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Special Report: Expanding Hospice to Alternative Sites

National trends show a need to link hospice care and long-term facilities

Marketing to nursing homes requires persistence

(Editor's note: This month, we begin a two-part series of articles on how hospices can extend their expertise. In this issue, we examine potential links between hospice and long-term care facilities. The December issue will discuss how to make the most of partnerships with assisted living facilities.)

Increasing numbers of elderly Americans spend their last days in nursing homes, and very few benefit from hospice services, experts say. Researchers and national health care experts predict that the number of people who die in nursing homes or other long-term care (LTC) facilities will continue to rise in coming decades as the baby boomers age. Already, many states are seeing an increase in nursing home deaths at the same time that the percentage of deaths in inpatient settings is falling, and some studies estimate that as many as 20% of all U.S. deaths take place in nursing homes.

"What needs to change is the way we view nursing homes," says **Diane Hoffmann**, JD, MS, professor of law, associate dean for academic programs, and director of the law and health care program at the University of Maryland School of Law in Baltimore. Hoffmann spoke about hospice care in nursing homes at the National Hospice & Palliative Care Organization (NHPCO) conference, held Sept. 30 through Oct. 2 in Washington, DC.

"Nursing homes have not acknowledged that they are places where people die, and more and more people are dying in nursing homes," Hoffmann says. "Forty percent of people over age 80 are dying in nursing homes."

In a survey of nursing home directors, a majority said there were nursing home residents in need of hospice care who were not receiving it, she says.

Hoffmann has investigated the reasons why nursing homes have

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underutilized hospice, and she found that the existing barriers are related to cultural and institutional differences.

"Nursing homes and hospice are very different animals in terms of missions and goals and how they operate," Hoffmann says. "Nursing homes tend to be more bureaucratic, while hospices are more democratic, using families and volunteers."

While nursing homes focus on custodial care, rehabilitation, and activities of daily living (ADLs), hospices focus on pain management and open communication about death and dying, Hoffmann adds.

Accordingly, one of the chief obstacles to partnerships between nursing homes and hospices has to do with ideas about pain medication.

"It seems that nursing home staff fear using large doses of medication and feel nursing home surveyors may accuse them of overmedication," Hoffmann notes.

"Also they have concerns about being cited for substandard care if a resident is not eating or is malnourished or dehydrated," she says, "whereas hospice regards a patient's unwillingness to eat as a natural part of the dying process."

Another obstacle involves the regulatory gray area created about five years ago when the Office of Inspector General came out with a fraud alert involving hospices being referred patients in nursing homes, Hoffmann says.

The alert noted that people were being referred from nursing homes to hospice when they didn't fit the eligibility criteria of having a life expectancy of less than six months, Hoffmann says.

"This alert reduced physician willingness to refer some patients to hospice, especially with non-cancer patients who had conditions where the ability to predict or estimate death was much more difficult because diseases didn't have the same trajectory as cancer," Hoffmann adds.

Although lawmakers have added some flexibility to this criterion, the damage has been done because of a few high-profile cases in which Medicare tried to recoup money from people who had lived longer than six months while in hospice care, Hoffmann says.

"Hospices appealed the decision, and Medicare lost," Hoffmann says. "An administrative judge said this wasn't an error, and you can't penalize people for living too long."

Still, these types of cases have left a distaste among some in the industry for any kind of referrals that might trigger a Medicare investigation.

Another regulatory concern involves the overlap of hospice and nursing home services, Hoffmann notes.

"There's the question of who should be doing the feeding and bathing of patients, and there may be a violation if either hospice or the nursing home cut back on services because the other's doing it," Hoffmann explains.

This gray area can cause confusion because while a nursing home's mission may include ADLs, such as bathing and feeding, a hospice may include these services as part of an array of aide services that are offered for comfort to dying patients, Hoffmann says.

"A lot of nursing home staff we spoke to said, 'Hospice is just duplicating what we're doing,' and so hospices in response said, 'Rather than duplicating what they're doing, we'll do aromatherapy and massages and alternative-type healing approaches that a nursing home is not paid to do.'"

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Editorial Questions

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

Despite the challenges, there are many positive reasons why hospices may desire to form partnerships or collaborative relationships with skilled nursing facilities, experts say. **(See story on marketing hospice to skilled nursing facilities, lower right.)**

For instance, some research indicates that nursing homes struggle with palliative care and pain management, which means there is a long-term growth possibility for hospices that would like to form collaborative relationships with nursing homes.

