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Hospices need to embrace the challenge of measuring quality

Start small, but measure something that matters

By Larry Beresford

Experts have repeatedly warned America's hospices that they need to elevate quality as a priority at both the organizational and the industrywide levels. Hospices must find ways to quantify, measure, compare, and improve the quality of care they provide to terminally ill patients.

This is because quality measurement, report cards, benchmarking, and the use of quality data to make comparisons among providers to guide consumers' choices are becoming standard practice throughout the health care system. Hospices that receive third-party reimbursement shouldn't expect to be exempt from such trends. Experts say that if the industry doesn't act to define and implement its own meaningful measures of hospice quality — admittedly a significant methodological challenge — then measures are likely to be imposed from without. And externally imposed measures, like home health care's OASIS, may not be a good fit with hospice's mission and values.

Hospice quality measurement already under way

The challenge of quality measurement will be familiar to anyone who has attended a hospice conference presentation in the past six years on the Missoula-VITAS Quality-of-Life Index, a multifaceted measure of the experience of terminally ill hospice patients. Another attempt to measure hospice quality is the National Hospice and Palliative Care Organization (NHPCO) National Data Set, a collaborative effort to validate usable measures of previously identified outcomes of hospice care (safe and comfortable dying, self-determined life closure, and effective grieving).

However, the urgency of demands for quality is rising at the same time that many providers seem not to be keeping pace. Anecdotal

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concerns about hospices providing inconsistent or inadequate care are increasingly discussed whenever hospice professionals get together (see related story in *Hospice Management Advisor*, November 2003, p. 124). But without some universal, quantifiable, comparative definitions of quality, how will the industry get a grip on quality and protect its good name?

To give just two current examples of the accelerating pace of quality demands, NHPCO will be working with a consultant this summer to develop a Quality Advisory Council with the aim of promoting a broadly based quality initiative that builds on existing quality programs and measures. And the California Hospice and Palliative Care Association (CHAPCA) earlier this year empaneled a Quality Initiative Work Group to study the issue and propose a statewide quality program in response to growing consumer complaints reaching the state body.

“As a board, we needed to get a better picture as to what was happening out there,” explains former CHAPCA president **Laura Miller**, of Elizabeth Hospice in Escondido, CA, who spearheaded the state initiative. “With more and more new providers entering the industry, we have a responsibility not only to set the standard of care, but to see that it is delivered.”

Moving too fast?

Melanie Merriman, a Florida-based quality measurement consultant and co-author of the Missoula-VITAS Index, is one of the experts who have been warning hospices to jump on the quality bandwagon. She says she wonders why the industry has made so little progress on quality measurement, when six years ago there seemed to be so much promise.

In retrospect, she says, “we tried to go too far too fast. We started on a different plane than most providers. I thought hospices were standing at the bus stop waiting for the quality bus to arrive, and I was 100 percent wrong. So I’ve been backing up and backing up ever since. I woke up one day and said, ‘A lot of these organizations aren’t measuring anything.’”

Too many hospices, Merriman adds, haven’t made the necessary cultural transformation to recognize their ethical responsibility to measure quality. They still want to know why they should have to prove that they provide high-quality care. Others participate in the Joint Commission on Accreditation of Healthcare Organizations or other accreditation programs, but they fail to appreciate how these externally imposed requirements are relevant to their own expectations about the quality of their services. For some of these hospices, accreditation becomes just a paper exercise.

There also is a mistaken impression among some hospices that something as subjective as a terminally ill patient’s quality of life cannot be measured, Merriman says. In fact, researchers are making steady progress on crafting tools to do just that.

“What’s important for hospices is to put a stake in the ground around quality,” Merriman says. “Decide each year what your three most important quality indicators are. Start small, but create an organizational culture where it becomes part of how you talk about your organization.” Indicators should be simple, workable, and meaningful to everyone in the organization. Results can’t just sit

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Editorial Questions

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in the computer, but should be discussed at every staff meeting, with bar charts posted on the bulletin board in the lunchroom.

Imagine the headline in the local newspaper a year from now announcing your hospice's commitment to measure the quality of its care, what it's learning, and how it's acting on that information to raise the quality bar, Merriman says. What do you want that newspaper story to say about your quality? What would a billboard advertisement say about the hospice's commitment to quality? How do you translate the hospice's vision of what it offers to dying patients into measurable outcomes?

