

# HOSPICE Management ADVISOR

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**FEBRUARY 2005**

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## ICUs and dialysis centers present untapped opportunities for hospice

*Here's how to help these patients obtain more benefit from hospice services*

Patients who are dying during the course of intensive care or end-stage renal disease could greatly benefit from referrals to hospices, even if such referrals are made within days of the patient's death, experts say.

"Three days is the longest time we've had with an intensive care unit [ICU] patient," says **Ruth Fillebrown**, RN, CRNH, clinical director of Lehigh Valley Hospice of Lehigh Valley Health Services in Allentown, PA.

"We may only have an ICU patient for 24 hours, but it's enough to establish a relationship," Fillebrown says. "It lets us get a handle on how well the family is doing, so we know how to follow up with them."

Previously, dying ICU patients often were sent to the hospice's eight-bed inpatient unit at the very last moment, Fillebrown says.

"We'd see that patients would die in the ambulance on the way to the hospice unit, or they'd get to the hospice unit and only live a few hours," Fillebrown recalls. "We were hearing from families that the hospital couldn't do anything more for the patient, so they'd ship the person to the death ward."

Hospice staff found this frustrating because they were limited in their ability to provide symptom control and palliative care expertise, Fillebrown says.

Then a private foundation grant enabled the hospital to create a palliative care program that later was expanded to the current more integrated approach, in which hospice nurses or social workers will become involved with hospitalized patients and their families while they are in the ICU, Fillebrown says.

As in all hospitals, many ICU patients die while hospitalized, says **Daniel Ray**, MD, associate director of the medical ICU at Lehigh Valley Hospital.

"So you're focused on curing, but when patients don't survive, you're at a loss for what to do," Ray says.

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Because of this experience, Ray says, he has become more compassionate about patients' end-of-life experiences. Now he believes it's important to pull hospice in early during a patient's ICU stay, since it's difficult to know which patients will survive.

Lehigh Valley Hospice staff are collecting data about ICU patients to see if it would be possible to expedite referrals so more hospice time and services could be offered to these patients, Fillebrown says.

"One thing we've seen is that certain diagnoses in the ICU, such as stroke patients, may end up in long-term care placement," Fillebrown explains.

These patients often are diagnosed with having less than six months to live and are thus eligible for hospice. It would benefit these patients and their families if hospice staff were called in before they are discharged from the hospital, she adds.

"The families are devastated and on this emotional whirlwind," Fillebrown says. "We'd like

to talk with them and let them know someone is there to support them, and we could be part of the conversation before they are transferred out of the ICU."

Another type of medical patient who typically lacks access to hospice is the end-stage renal disease patient, says **Lewis M. Cohen**, MD, medical director of the Renal Palliative Care Initiative at Baystate Medical Center in Springfield, MA.

"Hospices ought to be looking to areas which previously have not been offered its services," Cohen says. "There are 300,000 dialysis patients receiving treatment in the United States, and over 20% of them die each year."

### ***Nephrology and hospice open discussions***

The possibility of providing hospice access to dialysis patients is only beginning to interest hospices and the nephrology community, which now has some discussion on the topic at national conferences, Cohen says.

"The nephrology community has begun to recognize the need to attend to these matters," he says.

For example, the first book in nephrology to address this issue, *Supportive Care for the Renal Patient*, was published by Oxford University Press in November 2004.

"It has some excellent chapters in there that would open the eyes of hospice staff as well as nephrology staff," Cohen says.

Cohen, Ray, and Fillebrown offer these suggestions for how to improve hospice access in ICUs and dialysis treatment departments or centers:

- **Educate hospital administrators and ICU staff about hospice.**

Lehigh Valley Hospice staff now are invited into the ICU to meet with patients and families to discuss whether treatment will continue and when it's time to move into hospice care, Fillebrown says.

"Our nurse or social worker will go in and meet with the family, along with the ICU team," she says.

"The ICU philosophy is to constantly be aggressive in treatment, so it's bringing in a different approach when there are patients where aggressive therapy won't help," Fillebrown says. "When you reach the point where treatment is futile, it's important to let patients know we have other options for them."