"I think the potential for growth is definitely there," says **Gwendolyn Burk**, MSS, MEd, LCSW, manager of the assisted living and skilled nursing facilities team at the Hospice of North Central Florida in Gainesville. Burk spoke about collaboration with skilled nursing facilities at the NHPCO conference.

Likewise, hospices could take advantage of growth opportunities through developing partnerships with assisted living communities.

Hospice care in assisted living communities and LTC facilities probably won't replace hospice home care, but it's still an important option for growing hospices, says **Karen Carney**, director of community and provider relations at Hospice of the North Shore in Danvers, MA. Carney spoke about hospice and assisted living communities at the NHPCO conference.

"Hospice was designed to care for people at home and keep them home, and that's our first option," Carney says. "But the reality as we move forward is that for many people the home is not viable, so having good relationships with assisted living and skilled nursing facilities enables all of us to work together as someone's needs change."

Hospice of the North Shore began working in SNFs about five years ago, but it wasn't until a year and a half ago — when the organization put a major emphasis on increasing its work with long-term care facilities — that referrals increased significantly, Carney says.

The hospice's daily census rose from 120 to more than 300, and long-term care referrals played a major role in that growth, Carney says.

"We put a lot of emphasis into long-term care facilities and how we could be a better service to them," Carney says. "And now it's become comparable to our home health services, and we have two designated teams."

The need for hospice care in assisted living communities is increasing, along with a need for a specific and unique approach that might work best in that environment, Carney says.

"A lot of trends suggest more people are going to be living in assisted living communities," Carney says. "But many hospices overlook them."

Despite the opportunities for hospice growth in partnerships with LTC facilities, both hospices and LTC facilities have experienced barriers to forming relationships, says **Marion Keenan**, MA, MBA, president of Coastal Hospice in Salisbury, MD. Keenan also spoke about hospices and nursing homes at the NHPCO conference.

"I think we have so far to go," Keenan says.

The first of many barriers is convincing LTC facilities of the need for the kind of specialized end-of-life palliative care that hospices provide.

"More and more nursing homes are indeed looking at palliative care," Keenan adds. "But when you pay attention to all that's involved in palliative care, the intensive social interaction you have with interdisciplinary teams and just the reality of staffing in those nursing facilities on volunteer levels, even if the concept of palliative care takes hold, it would be hard for them to replicate what you can do in hospice." ■

Experts offer these tips for bonding with SNFs

Emphasize what you can do for them

When a hospice manager visits with a nursing home director to discuss hospice referrals, the focus should be on more than just what the hospice can do for patients; emphasis also should be placed on what the hospice can do for the skilled nursing facility (SNF) and its staff, experts advise.

That's just one of the tips hospices could follow to increase business through SNF referrals and collaborative relationships. Here are some additional suggestions for developing and maintaining collaborative relationships with SNFs:

1. Show how the hospice can support the SNF's mission.

"Figure out where you fit in with them," suggests **Karen Carney**, director of community and provider relations at Hospice of the North Shore in Danvers, MA.

"It's not just going to them to say, 'Do you

have somebody ready for hospice?'" Carney says. "It's knowing where you add value."

The biggest marketing point is that a hospice has expertise in palliative care and symptom management, and hospices have resources to handle these issues that a nursing home probably lacks, Carney says.

"Bringing in hospice services helps them expand what they are able to offer," she says.

"When I talk about the benefits of hospice, I'm talking about the benefits to patient care, such as another set of eyes and ears and an interdisciplinary team that relieves the burden on the nursing home's staff," says **Gwendolyn Burk**, MSS, MEd, LCSW, manager of the assisted living and skilled nursing facilities team at Hospice of North Central Florida in Gainesville.

"Hospice can help increase staff satisfaction in facilities because we provide education and support to them, and that decreases burnout and turnover," Burk says. "Hospice is very proactive in pain management and crisis care, and this helps to make sure every resident has a smoother stay."

Hospice managers also should talk about the benefits to residents, says **Marion Keenan**, MA, MBA, president of Coastal Hospice in Salisbury, MD.

"That's the bottom line and that's our reason for being," Keenan says. "The other thing I do try to talk about is the beneficial aspects of our presence on their professional staff as colleagues."

For example, hospice's presence brings the SNF an additional nurse with whom to collaborate, another social worker involved with a patient, pastoral care, and additional aide services, all of which help the nursing facility, Keenan says.

"I think nursing facility staff feel less guilty when they see a patient near death and hospice is there with them, so they don't have to feel like they're ignoring that patient," she adds.