Pain management is often chosen as the first target for hospice quality measurement. What is the patient's pain level (on a self-identified scale of 1 to 10) on admission and then 48 or 72 hours later? Is pain assessed and recorded in the chart on every nursing visit? If pain is above a certain threshold, is there evidence that the hospice team took steps to remedy it? In hospice care, there is an additional wrinkle, which is that the patient should get to define how much pain he or she is willing to live with, Merriman notes. The hospice's quality score should reflect whether the patient's actual pain level matches his or her desired pain level.

Tips for quality improvement

What else can hospices do to get serious about quality?

- Recognize that a commitment to quality is essential to the business of hospice care in the 21st century.
- Commitment should extend from the board level, with a feedback loop for reporting quality data back to the board for its careful review.
- Professional consultants are available to help hospices design quality approaches, but there also should be a staff champion or cheerleader for quality, whose job is to make sure everyone in the agency feels responsible for its quality.
- Small, ad hoc, multidisciplinary groups of veteran staff can come together around specific quality concerns, propose improvements, and devise simple measures to see if they made a difference, thereby moving the organization forward in small steps.
- Understand how all of these quality efforts (including those externally imposed by certification and accreditation bodies) relate to the agency's mission, values, and beliefs about care

for the dying. If they don't connect, go back to the drawing board. But measure *something* that your agency believes is an important indicator of its actual performance.

- Network with other quality professionals in the community, including those at the local hospital. Propose a communitywide "Pain as a Fifth Vital Sign" initiative.
- Participate in NHPCO's new "Family Evaluation of Hospice Care" survey process to report standardized family satisfaction data to a national pool.
- Take fuller advantage of the potential for existing hospice charting and billing software programs to provide actionable performance data to the management team.

The formal approach to quality

For hospices large and small that want to take quality improvement to the next level, one way is to participate in a more formal benchmarking program. An example of this is Perforum of Lyme, NH, an integrated benchmarking service explicitly designed for hospices. Participants, one-fourth of whom have an average daily census of fewer than 40 patients, submit and exchange data in standardized reporting formats and receive back reports charting how they compare to peers in such areas as revenues, costs, profitability, case mix, visits, productivity, and outcomes of care.

"All of them have made a commitment to performance improvement, which demands performance measurement and open-minded collaboration," explains Perforum president **Martha Tecca**. "They agree to discuss the data, as well as the agency practices and structures that lie behind them." The hospices participate in technical assistance teleconferences, share practices, and learn from each other, while Perforum helps them develop operating performance targets and measure their improvement over time.

"First, you can compare yourself to overall averages," Tecca notes. "Then find two or three peers who are achieving a level of performance that you would like to achieve, and contact them to find out how they did it," she says.

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New guidelines created for palliative care

Blueprint for new and existing programs

In an effort to better standardize and improve the quality of palliative care services available nationwide, a consensus group has released new clinical guidelines detailing what services a palliative care program should provide and listing places where providers can go for more information and support.

The new guidelines were issued by The National Consensus Project for Quality Palliative Care, a consortium comprising representative members from the American Academy of Hospice and Palliative Medicine, the Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, the Last Acts Partnership, and the National Hospice and Palliative Care Organization.

"In palliative care, which is a relatively new field in health care, there has been extremely rapid growth," explains **Diane Meier, MD, FACP**, director of the Center to Advance Palliative Care (CAPC) in New York City. "As recently as six or seven years ago, there were relatively few programs. As of 2002, there were 950 programs. And the number of new programs is probably growing 20%-30% per year. But there are quality concerns because, without a shared definition about what palliative care is or should be, there are a lot of programs doing very different things and calling it palliative care."

While many institutions have complex interdisciplinary programs that address a variety of needs, some may have a part-time social worker who has "palliative care" included in his or her job description, and others may employ a massage therapist and consider that their palliative care program. "A nursing home that has liberalized visiting hours may consider that their palliative care program," Meier adds. "While all of those things are good and helpful, they do not qualify as palliative care programs, at least in the opinion of those of us working in nursing and medicine."

The goal of all palliative care is to address patient suffering, she notes. Palliative care measures include aggressive treatment of pain and other physical symptoms, but also should address the patient's and family's psychological, emotional, and spiritual stress. It also should provide

support for daily living, helping patients and families make medical decisions and ensuring that patient and family wishes are heeded.

