should be assigned to a visit or documentation.

In assigning costs under ABC, providers will have to abandon the notions of direct costs and indirect costs. ABC holds that all costs are indirect. For instance, nursing costs are traditionally seen as direct costs. ABC, however, says nursing costs can be divided among several activities — patient care, documentation, and travel, to name a few. When assigning costs, providers will find additional costs that they had not associated with patient care in the past, such as administration and billing. While ABC is a complex exercise in costing, providers should not get hung up on getting costs down to the last penny. Attempting to be too precise will only bog the process down and require more resources to complete.

- **Accept outcomes measurement.**

Nurses tend to balk at the idea of treating patients with specific outcome goals in mind. They often have difficulty looking at outcomes measurement in general terms. Pain management is a good example. With the variety of pain drugs

available, finding the most cost-effective drug can be difficult. By measuring outcomes, a hospice can make sound clinical decisions that are financially valid, as well.

- **Change your mindset.**

In the past, hospices paid little attention to cost. Services like nursing visits were ordered without consideration of their financial impact. To link the two data sets, an organization must be willing to look at patients from a cost perspective as well.

Follow these 12 steps to change mindsets

Changing the hearts and minds of those dedicated solely to patient and family care is not easy. Hospices should employ the following 12 strategies to handle acceptance and mindset issues:

1. Merge data with other key utilization and financial statistics for a balanced picture of the organization's performance.
2. Create or purchase tools to facilitate easy reporting of many different slices of data.
3. When using outcome data for performance improvement, focus first on areas with significant variance from the norm and examine the process of care associated with these areas.
4. Use data derived from outcome measurement for both marketing and performance improvement.
5. You can manage what you measure. Hospice management should understand the different types of available outcome data and decide which outcomes they should track.
6. Benchmark your data and other utilization and outcome information against other organizations to identify your agency's strengths and opportunities for improvements.
7. Systematically use information derived from benchmarking to identify best practices and devise strategies to improve overall organizational performance.
8. Use outcomes and benchmarks to determine the optimal mix of resources necessary to achieve the desired outcome.
9. The key to changing behavior is ongoing feedback. Regularly provide agency staff with outcome reports illustrating their performance.
10. Involve staff in identifying opportunities for improvement by providing training on the use and interpretation of data.
11. Welcome opportunities for staff to question the validity of information. Such behavior means they are engaged and paying attention.

12. Agency leadership must view OASIS and other outcome information as more than just complying with a government mandate. View outcome information as a key strategic advantage.

Hospices that take outcomes measurement — both clinical and financial — beyond their government obligations will be more competitive. The organization that masters data collection and reporting will have a significant competitive advantage over those that simply collect hospice cost report data to fulfill Centers for Medicare & Medicaid Services requirements. More important, hospices with strong data collection and outcomes measurement will be the most efficient organizations in the industry. ■

Leadership Centers aim to boost palliative care

Six centers will provide hands-on training

The Center to Advance Palliative Care (CAPC) in New York City has launched a Palliative Care Leadership Center (PCLC) initiative to help health care organizations create programs to more effectively manage advanced chronic illness.

Under the initiative, health care teams are invited to visit one of six palliative care programs to receive hands-on training and technical assistance to fast-track their own palliative care programs. In an early sign that the three-year initiative is addressing the growing demand for this type of training, more than 100 health care institutions have already registered to make visits, CAPC says.

Palliative care is medical care focused on relief of suffering and support for the best possible quality of life for the growing number of patients facing advanced chronic illness. It is offered at any stage of illness, simultaneous with all other appropriate medical treatment. Palliative care has been shown to improve pain and symptom management, improve patient outcomes, and increase patient and family satisfaction, as well as facilitate compliance with pain management and quality accreditation standards.

Palliative care programs also improve continuity of care and reduce fragmentation of care delivery, contributing to efficient and effective

use of health care resources. The number of hospital-based palliative care programs has doubled in recent years to more than 950 in response to the critical need to provide high-quality care to seriously ill patients living with advanced chronic illness.

The PCLCs, located at academic medical centers, cancer centers, health systems, and community-based organizations, will provide visiting health care teams with expertise on the financial and operational dimensions of establishing a palliative care program. This includes:

- hospital needs assessment;
- financing and business planning;
- how to choose organizational and service models;
- staffing;
- measuring clinical and financial impact;
- strategies for ensuring and managing growth;
- hospice-hospital collaborations;
- marketing palliative care to clinicians and patients.

“The large number of health care organizations already participating in this initiative signals the increasing recognition that palliative care effectively addresses top health care concerns: quality improvement, the aging boom, and the need to manage patients with advanced chronic illness well,” says **Diane E. Meier, MD**, director of CAPC.