Keenan also explains to SNF directors that patients and their families typically have a more favorable impression of a nursing facility when hospice is there, because they don't separate hospice services from the SNF's services.

"They think about the overall care that Mom or Dad got in this facility, and so there's more satisfaction overall," Keenan says.

2. Understand financial drawbacks.

SNFs benefit financially from being able to bill Medicaid for a resident's room and board and then billing Medicare for any rehabilitation the patient might need, Burk explains.

However, when a patient is referred to hospice, the Medicare portion of reimbursement ends for the nursing home, and it's the hospice that bills Medicare for palliative care services. So some SNF directors may weigh the financial drawbacks of bringing in hospice.

Another issue that may concern SNF directors involves the convoluted way Medicare and Medicaid pay for SNF residents when hospice is involved. The typical arrangement is for Medicaid to pay the SNF directly for a client's room and board, says **Diane Hoffmann**, JD, MS, professor of law, associate dean for academic programs, and director of the law and health care program at the University of Maryland School of Law in Baltimore.

Hospice involvement may delay SNF payment

Once the hospice is involved, both Medicare and Medicaid pay the hospice directly for the patient, and it's up to the hospice to pay the nursing home the Medicaid portion, Hoffmann says.

"Nursing homes in many states get paid electronically from the state Medicaid, and hospices may not be paid that way, so the timing of the payment to the nursing home is much slower, and nursing homes may see that as a problem," she says.

3. Maintain strong communication lines between the hospice and the SNF.

Hospice of North Central Florida staff first meet with SNF staff to establish parameters of care and to learn the exact needs of a patient, Burk says.

"In terms of collaborative practice, we'd meet quarterly with facility staff to see if everything is going as well as it needs to be," Burk says. "We're involved in patient conferences and will document any education or anything that has to do with the [SNF] staff."

For instance, the hospice will offer SNF staff inservices on pain management and other topics at least quarterly, Burk says.

"We offer an interesting class on the signs and symptoms of approaching death," Burk says. "The social worker and nurse discuss this and give facility staff time to say what they've seen and how it affected them."

The hospice's chaplain has conducted patient memorial services for both surviving SNF residents and also for staff, Burk notes.

"There are lots of layers of support, and one

of the things that's important is for staff to feel they are not out there doing it alone," Burk says.

4. Train staff to work in an SNF environment.

If possible, a hospice should place nurses and staff with backgrounds in long-term care work in SNFs, Carney suggests.

"The secret to what has helped us grow long-term care volume is we specifically recruited nurses with a long-term care background because they know what it's like to be on the other side of the desk," Carney says. "SNF nurses don't want hospice nurses to come in and give the impression that they know how to do it better."

Also, hospice nurses with SNF backgrounds will speak some common language more easily. For example, SNF nurses use acronyms such as MDS, which stands for minimum data set, and MMQ, which stands for managed minute questionnaire, and a hospice nurse with a background in long term care will know immediately that the MMQ is a tool that determines the Medicaid reimbursement rate paid to the nursing home for a patient, Carney explains.

Another strategy is to teach hospice staff that they are guests in the facility and will be working there as consultants who are trying to help the facility, she says.

"One of the other things we do is assign all of the LTC team to specific facilities, and that way they really develop a relationship with the staff at the facility and are comfortable with each other," Carney says. "There is a consistent person coming in and a consistent way of doing things."

At Hospice of North Central Florida, most of the staff are seasoned professionals, and some come from the SNF environment, Burk says.

"They have a strong sense of advocacy for older people," Burk says. "As we interview people, we look for people with really good interpersonal skills and a sense of diplomacy."

Staff are trained in a week-long orientation, followed by a one-month orientation on a team, Burk says.

Part of the training for hospice staff who will be working in nursing homes is to emphasize the importance of having an attitude of mutual respect, Keenan says.

"And the people who are most important in making that happen are the leaders," Keenan adds. "So it's important for me and the nursing facility administrator to keep encouraging staff to be open to the suggestions and perceptions of the other group." ■

Turn core values into value-added improvements

Florida hospice improves all areas of organization

It may be popular these days for hospices to create a statement of their core values as part of a management and organizational exercise, but that's just the easy part.

The real challenge is making the core values mean something and translating the mission statement into a quality improvement foundation for all that a hospice organization does, says **Mary Lou Proch**, BSN, MA, EdD, director of education at LifePath Hospice and Palliative Care of Tampa, FL.

LifePath Hospice staff and administrators have successfully incorporated the organization's core values into their jobs and goals, and the result has been rapid growth and lower employee turnover rates.