The program Ray helped to create for Lehigh Valley Hospital expands the hospice philosophy

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#### **Editorial Questions**

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to ICU patients and families, as well as to ICU nurses and physicians.

"It needs to be a team approach, empowering nurses in decision making because they're with the patients and families and recognize the social issues and spiritual issues," Ray says. "They can allow families to bring those issues to the forefront, so they're not always talking about drips and sedations and ventilators but also are talking about the big picture and psychosocial issues that follow."

ICU nurses take a one-day inservice that covers palliative care and end-of-life issues, Ray says.

- **Have a dedicated liaison between hospital and hospice.**

From an educational standpoint, it helps to have someone who is familiar with both hospice and the ICU to serve as a liaison who will promote the hospice philosophy in the hospital, Ray says.

"If we anticipate a patient not surviving, and we move toward comfort measures only, we want to make sure hospice philosophies are applied right away, and a liaison allows us to do that," Ray adds. "They help to apply protocols and educate the family on what hospice is all about, so within 24 hours we are able to transfer the patient to the inpatient hospice unit."

If medical staff believe the patient will not survive the transfer, then the liaison is there to help the ICU team and the patient's family apply hospice philosophies within the ICU setting, Ray says.

- **Initiate discussions with physicians and clinics.**

The first step to improving hospice access to end-stage renal disease patients is for a hospice administrator to contact local nephrologists and dialysis centers to introduce the possibility of working with them, Cohen says.

"This can start with a telephone call to dialysis clinics, expressing some willingness to come over and talk with staff," he says.

### ***Some patients decide to stop dialysis***

Even if some doctors and patients have a desire to continue dialysis as long as possible, there are many patients who have made the decision to stop dialysis treatment, and these patients are especially good candidates for hospice care, Cohen says.

"So there are always a substantial number of these folks for whom there'd be no question that they'd be covered," he says. "And if a hospice

was available to them, they might be able to get out of the hospital and die a more satisfying death at home."

The palliative care demonstration project at Baystate Medical Center, funded through a private grant, has resulted in an educational program that is offered to members of dialysis medical teams, Cohen says.

"We encouraged them to come up with different interventions that might improve palliative care of their patients," Cohen says. "Among the things they came up with were some treatment protocols for common symptoms of this population, so we posted copies of these protocols at all of the dialysis clinic nursing stations."

Another intervention that has been well-received is an annual memorial service for staff and families, Cohen says.

- **Provide hospice-specific training for hospital residents.**

"The biggest thing we've accomplished is allowing physicians, particularly the residents, to realize that not every disease is curable, and we're not always very good at predicting those who will survive and those who will not survive," Ray says.

### ***Care should include spiritual, family concerns***

The program trains physicians to have an open-ended discussion with families and to share collaborative goals of care with families and patients, he says.

"It's still directed by the attending physician, but we try to give residents as much autonomy as possible," Ray notes. "They're very concerned about telling what the blood pressure is and the subsequent blood gases, while we focus on whether the patient is in any pain."

The goal is to encourage physicians to look at a patient's spiritual and family concerns, creating a goal of care that incorporates all of these issues, rather than just looking at the medical issues, Ray says.

Fillebrown teaches a hospice session to residents as part of their required education, and there's a mandatory palliative care rotation incorporated into the education for medical residents, she says.

"In our system, hospice is a core service just like pediatric care, cardiac care, and everything else," Fillebrown says. "It's not for everyone, but when it's appropriate, we want them to understand how good our program is here."

Residents learn how to communicate bad news and run a family meeting, Ray says.

"In a monthly conference we talk about those who died and raise questions about whether they've had any problems with family communication," Ray adds. "We've dovetailed this into a larger residency program in which we have a monthly lecture for all residents, including surgery, internal medicine, and ob/gyn, related to communication and symptom management and goals of care discussions." ■

## To enhance relationships with hospitals, dispel myths

*Hospice director works to open eyes, minds*

Sometimes all it takes is a myth to prevent hospices from developing a more productive relationship with hospitals.