Palliative care is properly delivered both by providers specializing in the discipline and by providers in other specialties seeking to improve every aspect of care for seriously ill patients.

In 2001, members of the five national organizations decided to convene the consensus project in an attempt to develop national, evidence-based guidelines to help standardize the delivery and quality of palliative care services.

Over the next three years, a 20-member steering committee and 100-member advisory panel developed draft guidance that was then circulated to other stakeholders in palliative care for their feedback. The resulting document takes into account the perspectives of health care providers in a wide variety of settings.

Sections of the guidance dealing with pediatrics and long-term care are particularly compelling, Meier says.

"We got some really helpful feedback. The draft guidelines were completely overhauled to include pediatrics and feedback from peers and colleagues in pediatrics," she explains. "Rather than assuming that the guidelines apply equally to children and adults, there are numerous sections focusing exclusively on the special needs of infants and children, as well as the children of patients."

The document addresses the specific needs of the long-term care setting, which has different financial incentives, financing patterns, and disease patterns, she says.

"This editing process, while lengthy and time-consuming, was extremely valuable, and the guidelines are dramatically improved in both their applicability and their quality as a result of that process," Meier says.

Guidelines — not standards

Programs in different settings and in different stages of development will find the new guidelines useful, says **Charles von Gunten, MD, PhD, FACP**, medical director of the Center for Palliative Studies in San Diego and associate clinical professor of medicine in the cancer symptom control program at the University of California-San Diego Cancer Center.

"There are really three groups out there," he notes. "The first group is the group that has just heard the term 'palliative care,' and they know

Palliative care guidelines available on the Internet

The new palliative care guidelines developed through the National Consensus Project for Quality Palliative Care are available on the Internet at www.nationalconsensusproject.org.

The document divides the guidelines into eight areas, or domains. Those domains, and some of the topics covered by each, are:

1. Structure and Process of Care

- Basing a care plan on a comprehensive interdisciplinary assessment of the patient and family

- Basing a care plan on identified and expressed values and needs of the patient and family

- Use of an interdisciplinary team approach using trained personnel

- Dedication to quality improvement

2. Physical Aspects of Care

- Management of pain and other side effects based on scientific information

3. Psychological and Psychiatric Aspects of Care

- Managing psychological and psychiatric issues based on the best available evidence

- Availability of a grief-and-grieving program

4. Social Aspects of Care

- Using a comprehensive interdisciplinary assessment to identify social needs of patients and families

5. Spiritual, Religious, and Existential Aspects of Care

- Assessing and skillfully responding to spiritual needs based on the best available evidence

6. Cultural Aspects of Care

- Assessing the culture-specific needs of the patient and family

7. Care of the Imminently Dying Patient

- Recognizing and communicating signs of impending death

8. Ethical and Legal Aspects of Care

- Respecting the patient's goals and preferences, and using them to form the basis of the care plan

- Addressing the complex ethical issues in the care of people with life-threatening illnesses

they need to do something, but they are not sure what. The second group [is composed of] those programs that have something in place that is very limited in scope. They can use this document to see where other programs are and where they really should be headed. The third group [includes] institutions that have thorough programs in place but can use the document to benchmark where they are and decide where they want to go in the future."

Particular programs will continue to have unique features based upon their care setting and individual population. For example, a palliative care program in a large hospital will have different goals and a different patient population from a program in a nursing home in a smaller community, so their programs will naturally vary.

"That is why it is important to note that these are guidelines, not standards," he says. "We want people to take into account that this is a relatively new specialty that has grown rapidly and has a lot of room for growth in the future."

Palliative medicine also has changed significantly in the last several years, and providers need to remember that it is an evolving specialty.

"So many times, we think of improving palliative care as doing things that we haven't been doing and should have been doing," von Gunten says. "Many institutions tend to feel ashamed and defensive or guilty, but that really doesn't serve a purpose. We need to remember that there is simply more now that we can do for our patients who are suffering than we could do in the past. Our main focus now should be on making sure that everyone in this country has the same access to these new strategies and treatments, as is possible under our current medical system."

Many have told Meier that they use the new guidelines as a checklist to see where they are and now are aware of the important palliative care resources they already have that may be underutilized.

"For example, many hospitals have extensive case management capabilities, but they don't work with the people who discuss symptom management and goals of care with family," she explains. "And many hospitals have contracts with hospices on paper but not in an operational way. Just having that list was a way for people to

really appreciate the riches they already had in front of them that they didn't know about."