Patient census up, staff turnover down

"We have had tremendous growth, with patient [cases] increasing 200%," Proch says. "In 2002, we had a staff turnover rate of 38%, and our projected turnover rate for 2004 is 20%, so it's gone down tremendously."

LifePath's recent successes prove that if an organization is giving good service, referrals will increase over time, resulting in sustained growth rather than a one-time fluctuation, Proch says.

And this growth directly coincides with the organization's new focus on core values.

"Up until 10 to 15 years ago, nobody understood the importance of having values articulated to the organization," Proch says.

Now many organizations believe that developing a list of core values and letting employees and clients know what these are is key to quality improvement and continued growth, she says.

"The more employees see their organization's core values at work, the more satisfied they are and the more it develops trust," Proch explains. "But if you say one thing and do another, then you destroy employee satisfaction."

When LifePath Hospice was undergoing major management changes, the organization's administrators decided to identify the hospice's core values and use these to guide the hospice, Proch says.

An interdisciplinary team worked together to come up with five core values for the hospice, which are the following:

- patients and families come first;
- honesty and integrity;
- stewards of our resources;
- work together to meet common goals;
- find new and better ways to care for our communities.

"We also have the core purpose of making the most of life," Proch says.

Once the job of identifying core values was complete, the organization began the more difficult job of deciding what to do with these core values and making them a part of the hospice's culture and mission.

Here's how LifePath Hospice used core values to improve quality, employee satisfaction, and processes:

1. Get the word out.

The first step involves presentation, Proch says.

"We put the core values in posters and talked about them at meetings," she says. "We knew it would take a long time to make sure everything was connected."

The culture change resulting from getting the word out about core values took from 1998 to 2002, which is when the hospice began to integrate different systems with the core values, Proch explains.

"We had the values and then thought about what else we could do to put them into practice," she says. "It has to get to a point where it's subliminal and automatic; first we make a conscious effort of it, and then it gets into the subconscious."

2. Hire employees according to core values.

"We started hiring people according to the core values in late 2002, and that's when we first saw a dramatic decrease in our staff turnover rate," Proch says.

For example, the core value of working together to meet common goals essentially refers to teamwork, so hospice hiring interviewers ask potential employees to discuss the experiences they've had working with teams and the qualities they have that support teamwork, Proch explains.

"We say, 'Tell me about the time you worked on a team, and what do you do to support teamwork?' and their stories let us know what they personally do," she says.

Likewise, for the core value of honesty and integrity, an interviewer might ask the applicant: "I'm sure you've been asked to do something you weren't comfortable with. How did you handle that situation?" Proch says.

"What we're looking for is the best fit; when someone's personal values match organizational values, their job satisfaction goes way up," she says. "So if their answers don't meet our standard, they don't go past that interview."

Job applicants who pass the first round of interviews will then be assessed for their professional and personal skills with regard to their particular profession and their potential work with a clinical team, Proch says.

3. Evaluate staff according to core values.

The performance evaluation form now includes statements that pertain directly to the organization's core values, with sections on job knowledge, quality, productivity, and compliance.

The various sections include statements such as, "Makes good ethical decisions," Proch says.

Judging staff on more than their smile

"Every one of those values has a statement in the job performance review that supports it," Proch notes. "These include statements saying, 'Bases treatment plan on what patient's families' goals are,' and 'Do you put the family first?'"

It's important to have processes for keeping people accountable, because otherwise there won't be behavioral change, Proch says.

"Our performance review's bar was raised last year, and it's more outcome-based," she says. "It's not just that you smile and are pleasant."

Staff outcomes also are measured at departmental levels, such as whether individuals are able to work with other departments to achieve organizational goals, Proch says.

For instance, an employee who does her or his part to help the pharmacy department achieve its goals is supporting teamwork between departments. Likewise, the employee will be rated higher on the evaluation if she or he is perceived as being a person of influence who is asked to be on various committees, Proch says.

4. Develop a leadership education program using core values.

"We're developing a leadership education program for the first-line supervisors and the second-line managers," Proch says. "The third line is the director's level."

If the hospice's philosophy is that patients and their families come first, then the employees are the ones who must come first for managers,

because the people they supervise are their clients, Proch says.

The crucial question for supervisors and managers is: "What are some of the outcomes managers would implement to support the core values?" Proch says.

"We also distributed an employee opinion survey this year," she says. "There were 35 questions related to the immediate manager and also questions about job satisfaction."