For example, hospital staff might think a patient has to have the potential for home care in order to take advantage of hospice services. Or, referring doctors might believe patients need an intact family system in order to receive hospice care or that patients need to sign a do-not-resuscitate order, says **Carolyn Cassin**, MPA, president and CEO of Continuum Hospice Care, which is part of Continuum Health Partners, a seven-hospital health care system in New York, NY. The system has hospitals in Manhattan and Brooklyn.

### **Hospice must understand hospital's goals**

Cassin speaks to hospital administrators and physicians to dispel myths and show how hospices can help hospitals meet their own goals.

"Hospice [staff] don't really understand the hospital system's goals, objectives, and incentives," Cassin says. "We didn't understand each other's goals and missions and the value hospice could bring."

Hospital staff often see hospices, even when they are part of a health care system, as a sideline business — a charity care that is unimportant but nice to have, Cassin explains.

"But they didn't see us as essential to the mission, to the vision of the hospital," she notes.

So as a former CEO of several hospice programs that were separate from hospitals — and now as the CEO of a program that operates within a health care system — Cassin has tried to find out what it is that hospitals want and need from hospices.

### **What are you doing for the hospital?**

"I found out that their issues were length of stay [LOS], creating a positive bottom line for the hospital system, and providing high-quality care," Cassin says. "That was something our hospice had never cared about — whether we were providing anything positive for the hospital."

So Cassin initiated a philosophy change in which the hospice staff began to look at how hospice services could help the hospital improve its LOS and bottom line while providing better quality of service.

She attended hospital operations committee meetings and participated in the sorts of programs in which other hospital leaders would be involved. She visited other hospitals in the system and is involved in a work group that meets monthly or quarterly to deal with various discharge and care issues.

"Hospitals are huge; they have complicated systems," Cassin notes. "There are a lot of operational issues, like, 'How do we turn a hospital patient into a hospice patient?'"

Hospice staff volunteered to participate in a hospital LOS committee and helped to develop a project in which the hospice helps the hospital reduce LOS by taking patients who are inappropriate for continued hospital stay and putting them into hospice care, where they are better served, Cassin says.

"The program was a huge success, and hospital administrators loved it and eventually looked at us in a different light," she says.

By more fully integrating hospice services and staff into the hospital, Cassin and other hospice administrators have helped to dispel misconceptions and shift thinking among both hospice and hospital staff.

"What I'm trying to do is shift their understanding of hospice from it being a program where you send dying patients to a program that has an outstanding set of services that are the appropriate place for all patients at the end of life," Cassin explains. "That's a very important shift in their thinking, because there is a range of services for people."

As an open-access hospice, Continuum Hospice Care provides hospice services to anyone who meets eligibility requirements and provides consent. This often is an eye-opener for physicians and hospital administrators, Cassin says.

"Everyone has the same reaction, an observable reaction where their eyes open up and they say, 'I didn't know that was hospice,'" she says.

Now that the health care system staff and hospice staff are working from the same page, Cassin is focusing on educating administrators at unaffiliated hospitals about the importance of hospice care.

"I know and understand what their issues are, so I try to quit selling them hospice and pain and symptom control," Cassin says. "That's not at the top of their list; they think they do great pain and symptom control."

Instead, Cassin stresses how the hospice can help them with their LOS and bottom line.

"How can I help them to free up beds by getting people eligible for hospice out of their bed and into hospice?" Cassin says. "Their core business is not end-of-life care, and that resonates with them."

Another way Cassin promotes hospice care is by suggesting that hospital staff call the hospice in to explain its services to patients and families rather than try to explain it themselves.

### ***Hospice can handle emotional issues well***

There is no reason for hospital nurses to become experts at promoting hospice care when all that's really necessary is for them to say, "I've got a great team of people who will come and see you and explain everything to you about hospice; it's a great program, and you're eligible for these services," Cassin explains.

"Hospitals don't have the time to get involved with all of the emotional issues, so the hospice can do this for them," she says.

"I don't encourage people to mention hospice if it will scare people," Cassin adds. "They can say, 'We have a program for patients in the same situation as you.'"

The main point is that hospices should be working more closely with hospitals to provide end-of-life care because hospices do the job better, she says.

"If you can scratch below the surface of a good hospital, they'll admit the truth: that they don't have people trained in end-of-life care, and they don't have the time," Cassin says. "There isn't

time to get around to everybody who may need to understand the changing goals of care and transition [to palliative care]."