Meier has been pleasantly surprised at the reception the consensus project and its work have received, and she feels it indicates a great deal of support for improved palliative care nationwide.

"When we presented this to the American Academy of Hospice and Palliative Medicine in January, we weren't sure if anyone would show up. But it was standing-room-only," she notes. "There were 7,000 downloads within the first 24 hours. People knew about what we were doing, and they were interested."

At a time when there are so many disagreements about strategies to improve the health care system, this is one area that everyone can agree on, adds von Gunten.

"I don't think you can find anyone who doesn't think more effort needs to go into improving palliative care and who doesn't feel that they want to do it," he states. ■

Set yourself apart with specialty programs

Choose specialties you may already serve

"We do a great job. Everyone loves our nurses, and our outcomes are great."

This may be your opinion of your agency, and you may be right, but is this enough to make your agency stand out from the multitude of agencies with which you compete?

The challenge in marketing a home health agency is that every agency sounds the same, says **Alison Cherney**, a marketing consultant with Cherney and Associates in Brentwood, TN. "Everyone offers the same basic service 24 hours each day, 7 days each week," she says. "A home health manager needs to find a way to differentiate his or her agency by providing the service in a way that is better and different from competitors."

"Nordstrom is a retail store like many other retail stores, but people choose to shop at Nordstrom because the customer service is better," explains Cherney. "Just as Nordstrom offers personal shoppers and friendly employees, a home health agency can offer an intake process that is easier and more efficient, an assessment process that is more thorough and includes better communications, and a discharge process that

results in patients who are better prepared to manage their conditions on their own."

Another way to differentiate your agency from other agencies is to develop a disease management program or to promote a special expertise your agency has, suggests Cherney. "Many agencies may already have a specialty, but it isn't packaged and promoted as a specialty," she says. For example, a home health agency may provide services for a large number of diabetic or wound-care patients by using employees with extra training to handle these patients. "If you already provide the care, you just need to take a few steps to make sure you are meeting the needs of the special population, and then promote yourself as an expert," she says.

An advisory board that includes physicians and other experts related to the disease management program can give you some good ideas about features that are important for a successful program, says Cherry. "Package your service by medical specialty, such as respiratory or heart, or by disease, such as diabetes," she suggests.

To find the right service for your agency, look at your current patient population, says **Amor Bango**, RN, BSN, director of clinical operations at Visiting Nurse Association of Central New York (VNA) in Syracuse. Two years ago, she and other managers noticed that more than 20% of their new admissions were for cardiac-related reasons, and about 33% of all of their patients had cardiac disease, even if that wasn't the reason for admission to home health. Congestive heart failure is the top cause of readmission to the hospital for VNA's home health patients. Therefore, agency managers developed a team to focus on heart patients and improve monitoring and education for this group, she says. The program was launched in February 2003.

"We developed a cardiac team, and we named the program Heart Smart," says **Diane Nanno**, RN, BSN, clinical nurse manager for VNA. But the agency did more than just create a name. "We chose nurses for the team that either have a strong interest in cardiac care or a background in cardiac care," she says. All of the nurses are also experienced home health nurses, she adds.

The Heart Smart nurses, who were chosen from VNA's staff, underwent intensive training to learn more about characteristics, diagnosis, and treatment of cardiac disease, she explains. This cardiac education continues on a monthly basis as Heart Smart team members meet to discuss the program, current patients, and new literature that relates to

their patients' conditions, she adds. "We also look for inservice opportunities using outside experts who can increase our knowledge," she says.

In addition to purchasing equipment such as pulse oximeters and scales, the agency developed a teaching guide that serves as a written record of the patient's daily status as well as a reference guide to support patients when the nurse is not in the home, says Nanno. There was no need for a large financial investment to develop the program because it did not require anything VNA wasn't already doing, except specialized education for the nurses, she says.

Benefits to the agency include a more positive relationship with referring physicians and a new relationship with a local hospital that has set up a program for patients with advanced heart failure, says Bango.

Specialty program helps abuse victims

Sometimes the specialty doesn't relate to clinical issues, as discovered by staff at Wellspring Personal Care in Chicago. "When I joined this agency, I was struck by the number of our clients who came to us after exploitation by a family member or other in-home caregiver," says **Gwen W. Watkins**, MSW, LSW, director of marketing for the agency. In addition to the medical issues of the patient, Wellspring staff members were dealing with emotional issues related to the patient's experience following financial exploitation by people the patient had trusted, she says.