Survey statements had responses on a one-to-five scale of agreement, Proch says. One survey statement is, "My immediate supervisor removes barriers that keep me from doing my job." Another says, "My immediate supervisor communicates effectively to patients, family, and staff if there is a problem."

The survey was distributed anonymously by a contracting company so employees were convinced that no one's name could be traced back to the answers given or that a hospice manager could access the data and change it, Proch says.

"We went the extra mile to make it appear completely anonymous and that no one can touch the data," she says.

When the data results are distributed, administrators will make certain supervisors own the data and learn from what it says about their managerial skills, Proch says.

The process is expected to identify managers who need extra training and to help others identify their strengths and weaknesses, she says.

5. Infuse training with core values.

The general orientation includes a presentation of speakers who are grouped under the core values, Proch says.

"We have checklists to make sure people can do these certain behaviors, and we have outcomes that can support these values," Proch says. "The checklists have some clinical skills and some are judgments, but we always have the employee demonstrate integration of our LifePath values."

The orientation period includes the employee's first 30 days of work, so the checklist is completed by supervisors who can answer the questions, such as whether the employee puts families and patients first, Proch notes.

"Besides evaluating how well someone does with the job skills, we look at their values," Proch says. "If you have a performance issue as far as the skills, we can always teach you the skills, but if we're different on values, we can't always do something about that." ■

GUEST COLUMN

Managing pressure ulcers lowers liability risks

Teach patients, families to know the signs

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

Calculation of damages in malpractice cases involving negligence often includes the life expectancy of injured patients as a key component. Therefore, agencies should, at least in theory, have some added protection against large monetary awards. It now appears, however, that courts and juries may have a great deal of sympathy for patients with limited life expectancies, so providers must devote increasing attention to risk management issues when caring for terminally ill patients.

Hospices and home health agencies are generally familiar with liability based upon substandard wound care. Based upon the possibility that terminally ill patients may develop a type of pressure ulcer called a "Kennedy Terminal Ulcer," providers must take steps to minimize claims of substandard wound care.

The Kennedy Terminal Ulcer was first identified by Karen Kennedy. Her web site, at www.kennedyterminalulcer.com, says a Kennedy Terminal Ulcer is a pressure ulcer that some patients develop as they get closer to death. These ulcers are often shaped like a pear; located in the sacral area; red, yellow, and black in color; and have irregular borders.

Kennedy Terminal Ulcers often have an extremely sudden onset. They usually start out as blisters or Stage II pressure ulcers and rapidly progress to Stage III or IV. They tend to start out larger than other types of pressure ulcers, and are usually more superficial initially but increase very rapidly in size and depth.

The causes of these ulcers are unclear. Kennedy suggests on her web site that they may be caused by a blood profusion problem exacerbated by the dying process. They also may be a symptom of multi-organ failure toward the end of life.

When Kennedy Terminal Ulcers progress to Stages III or IV, they may look terrible to patients

and their families who do not know very much about pressure ulcers. It may be hard for them to understand that such awful-looking wounds developed even though care rendered met applicable standards of care. It may be equally difficult for judges and juries to comprehend how such terrible wounds could develop unless hospice providers were negligent in some way.

Following are some practical steps home health agencies can take to minimize risks associated with claims of substandard would care:

1. Educate all staff providing direct patient care about the signs that a Kennedy Terminal Ulcer may be developing. Specifically, staff members need to know that these types of ulcers often begin as little black spots. Providers may think it is a speck of dirt or dried bowel movement and try to wash it away only to find that it is under the skin, not on the surface of the skin. In a matter of hours, the spot may look like a small black blood blister or like someone colored it with a permanent marker. The patient's skin may be intact in the morning, but by the same afternoon, providers may observe the above signs.

2. Develop a policy and procedure for routine observation of all patients for development of pressure ulcers, including the Kennedy Terminal Ulcer. The policy and procedure should, of course, include routine documentation of compliance with the protocol.

3. As soon as staff members identify a possible onset of a Kennedy Terminal Ulcer, they should begin treatment. Applicable standards of care indicate that these types of ulcers should be treated just like other pressure ulcers.

4. Educate patients and their caregivers about the possibility of rapid onset of Kennedy Terminal Ulcers. Staff may even want to show patients and their caregivers pictures of these types of ulcers in various stages so that they are alert for possible development of them. Staff who provide this education should emphasize to patients and their caregivers that these types of ulcers often develop in terminally ill patients and do not necessarily mean that caregivers, both professional and non-professional, failed to provide appropriate care. In other words, appropriate expectations about these types of ulcers may prevent caregivers and families from reaching erroneous conclusions about the quality of care provided by agencies.