While some hospitals have palliative care programs to which they'll refer patients, there remains a reimbursable benefit for end-of-life care that should not be denied to patients, Cassin says.

"We package it as, 'Let us be your end-of-life care experts,'" Cassin says. "The hospital wants to have the best emergency medicine and oncology services, and so we promote our service as a specialist program in palliative care with physicians trained in end-of-life care."

### ***Study hospital data on diagnoses, deaths***

After broaching the subject with hospital administrators, the next step is to take an objective look at potential hospital referrals by studying the hospital's data on diagnoses and deaths, Cassin says.

"I start with deaths and say, 'Let's look at every death in the hospital and see which ones should have been in hospice care,'" she says. "We should be attending every death in the hospital."

While a hospice referral often wouldn't have changed any of the services the hospital provided to the dying patients, hospice could have offered patients and families additional assistance, such as bereavement care, Cassin says.

There also is a group of patients who could have been given a terminal diagnosis in a previous hospitalization or earlier in their last hospitalization, and this would have meant they might have benefited from hospice care for weeks or months, Cassin says.

For example, a hospital administrator may discover when examining death data that some categories of diagnoses have patients who are spending an average of 13 days in the hospital before they die, and the hospital is reimbursed for only half of that time, she says.

"So let's look at those patients and figure out how to intervene when we first see the patient going downhill," Cassin says. "Let's use these diagnoses as a trigger to get started, and if the hospice hasn't been helpful and the hospital doesn't see its LOS drop, then we'll re-evaluate and figure out something else."

Typically, this approach results in the hospice making a formal agreement with the hospital to help identify patients eligible for hospice care, Cassin says. ■

# Improve admission process by following best practices

*Cut costs and improve quality*

Admitting patients into hospice care is a significant challenge because of issues related to timing and making the first contact with the patient a pleasant experience.

"It's also important because if you do it right, you'll probably get a higher percentage of patients referred to hospice to sign on for hospice services," says **Martha Tecca**, MBA, president of Perforum in Lyme, NH. Tecca has spoken at national conferences about optimizing the admissions process in hospice care. Perforum provides performance management services through benchmarking and works with individual hospice agencies.

Drawing on her experience with benchmarking hospice performance data and developing best-practice guidelines, Tecca offers these suggestions for improving the admissions process:

- **Make the intake effective.**

Hospice managers need to ask themselves these questions:

— How do we make sure we're picking up the telephone without letting it ring too many times?

— How can we ensure our intake staff are polite?

— How do we prevent patients and family members from being transferred to people who will repeat the same questions they were asked by the first person who answered the telephone?

— What is our admitting intake strategy in terms of what kind of staff will first see the patient?

"For example, we've had clients who were committed to having a non-critical person, a marketing person, make the first visit to the patient," Tecca says. "The belief was that this person would have a way of speaking openly and really listening well to the patients, helping the hospice put forward the best foot."

Some hospice managers also believe that nurses have a mindset focused on solving problems and are committed to a certain approach, rather than having a flexibility that might improve hospice-patient relations, Tecca adds.

Another intake issue is related to timing: How quickly should a hospice send out someone to visit a patient or family member after the first telephone call comes in?

"The two schools of thought are that, one, we send somebody out as quickly as possible without asking very many questions of the person who called us," Tecca says. "The other approach is to talk with the caller to help them get through their current crisis and delay having them act on their need to get somebody into hospice."

The philosophy behind the first approach is that a prospective patient's questions can be answered in person, and it's more likely the patient and family would engage in hospice services after an in-home meeting, Tecca explains.

The philosophy behind the second approach is that if a patient calls and is not yet ready to switch to hospice, then the hospice is serving the patient's best needs by giving the patient and family time, Tecca says.

One organization with which Tecca has worked found that switching to the first approach — sending someone out to the home after the first call — immediately worked better, contributing to the hospice agency's growth from a daily census of about 200 to more than 400 within two years, she says.