The agency's reputation and record of responsiveness had created a group of attorneys and bank trust officers who would call upon the agency when a case of exploitation was discovered or suspected, says Watkins. Although the agency didn't purposely choose to specialize in this type of case, Watkins realized that it was important to define the process to make sure the patient was protected.

"When an older adult falls victim to exploitation, a nursing home is often considered the best place to protect them from further exploitation," says Watkins. "We wanted to provide a service that enables the person to stay in their home," she adds. The program includes a "SWAT" team that sees the client within 24 hours of a referral from an attorney, bank trust officer, physician, or family member who suspects abuse. "We go into the home to evaluate the patient's health and assess the home environment," says Watkins.

Because staff members are trained to recognize signs of both physical and emotional abuse, they are able to recognize and document any indication that there may be something going on, she says. **(For more information on the Wellspring elder abuse program, see story on p. 80.)**

Marketing of the program includes educational articles related to elder abuse as well as presentations to groups that might come in contact with victims, such as bank trust officers and attorneys, says Watkins. Signs of financial exploitation can be as obvious as a request to change a will or transfer a power of attorney to someone not known to the family or to a family member who has not been involved in the care of the patient. Or it can be as subtle as a caregiver isolating the patient from contact with others, she explains.

Both Wellspring and the VNA programs were willing to change traditional approaches to meet the needs of their clients. "A willingness to change processes or organizational structure is important to create an effective disease management or special expertise program," Cherney notes. "Nothing is worse than saying you have a program specially designed for one group, [and] then providing a service that does not differ from every other service you offer." Also, make sure intake, billing, and other administrative areas of your agency are doing their jobs well. "Even if your clinical program is excellent, if referral sources can't get through to send you patients, you won't succeed," she explains.

Now that the Heart Smart program is established, staff members at VNA are looking at other groups of patients who might benefit from a disease management program, says Bango. "We are developing a wound-care resource team, and we're evaluating the use of telemedicine to enhance the cardiac program and support other patients," she says.

While development of a disease management program or a special focus may give you a marketing edge over your competitors, Bango says this is also a natural move for today's home health agencies. "I've been in home care for over 30 years, and for most of that time, you had to know a little bit about everything," she says. "Today, home care patients are more ill, their care is more complicated, and they have less family support, so home health nurses need to know more about specific conditions. Nurses appreciate the opportunity to become experts, and they are rewarded by seeing the impact they have when they can focus on one type of patient." ■

Chicago agency develops program for abuse victims

Safe environment, stable routine lead to recovery

More than 12% of substantiated elder abuse cases reported in the United States involve financial or material exploitation, according to statistics compiled by the National Center on Elder Abuse. Caring for victims of exploitation after the abuser is removed requires more than just meeting their medical and daily living needs, says **Gwen W. Watkins**, MSW, LSW, director of marketing for Wellspring Personal Care in Chicago.

"These patients have been traumatized by a family member or other person that they trusted, and we have to create a sense of order and safety for them before they can begin to recover," says Watkins. Wellspring has a team of nurses, aides, and social workers who specialize in caring for abused elders. Team members are trained to recognize signs of physical, emotional, and financial abuse and to work with the patient to develop a trusting relationship, she says.

Response to abuse referrals within 24 hours

Once the agency receives a referral from a bank trust officer, attorney, or family member who suspects abuse, a team from Wellspring responds within 24 hours to assess the patient's medical condition as well as the home environment. Any signs of abuse are reported to the referral source or to the appropriate authorities, says Watkins.

Signs of neglect can be little or no food in the refrigerator or pantry, dirty bed linens or clothing, unkempt appearance of the patient, and lack of necessary medical supplies. Signs of emotional abuse are more subtle, says Watkins. "Abuse victims look and act like victims of war. They are fearful, anxious, fatigued, and reliant on another person to answer questions or make decisions," she says.

Techniques used to exploit and manipulate an older person include destruction of the routine of normal life and creation of turmoil, says Watkins. This turmoil makes the person feel unsafe and dependent upon the abuser, she says. "Our role is to come into the person's home to restore order and create a safe environment," she adds.