The six PCLCs are:

- Fairview Health Services, Minneapolis;
- Massey Cancer Center of Virginia Commonwealth University Medical Center, Richmond;
- Medical College of Wisconsin, Milwaukee;
- Mount Carmel Health System, Columbus, OH;
- Palliative Care Center of the Bluegrass, Lexington, KY;
- University of California, San Francisco.

The nationwide initiative is funded by a \$4.5 million grant from the Princeton, NJ-based Robert Wood Johnson Foundation, the largest U.S. philanthropic organization devoted exclusively to health and health care. Technical assistance for the initiative is provided by the CAPC, located at the Mount Sinai School of Medicine in New York City. The CAPC is a national initiative of the foundation, providing hospitals and other health care organizations with tools and technical assistance to develop hospital-based palliative care programs (www.capc.org).

To register for a CAPC site visit or to obtain more information about the program, visit www.capc.org or e-mail pclc@mssm.edu.

For more information about palliative care and the Palliative Care Leadership Centers, contact Elana Schaffer at (202) 342-1333 or eschaffer@suttongroup.net. ■

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 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 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 dying residents. "Sometimes, residents will tell the caregivers something that they would not tell their immediate family. And staff 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.

After residents died following a long illness, the staff members often would do only 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 says.

"They tended to shut down and feel as if they had to distance themselves from the people they cared for," she says. "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," she explains. "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 the 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.

Spiritual, psychological support essential

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**, a former chaplain with the New York United Hospital Medical Center. Jacobs now is associate director of pastoral education and community-based programs with The Healthcare Chaplaincy, a nonprofit, multifaith 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 the deaths of patients, particularly when a patient's case has been very difficult or when a dying patient is close to the same age as the caregiver, Jacobs says.

"That challenges the chaplains a lot as well, when someone close to your own age dies," she notes. "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 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 support group meetings or debriefing sessions to be held at an out-of-the-way place, Jacobs adds, because sometimes there still is a stigma associated with health care providers who need help.

"I found this to be true during 9/11," she says. "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 being taken away from their duties."

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

"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," she says. "In reality, I think the day you don't have a problem when patients 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, says Gross. This information is particularly necessary for staff who may help care for patients but who have little medical training themselves.

Gross does training workshops for nursing home staff to help them understand death and

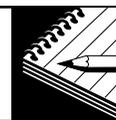
dying. She covers common clinical stages of dying and some of the physical manifestations that might occur. She also covers how to interact with dying patients and to their families.

"Especially in a nursing home, the housekeepers and even the dietary staff will get to know a patient, and they are so relieved to learn these things," she notes. "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 during the dying process, she adds.

"I've seen such a change in people," she notes. "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," she says. "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." ■

GUEST COLUMN



The ethics of discontinuing home health services

Consider autonomy, justice, beneficence

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

Over time, patients who initially are appropriate for home health services may no longer meet the agency's care criteria. For example, a patient's clinical condition may become so complex that he or she 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 any longer. Case managers or discharge planners

may recommend nursing home placement for patients they reject.

However, under these circumstances, staff may have concerns about termination of services that they express in terms of ethics. They may, for example, acknowledge that it is legal to terminate services, but they may express uncertainty about whether 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 members 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;**
- **beneficence/nonbeneficence.**

Autonomy generally means that patients make choices and act upon them.¹

The primary mechanism for ensuring patients' autonomy in home care is through the use of a process of informed consent. Patients are given information about treatment alternatives upon which they base their choices. This ethical 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 are ethically obligated to honor patients' choices.

But does the patient's decision to refuse treatment mean staff should continue to arrange for or provide care in inappropriate settings? Must staff members help patients refuse treatment by continuing to provide care at home?

The principles of justice and beneficence/non-beneficence may provide some insight into the answer to this crucial question.

Justice means every patient receives his or her due. Individuals are entitled to justice. According to the principle known as distributive justice, justice must also be applied on a communitywide basis.¹

So a key question is: What is "just" for both individuals and the community in the case of patients who refuse nursing home placement?

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, including staff members, involved in the care of patients. Do staff members receive their just due when they are 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, which may prevent others from receiving 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, agencies may not be acting in a manner consistent with ethical principles.

Beneficence/nonbeneficence also must 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.¹

Some care may not be better than no care

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 conclusion 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 with various participants' points of view. 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 the "gut," 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 or discontinuing services

for patients who are no longer appropriate for home care.

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Fear of investigation can hinder treatment

Survey finds pain management affected

Despite all of its successes in improving care for patients facing the end of life, Oregon still has not made headway in treating pain and suffering, according to researchers at the Center for Ethics in Healthcare at Oregon Health Sciences University in Portland.