## **Quicker visits mean more admissions**

"They found they previously were doing a lot of consulting support over the phone, and that turned people away rather than turn them more quickly to hospice care," Tecca says. "So, if you ask the caller fewer questions, get the basic information, and then say, 'Gosh, we'll be right there,' you have a much higher chance of turning that referral into an earlier admission that is more appropriate and has a longer length of stay."

With the new approach, the hospice changed the staff's mindset to one of "What can I do for you now, and let me come solve your problem," Tecca says.

- **Improve admissions staff productivity.**

Expediting the referral-to-admissions process is one side of the coin; the other is monitoring and improving productivity among admissions staff, Tecca says.

"In addition to growth, there's the productivity side," she explains.

At one hospice agency, the inpatient admissions staff used to have a list of questions and a set of criteria to check off when potential clients called, Tecca says.

"The amount of work they had to go through for each patient was much more substantial before they changed the process to a simple

‘Where are you? Can we send somebody out there?’” Tecca says.

That change has shortened the time admissions staff spend on the phone, improving their productivity.

Hospice organizations can assess their productivity by looking at outcome indicators and other performance measures. For example, one measure might be the percentage of patients who are visited within 24 hours of receipt of the referral; another might be the percentage of these potential clients who are visited, Tecca says.

“What percentage see an admission nurse within X period of time?” Tecca asks. “You can do correlations between those indicators and other measures of quality to try to understand whether it does matter that you get out to visit the patients quickly.”

Another productivity improvement strategy, and a way to cut costs, is to have someone in the intake process involved with claims processing or vice versa, Tecca suggests.

“So when it comes to following up on claims, concerns, or understanding [payment] details, you have a person, and not an entirely different department, who can come up to speed with this patient’s details,” Tecca says.

### **Bring intake, claims processing together**

The logic is that during the admissions process there would be someone to check Medicare, insurance eligibility, and other financial details in order to streamline the admissions process and make things easier for clients, she adds.

“So one individual who knows enough about patients and billing from the beginning will be involved in insurance verification,” Tecca says. “Then if problems come up concerning the billing process, it’s useful for somebody, an RN or someone else involved with both sides, to help out with the claims processing and insurance verification details.”

- **Create a best admissions model for the organization.**

At the back end of the admissions process, a hospice organization should determine how admissions visits are done, Tecca advises.

“About half of agencies use an admission nurse model, where an admission specialist goes out and does all of the admissions,” Tecca says. “An admitting specialist will no longer do typical visits, and will spend two to four hours rather than 45 minutes to two hours at each visit.”

The alternative strategy is to have a primary nursing model in which one nurse visits the patient during the admission process and then follows that patient throughout the patient’s care, Tecca says.

“That model may create productivity challenges because those nurses have to manage some two-hour and one-hour visits, along with smaller visits,” Tecca notes.

“Really, it’s my observation that which one of those two models works best depends on the overall philosophy and strategy of the organization,” Tecca says. “Both can do really well from the standpoint of patient care and productivity.” ■

## **Small changes for HHAs in new labor standards**

*Salary/bonus ratio important; check state laws*

Changes to the Fair Labor Standards Act (FLSA) that passed in 2004 still may be under fire from opponents, but experts say home health managers should not wait for any rollback of the rules.

“The changes were made to bring clarity to white-collar exemptions for overtime that applied to professional, executive, and administrative employees,” explains Indianapolis attorney **John C. Gilliland**, who specializes in labor and employment law for the health care community.

“Lawmakers were trying to bring the regulations up to date by adjusting minimum salary requirements for exemptions and defining exemptions more clearly,” he says. “The impact in home care is pretty small. If your RNs are paid a low salary combined with a per-visit bonus, you will need to evaluate your pay arrangements.”

The law requires employees who are paid both salary and bonus to receive a salary that is a significant portion of their expected income. “While a certain amount is not specified, I recommend the nurse receive at least two-thirds of expected income as salary,” he adds. “This change may mean that some agencies need to revisit the mix of salary and bonus they pay, and raise the salary portion.”

One aspect that did not change — although many home health managers wanted it to — was

the nonexempt status of LPNs, Gilliland notes. "An RN can qualify for a professional exemption from overtime, but LPNs are not exempt from overtime," he says. The educational requirements for the exemption reflect the difference between the two positions, he adds.