5. As soon as there are signs of the development of Kennedy Terminal Ulcers, visiting staff should take pictures of the wound. In view of the rapid onset of these ulcers, staff may initially wish to take pictures during each visit. The name of the patient and the date on which the picture was taken must appear *in* the picture as opposed to writing it *on* the picture. Patients must also, of course, give written permission for the taking of photographs. Agencies are well-advised to obtain general consent for the taking of pictures upon admission.

Home care providers generally care very deeply for patients and their families and have very positive relationships with them. Allegations of substandard wound care based on the development of Kennedy Terminal Ulcers should not adversely affect an otherwise excellent relationship if agencies take proper precautions to manage risks associated with these types of pressure ulcers.

[To obtain more information about negligence and risk management related to wound care in a book titled Legal Liability, *send a check for $30 (includes shipping and handling) made out to Elizabeth E. Hogue to the address below. To obtain a copy of* Wound Care: Legal Issues, *send a check for $35 (includes shipping and handling) made out to Elizabeth E. Hogue to the address below.*

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Follow your own rules for background checks

Verify employee's suitability for unsupervised care

By **Jan J. Gorrie**, Esq., and **Blake Delaney**
Buchanan Ingersoll Professional Corp.
Tampa, FL

In July 1995, a baby boy was born with esophageal reflex, causing him to vomit day and night. The child's condition prevented the mother and father from sleeping through the night. In addition, the mother suffered from postpartum depression. Seeking relief four months later, the couple's

insurance company retained a home health agency to provide overnight in-home child care for 12 nights.

When selecting the particular nurse's aide for the job, the agency failed to comply with its own pre-hiring screening policies; therefore, neither the agency nor the parents knew that the nurse's aide was addicted to Vicodin (hydrocodone), a narcotic pain reliever. As with all narcotics, Vicodin has been known to impair a person's mental and/or physical abilities by causing hallucinations, mental clouding, and severe confusion. The couple also did not know that the nurse's aide allegedly had stolen a credit card from a previous client of the home health agency. Nevertheless, the aide was given the 12-night assignment in November, and she provided adequate care for the baby during that time.

Aide violated contract with agency

When the couple's insurance benefits ran out in December 1995, the agency discontinued its overnight child care in the parents' home. Later that same month, the mother began treatment for severe depression and panic disorder at an outpatient psychiatric clinic. Consequently, the couple offered to hire the nurse's aide to moonlight at their home. Despite a clause in the aide's contract with the home health agency prohibiting such unofficial services, the aide agreed to the couple's offer in late December.

On Dec. 29, the nurse's aide babysat overnight without incident. The aide next babysat during the early hours of Jan. 3, when the parents asked her to watch the boy for the last six hours of the night. The following morning, the aide saw the baby was unresponsive and called the father, who attempted to resuscitate the child while waiting for the paramedics to arrive. The baby was pronounced dead as a result of blunt trauma and shaken baby syndrome. The most noticeable injuries were brain and eye hemorrhages.

An Illinois state court convicted the nurse's aide of murder. In her appeal, the aide argued that because so many people had access to the baby that night, including the mother and father, it was improper for a jury to have found her guilty beyond a reasonable doubt. After the aide spent several years in prison, the Illinois Second District Appellate Court reversed the aide's conviction in May 2000. At that time, she pleaded guilty to attempting to obtain prescription drugs without a prescription and to theft of a credit card.

Following the reversal of the aide's criminal conviction, the parents sued the nurse's aide for willful and wanton conduct. The couple also sued the home health agency for negligence, claiming the agency's failure to comply with its screening policies caused the baby's death. The parents alleged that the agency's screening policies would have led to discovery of the Vicodin addiction, and the plaintiff's expert argued that the Vicodin addiction led directly to the killing of the baby.[1]

The defendants first argued that the injuries happened before the nurse's aide arrived at the couple's home on the morning of Jan. 3. Defense experts testified that the injuries could have occurred any time during the 24 hours before the baby boy's death, and the fact that the aide was only present during the last six hours of the night created enough doubt about whether the aide was responsible. Furthermore, the defense argued that either the father or the paramedics were responsible for the eye and brain hemorrhages, given that the father observed none of those injuries when he was first called by the aide to attend to the unresponsive baby.

The second defense offered by the home health agency was that the aide's private contract with the parents released the agency from any liability. In response to this, the parents contended they relied on the agency's background check in making their decision to hire the nurse's aide.