Elder Abuse Resources

For more resources on elder abuse, contact the following organizations:

National Center on Elder Abuse

1201 15th St. NW
Suite 350
Washington, DC 20005-2800
Telephone: (202) 898-2586
Fax: (202) 898-2583
E-mail: NCEA@nasua.org
Web site: www.elderabusecenter.org

The web site contains fact sheets, publications, caregiver resources, state statutes, research, and links to other resources on elder abuse.

National Committee for the Prevention of Elder Abuse

1612 K St. NW
Washington, DC 20006
ATTN: Bob Blancato
Telephone: (202) 682-4140
Fax: (202) 223-2099
E-mail: ncpea@verizon.net
Web site: www.preventelderabuse.org

The organization offers a variety of publications and research materials related to elder abuse.

Clearinghouse on Abuse and Neglect of the Elderly (CANE)

This organization provides the nation's largest archive of published research, training resources, government documents, and other sources on elder abuse. The CANE collection is fully computerized. Web site for database: www.elderabusecenter.org

Click on "Clearinghouse on Abuse and Neglect of the Elderly" on the right navigational bar.

"We use the same nurses and aides for as long as it takes to stabilize the patient so he or she is not seeing new faces every day," says Watkins. "We also work with our medical director to make sure medical conditions are addressed, and we may suggest medications to help the patients sleep until they feel safe enough to fall asleep on their own," she adds.

Agency staff members try to re-establish daily routines for abused patients. "We have one client who loved to have her hair done at a certain salon before her exploitation. She is unable to go to the salon now, but the stylist does come to her home," explains Watkins.

While stabilizing a patient, Wellspring looks

for ways to keep the patient out of a nursing home and either in his or her own home or in the home of a nonabusive family member. "These patients want to stay independent as long as possible, and when they have financial resources to support care in their homes, we suggest ways to accomplish this," Watkins says. Adult day care programs and home health aides can help a person stay independent, for example. "The goal is to make sure that the patient isn't placed in a position where he or she is at risk of exploitation again," she says.

If your agency takes on victims of financial exploitation, make sure you don't put yourself in a position where you can be accused of exploitation as well, suggests Watkins. "We do purchase groceries, medical supplies such as incontinence [supplies], or clothing that they need, if necessary. But we pay for it, submit a receipt, and are reimbursed by an agent of authority who pays us from a trust," she explains.

One of the major components of a program to help victims of abuse is strong case management, says Watkins. "A nurse must plan to be on-site frequently during the first few weeks to help the aide or other caregiver establish a trusting relationship," she says. ■

Advance planning eases care during aging process

Seniors and their relatives should prepare now

Planning is something Americans do on a regular basis. They plan their vacations. They plan for the birth of a new baby. They plan for retirement. Some even plan for death. Yet few plan for the aging process.

"It is good for people to start to think ahead," says **Marilyn Rantz**, PhD, RN, director of the Center of Excellence in Aging and a professor at the School of Nursing at the University of Missouri in Columbia.

Families need to consider the various scenarios that could take place as people age, such as not being able to drive or maintain a house. Then they should research the services and options available within their community and work with close family members to develop a plan.

Rantz has talked to seniors and family members who volunteered at nursing homes, assisted living facilities, or senior centers to help them become familiar with the services available to seniors in their community.

"That saved so much stress in those families who were proactive and took the time to understand what services there were in their community," says Rantz.

Michael Doran, CSW, coordinator of caregiver services for Health Outreach at New York Presbyterian Hospital in New York City, often meets caregivers who are overwhelmed with the responsibilities of caring for an elderly loved one while trying to meet work and family obligations. "Quite often when people present for help, they feel things are out of control," says Doran.

Provide list of community outreach centers

To help families prepare for the care of aging relatives, hospice staff members can provide information on what types of resources might be needed by seniors and their family members, how to determine when it is time to make use of such services, and how to find services that meet budget constraints and family requirements.

A list of community outreach centers would be very useful to families looking for help with the care of aging family members, says **Collette Schelmety**, RN, assistant nurse manager on the acute care for the elderly (ACE) unit at New York Presbyterian-Cornell Hospital in New York City.

These community outreach centers have access to the resources that families may eventually need for an aging relative, says Schelmety. For example, some have social workers who can help explain which services Medicare might cover, or they might offer home safety evaluations.