"I was hoping for the opportunity to change the status of our LPNs from nonexempt to exempt, but it didn't happen," explains **Kay B. Sykes**, SPHR, director of human resources at Alacare Home Health & Hospice in Birmingham, AL.

Elimination of overtime pay for a large group of employees would be beneficial to the home health agency financially and administratively. However, home health managers need to keep the employee in mind when adjusting pay, should the rule change in the future, Sykes says. "We had planned to increase LPN pay scales to provide a set salary that was comparable to the LPN hourly wage plus overtime," she says. "We have to remember that, for many of these employees, the overtime pay is a part of their income upon which they depend to pay bills and meet expenses. We wouldn't want to just eliminate overtime pay without recognizing the effect on our employees," Sykes explains.

### ***Employers must have complaint process***

A new provision that will help home health agencies as well as other employers provides some protection for employers who inadvertently violate the FLSA, Gilliland says. "As long as the agency has a bona fide internal complaint process that gives employees a chance to complain about their pay if they believe they are not being paid according the law, the employer will not lose exemptions for all of their employees," he explains.

The process must be designed to enable employees to file complaints that are investigated thoroughly, in a timely manner, with the decision supported by evidence that the agency followed the law or that a mistake was made and corrected, Gilliland adds. Previously, inadvertent violations might cost an employer the loss of all overtime exemptions, no matter how many employees were affected originally, he notes.

Another clarification in the law points out that if federal and state laws related to compensation differ, whichever law is most beneficial to the employee applies, Gilliland explains. "Federal law may say the employee's position is exempt from overtime, but state law allows it. In this

case, the employee might receive more money under the state law if he or she can collect overtime, so the state law would apply. Not paying attention to state law is a big error that is easy to make. It's important to remember that your state has laws related to employee compensation, and you need to know them and compare them to federal laws," Gilliland notes. ■

## **JCAHO self-assessments to become yearly event**

*Annual PPRs required beginning in 2006*

Many home health managers initially were apprehensive about periodic performance reviews (PPR), the self-evaluation required by the Joint Commission on Accreditation of Healthcare Organizations at the midpoint of an accreditation cycle. However, the response to the process following implementation has been so positive that the Joint Commission will make the PPR an annual requirement beginning in 2006.

The Joint Commission's goal for Shared Visions-New Pathways — the survey process introduced in late 2002 — always has been to promote continual survey readiness, with the PPR as an integral part of that readiness, says **Darlene Christiansen**, RN, LNHA, director of the Joint Commission's Standards Interpretation Group and Office of Quality Monitoring. "Comments we received in feedback sessions from organizations that had used the PPR tool were very positive," she notes. "The only negative comments were that the tool was not available on an ongoing basis to be used as part of the organization's performance improvement program."

Beginning Jan. 18, 2005, the on-line PPR tool will be available to all organizations, not just those that are at the midpoint of their accreditation cycles, Christiansen adds. "This will give everyone a full year to complete their initial PPR," she explains. "Then they will just need to update it on a monthly or quarterly basis, or whatever time frame they choose to fit their performance improvement program."

The incorporation of the PPR tool into a home health agency's regular performance improvement process will present a true picture of how the organization is meeting Joint Commission standards on a continual basis, rather than the

## Options to Joint Commission Periodic Performance Reviews

In response to concerns of health care attorneys and risk managers that information contained in a health care organization's periodic performance review (PPR) may be discoverable in a legal action, the Joint Commission on Accreditation of Healthcare Organizations developed these options to the PPR:

- **Option 1** addresses the waiver of confidentiality that can be implied if the home health agency shares the self-assessment information with the Joint Commission. When an organization chooses Option 1, it may:

- Perform the PPR and develop a plan of action and measure of success for areas in which accreditation standards were not met.

- Attest that the foregoing activities have been completed, but for substantive reasons, advice has been given to the organization not to submit its self-assessment or plan of action to the Joint Commission.

- Discuss standards-related issues with Joint Commission staff without identifying specific levels of standards compliance.

- Provide measures of success to the Joint Commission for assessment at the time of the complete on-site survey.