At the conclusion of the trial, the jury was not convinced that the nurse's aide was responsible for shaking the baby and returned a defense verdict in her favor. The jury then found that the home health agency was negligent in conducting its screening process. It found that the agency's negligence exposed the family to danger, even though the danger never materialized into any real damages. As a result, even though arguably inconsistent, the jury's verdicts released the aide from all liability, yet awarded the parents $75,000 in damages from the agency.

What this means to you

Because a home health care provider, by its very nature, has no control over the environment in which its employees will deliver health care services, such providers all establish procedures for screening prospective employees during the hiring process.

"This case presents a classic illustration of why it is absolutely imperative that an organization

follow the rules, especially when it was the organization itself that wrote the rules," states **Ellen Barton**, JD, CPCU, a risk management consultant in Phoenix, MD.

All screening procedures undoubtedly ensure an applicant's satisfaction of licensing and other technical qualifications required for providing medical care. However, part of the rules should also include reviewing a prospective employee's suitability for the unsupervised nature of home health care service.

Burden of trust is greater in home health

"The very core of a home health agency's operations is the delivery of care in a client's *home*. Thus, the agency not only needs to assure itself that the prospective staff are clinically competent, but also that the prospective staff can be trusted to deliver care in a safe and effective manner," Barton says.

During the screening process, a home health care provider should evaluate several aspects of an employee's background relevant to providing medical care while in a patient's home.

"First, no one would disagree that it is prudent for an organization in the home health business to conduct screening procedures that include criminal background checks on all applicants," Barton states.

A criminal history can signify an employee's general disregard for following rules and, depending on the specific nature of the criminal record, may indicate particular problems that are likely to arise in a home health care situation.

A second relevant aspect of a prospective applicant's background is the employee's lifestyle, including any illegal or destructive habits, such as alcoholism and other drug addictions. In this case, although the aide's Vicodin addiction would not have surfaced during a routine criminal background check, such information is nevertheless relevant to the quality of care that the home health care agency should expect from her. As the plaintiff's expert opined in this case, the narcotics habit may have impaired the mental and physical abilities of the nurse's aide to the point of causing the killing of the baby.

Thus, while a home health care agency has no control over the environment in which the care will be delivered, it does have some control over the staff that it hires to provide services. Such control will not only lead to a higher level of patient satisfaction, but it also will reduce liability in a field that depends upon unsupervised individuals providing care in the most intimate of settings: the patient's home.

"If the agency had followed its own screening procedures and conducted an appropriate background check, it is unlikely that the nurse's aide would have been hired. Even if the agency had not discovered the aide's drug addiction and criminal background, but had followed its own screening procedures, it is unlikely that the agency would have been held responsible for exposing the family to danger," states Barton.

This is because it would be difficult for a jury to find that a home health care agency acted negligently if the agency could show that it acted reasonably according to the relevant standard of care.

"On the other hand," Barton says, "What if the home health agency had conducted a background check, discovered the red flags in the prospective employee's background, and chosen to ignore them because of what it perceived as a business need to hire staff? It's likely that under those circumstances, the agency could have exposed itself to both civil and criminal liability.

"The lesson from this case is simple: Follow the rules!" concludes Barton.

Reference

1. DuPage County (IL) Circuit Court, Case No. 97L-1403. ■

JCAHO advises caution with certain drug names

Organizations to create watch list

Home health agencies must choose at least 10 look-alike and sound-alike drug names to place on their watch list of medications that can be easily confused, in order to meet the 2005 National Patient Safety Goal that focuses on improving the safety of medication use.

Organizations must choose the drug names from a list of problematic drug names recently released by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. The Joint Commission's list identifies the medications in two tables that address different types of organizations. In addition to the

organization-specific tables, there is an additional table that lists supplemental pairings of look-alike, sound-alike drug names.

Some of the drug names on the list include:

• **Amaryl and Reminyl.** Handwritten orders for these two brand-name drugs can look similar, according to the Joint Commission. Amaryl is used for type II diabetes, and Reminyl is used for Alzheimer's disease. If a patient receives Amaryl in error, he or she would not be provided with blood glucose monitoring, which could lead to a serious error.

• **Avandia and Coumadin.** Poorly handwritten orders for Avandia, which is used for type II diabetes, and Coumadin, which is used to prevent blood clot formation, have been misread and have resulted in potentially serious adverse events.

• **Celebrex, Celexa, and Cerebyx.** Patients affected by a mix-up among these three drugs can experience a decline in mental status, lack of pain or seizure control, or other serious adverse events.