Local, state, and national agencies provide resources for older adults, says **Jennifer S. Browning**, MS, RN, CS, gerontology clinical nurse specialist at The Ohio State University Medical Center in Columbus. Senior centers within communities are also an important resource. They often have classes for older adults as well as social activities and meals.

Associations and organizations are good resources for disease-specific information. For example, local chapters of the Chicago-based Alzheimer's Association provide services for caregivers of relatives diagnosed with this disease.

Organizations provide elder care resources

Find agencies, services, and handouts

People who have aging relatives need resources to help them address problems that arise as they take on the role of caregiver.

A source of support and information is important, says **Michael Doran**, CSW, coordinator of caregiver services for Health Outreach at New York Presbyterian Hospital in New York City. Doran gets calls from families looking for advice on legal issues, home safety, how to put advance directives in place, and other issues.

Following is a list of on-line resources to help hospice staff assemble a source of support and information for the families that utilize their services.

- **Administration on Aging: www.aoa.gov**

The Administration on Aging is a division of the federal Department of Health and Human Services, which has its headquarters at 200 Independence Ave. SW, Washington, DC 20201. The Administration on Aging web site has sections for Alzheimer's Resources and Caregiver's Resources. Information for caregivers includes how to find help, how to cope with the role of caregiver, and how to find support groups. The site also has a resource directory of names, addresses, phone

numbers, and fax numbers of organizations that provide information and resources on the needs of older adults.

- **Alzheimer's Association: www.alz.org**

The Alzheimer's Association National Office maintains a web site that provides information on Alzheimer's, including risk factors and warning signs, as well as connections to local chapters, resources, and services. Contact by mail: Alzheimer's Association National Office, 225 N. Michigan Ave., Fl 17, Chicago, IL 60601. Telephone: (800) 272-3900.

- **Best Caregiver Information: www.bestcaregiverinfo.com**

This web site contains articles, connections to organizations and associations that provide help, and information on standards of excellence. Articles include tips on identifying depression in older adults, home modification and repair for safety, and how to find transportation services. Telephone: (561) 212-5297.

- **Consumers' Guide to Quality Care: www.nursinghomehelp.org**

This guide, which was created by the School of Nursing at the University of Missouri in Columbia, offers advice for families searching for quality nursing home care and includes suggestions about what to look for inside nursing facilities and how to identify quality nursing staff. The site also provides links to other resources on the Internet. ■

As relatives age, it is important for family members to foster their independence, but the family also should stay involved and supportive as needed, says Browning.

For example, social isolation could become a problem if an elderly person cannot drive or is not physically able to get out much. "They need frequent contact, even if it is just a phone call," says Browning. Relatives also can encourage visitors. Interaction with other people and the stimulation of talking about current events and topics of interest is important, she says.

Caregivers need to be aware of the mental and physical changes that take place as people age so they can know when it is necessary to intercede, says Schelmety. For example, some forgetfulness is common as people age. Therefore, it would be

wise to take steps to prevent problems by putting a list of emergency numbers next to the telephone.

It's also important for caregivers to encourage elderly relatives to participate in activities that stimulate their minds. "Seniors can improve their memory by continuing to be active in such recreational activities as Scrabble or cards," says Schelmety.

Caregivers should be familiar with the signs of dementia, which include consistent loss of memory that affects activities of daily living and the ability to participate in social events, says Browning. In this case, an elderly relative would need more assistance and may need to be moved to an assisted living facility.

Older adults are also at risk of depression, which is underdiagnosed and undertreated, says

Browning. It is important for caregivers to know the signs of depression in the elderly. "Older adults present differently. Their only complaint may be physical symptoms such as fatigue," Schelmety says.

As people age, there is a decrease in strength and balance, and bones become less dense, rendering them more susceptible to fractures, says Schelmety. Thus, home modifications may be required to improve safety, such as installing better lighting and removing throw rugs. "One out of three people ages 65 and older falls each year, and fractures are the most serious consequences of the falls. Many of the injuries can be prevented," she explains. People can obtain environmental safety checklists to evaluate their homes. **(For a list of Internet resources for educating caregivers and seniors about the changing needs of aging adults, see box on p. 82.)**

Review all medications

Medications can cause confusion as well as falls. Caregivers should review all medications an elderly relative is taking and learn the side effects of each as well as the proper dosage and method of taking them. Medication containers need to be clearly marked for older adults, says Schelmety.