- **Option 2** addresses concerns that different

states describe protected information specifically enough to make the information included in a PPR fall outside the protected classification. Under this option, an organization can:

- Decline to conduct a PPR.

- Undergo an on-site survey approximately one-third the length of a full survey at the point at which a PPR is required.

- Develop and submit a plan of action for deficiencies found in the survey.

- Provide measures of success at the time of the complete on-site survey.

- **Option 3** allows a midcycle on-site survey to be conducted by surveyors rather than by the organization itself. Under this option:

- No written documentation or report of the survey is left with the organization.

- Findings are conveyed orally to management.

- At the subsequent full survey, surveyors will be aware of the findings of the midcycle survey but will not discuss them with the organization unless asked to do so, regardless of whether any particular standard had been found out of compliance. Instead, surveyors will focus on compliance with those standards at the time of the full survey. ■

episodic or point-in-time basis that the midpoint evaluation provides, Christiansen notes.

Being able to access the PPR tool on-line at any time will ensure continual readiness, says **Linda J. Doyle, RN, MHA**, director of Atmore (AL) Community Hospital Home Health. Doyle is familiar with the on-line tool and says the hospital has a Joint Commission team in place. She serves as a team member with representatives from hospital departments. "We will be using the on-line tool as part of our performance improvement throughout the organization. Although I am on the team and will be given responsibility for completion of the home health-related items, I will rely upon my staff members, including my performance improvement coordinator and clinical director, to complete appropriate parts of the assessment," she explains.

Concerns about information shared in a PPR resulted in the development of options to PPRs that organizations could choose, and those options still will be available, Christiansen adds. (See **description of options, above.**)

"Each organization has 30 days after the submission of their annual PPR to choose an option to the next PPR if necessary. This means a home

health agency can submit a PPR this year but indicate that next year the organization will choose one of the options to a PPR," she continues. "Organizations that choose a PPR option one year can indicate that they will submit a PPR the following year."

Only home health agencies that are submitting their annual PPRs at the midpoint of their accreditation cycles will have their PPRs reviewed by and commented upon by Joint Commission staff in a consulting session, but other organizations can call the standards interpretation group to ask questions once they've completed their PPR, Christiansen points out. "If someone wants to know if implementation of a certain policy or program will meet the requirements of a standard, he or she can call."

### ***PPR process easy to understand***

Feedback from organizations that have completed PPRs shows the process is easy to understand and complete, she says. "The biggest challenge may be to organizations that do not have the computer technology that some larger organizations have. These organizations can get

help from the Joint Commission's information technology group by contacting their account representative," she suggests. "In fact, I advise that all organizations work with their account representative prior to submitting their PPR to make sure everything goes smoothly," she says.

Christiansen points out that an organization's account representative is the proper contact prior to submission of a PPR, and Christiansen's Standards Interpretation Group is the proper contact after submission.

The Joint Commission is making the tool available on-line throughout 2005 for several reasons, she says. "We want to give organizations a full year to complete their first PPR before the annual requirement is effective," Christiansen explains. Not only will this full year give organizations a chance to work out the bugs within their own systems, but it will give Joint Commission staff the feedback they need to further improve the tool, Christiansen explains.

"We don't anticipate any problems with the technological part of the tool or the completion of the tool," Doyle adds. "This is one more way to make sure we are offering good patient care on an ongoing basis." ■

## Parents' skills crucial for pediatric patients

### *Sicker patients increase value of assessment*

Home care agencies providing care to pediatric patients must pay careful attention to the competency of the parent caregiver to make sure he or she is ready for the challenge of caring for a child on a ventilator or a feeding tube.

"The actual assessment of a caregiver's competency doesn't differ according to the patient's age. We have to be aware that parents have not always been prepared for their responsibilities, and the patient is usually unable to help in his or her own care," says **Carol Behnke**, RN, manager of education for Melmedica Children's Healthcare in Country Club Hills, IL. "If the child is old enough to participate in the assessment, we include him or her, but the majority of our questions are for the caregiver," she notes. "Questions are open-ended and cover practical knowledge as well as theory related to the patient's specific needs.