• **Zyprexa and Zyrtec.** Name similarity has resulted in mix-ups between Zyrtec, an antihistamine, and Zyprexa, an antipsychotic. Patients receiving Zyprexa in error have reported dizziness that sometimes results in injuries related to falls. Patients on Zyprexa who receive Zyrtec in error have relapsed.

Watch list must be in place by Jan. 1

Along with the list of names, the Joint Commission gives recommendations for prevention of mix-ups. Recommendations differ for various medication names but include suggestions such as using brand names rather than generic names, educating staff members, writing the purpose of the medication on written orders (many look-alike/sound-alike medications are used for different purposes), and accepting verbal or telephone orders only when necessary.

Home health agencies accredited by the Joint Commission must have a look-alike/sound-alike drug name list in place and educate staff members as to the potential dangers of these drug mix-ups no later than Jan. 1, 2005, to be in compliance with the patient safety goals.

To see a complete list of the medication names and recommendations, go to www.jcaho.org and choose "see look-alike, sound-alike drug list" under "2005 National Patient Safety Goals Released" on the right navigational bar. ■

News From the End of Life

Report shows value of telemonitoring

Remote physiological monitoring can help reduce hospital visits, length of stay, and health care costs for heart failure patients while improving patients' quality of life, according to a study by the New England Healthcare Institute. The study found that using remote monitoring for heart failure patients lowers rehospitalization rates by 32% and can produce net cost savings of 25% when compared to standard care.

Because the prevalence of heart failure has increased by 500% over the past 30 years, and because the baby boomer generation continues to age, the authors predict that the cost of providing standard care to heart failure patients could become catastrophic over the next decade.

The report also discusses barriers to the use of telemonitoring. Lack of Medicare payment for the purchase of telemonitoring devices and for the time spent by clinicians monitoring and responding to the data are two reasons some providers are slow to adopt telemonitoring. Other barriers include clinician concerns about a lack of outcome data to support telemonitoring's benefits and a lack of patient awareness of the technology.

To see the full report, "Remote Physiological Monitoring: Innovation in the Management of Heart Failure," go to www.nehi.net, choose "Research & Publications" on the top navigational bar, then choose "NEHI Publications" on the left navigational bar. ▼

Laws hinder adoption of health IT, study says

Legal barriers posed by certain fraud and abuse, antitrust, federal income tax, intellectual property, malpractice, and state licensing laws hinder providers' adoption of health information technology, the Government Accountability Office (GAO) concluded in a recent report.

"Because the laws frequently do not address health information technology (IT) arrangements directly, health care providers are uncertain about what would constitute violations of the laws or create a risk of litigation," the report says. Such "uncertainties and ambiguity in predicting legal consequences" make providers reluctant to invest significantly in IT.

The Physician Self-Referral or "Stark" Law and anti-kickback law, for example, make providers wary of establishing arrangements between providers that could promote adoption of health IT, the report continues.

GAO stated that while the Department of Health and Human Services, which is charged with fostering broader adoption of health IT, has attempted to address some of those barriers, the agency's efforts have not been sufficient to overcome providers' concerns. The report is available at www.gao.gov. ▼

Study: Inhalation drug reimbursement too low

A study of inhalation drug therapy services provided to Medicare beneficiaries in their homes finds the new 2005 Medicare reimbursement formula paid on average sales price (ASP) would under-reimburse for the actual cost of providing two key drug therapies by $68.10 per monthly supply.

The American Association for Homecare study includes responses from 109 pharmacies that represent 2,448 branch locations providing inhalation drug therapy services to 337,348 Medicare beneficiaries per month, or 61% of all Medicare inhalation drug therapy patients.

In a notice of proposed rule making for the 2005 Medicare physician fee schedule issued last month, the Centers for Medicare & Medicaid Services proposed 89% reimbursement cuts based on the ASP formula for albuterol sulfate and ipratropium bromide. These drugs are commonly prescribed to treat diseases such as chronic obstructive pulmonary disease. Survey respondents report that because of pharmacy, compounding, delivery, administrative, and patient-management costs, these drug therapies cannot be provided to Medicare patients at the ASP-mandated formula without a substantial service or dispensing fee. ▼

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Resources listed for HIPAA compliance

A comprehensive list of documents that provide guidance to compliance with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) can be found in a white paper produced by the Health Care Security Workgroup, a coalition of public and private organizations that work to provide guidance to health care organizations on privacy and security issues.

The document includes links to a wide range of presentations, tools, and publications that outline specific steps and challenges to obeying HIPAA rules.

The document can be found at www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/2004-02-09NUWWP.pdf. ■