Statewide, Oregon has made aggressive moves over the past decade to improve health care for its residents — particularly those facing serious or terminal illnesses. And initiatives aimed at improving end-of-life care planning, access to hospice care, and use of advance directives and living wills have all reported overwhelming success, says **Susan Tolle**, MD, the center's director. "But when people die, we are not seeing progress with treatment of pain," she explains. "We are seeing progress on every other front, but not that one."

In 2000, the center published a study in the *Western Journal of Medicine* reporting that 54% of family members of dying patients in 1998 reported their loved one experienced moderate or severe pain in the last week of life.¹ In addition, the study said previously gathered data showed that the percentage of dying patients who complained of pain increased from 33% in late 1997 to 57% in 2000.

Although researchers could not be certain why such a dramatic increase was reported, the feeling at the time was that there was both a greater awareness about pain treatment options on the part of family members and a noticeable change

in physician prescribing practices due to increased fears of regulatory sanctions, says Tolle.

Now, the Center for Ethics in Healthcare has gone back to take a second look at the number of patients and families reporting pain and suffering at the end of life, expecting to find improvement, says Tolle. They were wrong. "What we are finding is that there is something different about the politics of changing end-of-life planning, and making that work, and changing the practice of pain management," she says. "There appears to be something more vulnerable about pain management, and we have certainly found it harder to bring about profound change."

In most situations, it is not a case of a physician or nurse consciously deciding to undertreat a patient's pain, but rather there being an overall tendency to be conservative rather than aggressive when treating pain, she says.

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Many home health sentinel events are fires in the home

Patient education, staff vigilance needed

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 Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, almost 43% of sentinel events reported by home care programs are 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. This 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 patient 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,” says Popovich. “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 non-home-health-related reasons such as faulty wiring, unsafe holiday decorations, or the carelessness of a cognitively impaired patient operating a stove can cause fires, she says. “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, she suggests.

Home care nurses change the patient’s environment, bringing in equipment that may increase fire risks, so it is vital that the initial 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 says. While all Titusville 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, she says. “In rural areas, we are dealing with kerosene heaters and wood stoves, so we make a point of explaining fire safety and oxygen,” she explains.

“Don’t forget to talk about other open flames such as fireplaces, gas stoves, and candles when educating patients about fire safety,” points out Popovich. “Even if the patient or the family caregiver doesn’t smoke, remember that visitors or other relatives may smoke,” she says.

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, suggests Popovich. 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, says Popovich. “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.

Most important, document any suggestions you make to the patient and caregiver to decrease the risk of fire, suggests Apkins. 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, she says. “Although we are careful to document all clinical issues, we sometimes forget that documentation of non-clinical items is just as important,” she says. “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.” ■

News From the End of Life

JCAHO modifies patient safety goals

An important part of any accreditation survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations is the review of a home health agency’s compliance with the Joint Commission’s National Patient Safety Goals. 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. They 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) has been modified slightly to reflect home care services.

These modifications are the first step in 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 experience-based requirements for 2005. Any changes to accreditation requirements made during 2004 will be implemented Jan. 1, 2005.

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. ▼

MedPAC: No payment update for home health

Federal advisors were generous with recommendations to update Medicare payments to physicians and hospitals in 2005, but they showed no generosity to the home health sector. Commissioners on the Medicare Payment Advisory Commission (MedPAC) in Washington, DC, voted in late January to recommend to Congress that physician services receive a 2.5% update for fiscal year 2005, but voted against a payment update for home health services.

The commissioners further recommended that Congress continue to monitor access to care for home health services. The commission also recommended that skilled nursing facilities receive no payment update. In addition, MedPAC recommended in its January report that U.S. Department of Health and Human Services Secretary Tommy Thompson instruct skilled nursing facilities to report nursing costs separately from other costs, such as drugs and medical supplies.

The commission stated that a 3.4% update was adequate for inpatient hospital services, and hospitals not furnishing quality data to the Centers for Medicare & Medicaid Services would be subject to a 0.4% reduction.

"What we've learned in the past is that a recommendation for an increase to all hospitals is not an efficient way to keep Medicare up to par," explains commission chair **Glenn Hackbarth**, an independent consultant based in Bend, OR. "Rural hospitals aren't treated as fairly with every hospital getting an increase.

"I think the recommended updates are appropriate because there are a lot of uncertainties this

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year with the new Medicare legislation. It doesn't mean we won't be back next year saying that we should be making another adjustment," he adds.

The commission spent considerable time debating whether a 1.8% overall margin increase was adequate for all hospitals.

"This recommendation doesn't flow with what we know," says **David Durenberger**, director of the National Institute of Health Policy at the University of St. Thomas in Minneapolis. "We need to figure out the rationale on using the Medicare margin as a proxy for quality and access data."

"I'd like to remind you that this would be for one year only, and that the overall margin is only one factor determining Medicare payments," says **Julian Pettengill**, a staff analyst for MedPAC. ■

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