Certain immunizations and screenings are required for good health as people age, so it is a good idea for people ages 65 and older to begin seeing a physician who specializes in geriatrics, says Schelmety. Older adults should be vaccinated against pneumococcal pneumonia and influenza, because these illnesses are among the top 10 leading causes of death for this age group.

While good health practices are vital at any age, there are many things the elderly can do to maintain health as they age. For example, to increase strength, flexibility, and balance, they need to make exercise a part of their daily routine. Good nutrition and hydration are important as well, says Schelmety.

Communication between the aging adult and his or her caregiver is very important for as long as interaction is possible. Good health practices, living situations, and care provision should all be discussed, and advance directives should also be put in place.

"Caregivers should find out what the older adult wants. They shouldn't assume anything. [Caregivers] need to communicate well with their loved one," advises Browning. ■

How to use non-compete/ non-solicitation agreements

Terms of agreements must be 'reasonable'

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

Competition among home health agencies for referrals can be fierce. Agency managers are increasingly concerned about employees and independent contractors who leave agencies and take patients with them. Agencies have used a variety of strategies to prevent the loss of patients to other agencies when former employees or contractors take patients with them, including non-solicitation agreements and non-compete agreements.

Non-solicitation agreements frequently require employees and independent contractors to agree not to solicit patients who currently receive services from the agency at the time the relationship terminates. These agreements also may prohibit employees and independent contractors from soliciting employees and independent contractors of the agency to work elsewhere when the departing employee's relationship with the agency ends.

Of course, the difficulty with non-solicitation agreements is that it may be difficult to prove that "solicitation" occurred. Former employees and independent contractors may claim, for example, that patients who switched agencies did so on their own without any encouragement from the employee or contractor.

Nonetheless, it may be helpful to ask employees and independent contractors to sign non-solicitation agreements because this may deter them from engaging in attempts to get patients or staff to change agencies.

In view of the potential limitations of non-solicitation agreements, agencies have also utilized non-compete agreements. These agreements may, for example, prohibit employees and independent contractors from working for other providers of similar services within a specific geographic area for a specified period of time. Or they may prohibit employees and contractors from providing services to patients that they cared for at the agency for a specified period of time after the relationship with the agency ends.

The terms of non-compete agreements must be reasonable. If a non-compete dispute arises when an agreement has been signed, what counts as

“reasonable” is likely to be determined by a mediator, arbitrator, or judge. But, generally speaking, if the terms of a non-compete agreement amount to deprivation of the ability to earn a living, they will be considered unreasonable.

It is also important for agencies to be meticulous about getting non-compete agreements signed *before* they hire employees, as opposed to after they have already been employed. Some courts have ruled that non-compete agreements signed by employees who have already been hired are unenforceable.

The crucial issue for many courts is whether employees receive “consideration” in exchange for signing a non-compete agreement. With regard to employees who sign agreements before they are hired, the consideration is clearly getting the job.

Employees who were asked to sign non-compete agreements after they were already employed by the company have successfully argued in court that they received no consideration for signing the agreement, rendering the agreement unenforceable. Of course, employees asked to sign non-competes can always quit their jobs, but some former employees have claimed that they could not realistically do so. Since signing a non-compete agreement did not guarantee continued employment, the agreement was unfair, without consideration, and, therefore, unenforceable.

On the other hand, some courts have ruled that when existing employees sign non-compete agreements and continue to be employed, their continued employment was consideration for signing the agreement. After all, the employer could have fired them if they refused to sign the agreements.

What should agencies do in response to the different conclusions reached by courts in various jurisdictions about these issues?

- Ask employees to sign non-compete agreements as a prerequisite to hiring. This may increase the likelihood that non-compete agreements will be enforceable.
- Agencies should ask current employees to sign non-compete agreements before potential problems with a continued employment relationship are encountered or the agency contemplates layoffs. To the extent that employment continues after employees sign non-compete agreements, they are more likely to be enforceable.
- Enforcement of non-compete agreements is a rapidly changing area of the law. Agency managers should periodically review their agreements and

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any applicable state statutes and regulations and make amendments to them as needed to help ensure enforcement.

Competition among home health care agencies is increasing. Agencies cannot afford to lose patients and staff to competitors when staff members leave to work elsewhere. All reasonable steps must be taken to ensure that patients and staff are not lost, including the use of non-solicitation and non-compete agreements.

[A complete list of Elizabeth Hogue's publications is available by contacting Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@Comcast.net.] ■

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