"We often find parents who have watched the hospital nurses provide care, but they have not done it themselves," Behnke continues. "While these parents can verbalize how to suction, they've never actually suctioned. Other parents did have some experience with hands-on care while the child was in the hospital, but not enough that they feel comfortable providing it with no nurse for assistance," she adds.

### **Preparing patients and parents**

In these cases, the home care nurse must work with the parents to make sure they get the hands-on experience they need to feel comfortable. "We'll spend time with the family before discharge from the hospital, and we spend the first day — the transition day — with them," Behnke explains. The transition day is when the nurse thoroughly assesses the parents' abilities as caregivers, she adds. "We demonstrate how to suction, and then we have the parents perform a return demonstration. We also have the parents provide care while we observe.

"While our nurse cannot be available in the home every day as a hospital nurse can be, we can be reached by telephone 24 hours a day," Behnke points out. Nurses also give parents written instructions with pictures explaining care of suction tubes, nebulizers, and feeding tubes, she says.

"One of the reasons some parents are not comfortable when the child comes home is because the equipment they have in the home is different from the hospital equipment," explains **Karen Gunter**, RN, MSA, president of Melmedica Children's Healthcare. "It looks different; it sounds different; it functions differently; and these differences overwhelm the parent," she explains.

For this reason, Gunter's agency staff members often suggest that the family have the durable medical equipment (DME) provider obtain the same equipment that will be used in the home and place it in the hospital for at least several days prior to discharge. "While we recommend this, it doesn't always happen for reasons that include either the DME company, the hospital, or the family," Gunter admits.

Home care nurses have to spend more time assessing and educating parents, she notes. "We used to see more in-depth training in the hospital, with parents even spending a couple of nights in the hospital with the child or with the child going home for a weekend, then returning to the hospital for assessment," Gunter says.

"The challenge for home care nurses is the fact that no two homes are exactly alike in terms of the parents' abilities to care for the child," she explains. "Homes with single parents or two parents who are working have to juggle more of their time and effort to learn how to care for the child because they are not with the child all day. We also see difficulties when the primary caregiving parent becomes ill and the other parent doesn't know what to do."

While her agency doesn't have a social worker on staff, there are social worker consultants available for specific cases, she adds. "The majority of assistance our families need are resources for the time when the child ages out of insurance coverage and needs access to state waiver programs. All of our nurses have the information about resources to help parents obtain the assistance they need," Gunter says.

While it sometimes is easier to make contacts for the family, it's important to just provide information and let the parents orchestrate the contacts, she points out. "These children will need lifelong care, and parents have to assume responsibility for that care. We can't allow them to depend upon us to do things they need to do. We make it as simple as possible, with step-by-step information on how to access the services they need."

### ***Be sure to train long-term caregivers, too***

One thing home care nurses need to keep in mind as they assess caregiver capabilities and teach the family is the actual makeup of the group of adults who will provide care. "You might be teaching grandparents who are very comfortable with providing care, but they will be going back to their home in two months," Gunter explains. "In this case, make sure that the parent or other adults who will be the caregiver for the long term are assessed thoroughly to ensure they will be able to provide care without the assistance of the grandparents," she says.

In addition to assessing knowledge and ability to perform the caregiving tasks, look at the physical requirements of providing care, Gunter suggests. "If mother is petite and her child is her size or bigger, how will she physically move the child to provide care?" she asks. Finding other caregivers to help the mother is an option that must be explored in this case, Gunter adds.

If the nurse believes the parents truly don't know how to provide care and can't be taught, there are several steps to take, Behnke explains.

"We work with the case manager and may arrange a temporary admission to the hospital while we explore our options," she says.

In some cases, the child may be placed in a foster home that has adult caregivers who can provide care and [where] the parents still can spend time with their child, Behnke says. "The goal has to be the best care for the child," she says. ■

## **Protect patients' right to choose their own provider**

*Patient choice must be free of duress*

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

Providers increasingly are concerned that physicians may violate their patients' right to freedom of choice of providers. First, it is important to note that long-term care, home health, home medical equipment, and hospice services are provided under the supervision of physicians, based upon specific orders from them.

Because physicians supervise these types of services, they are at risk for legal liability, along with providers and staff members, if applicable standards are not met by providers that the physicians supervise. Consequently, physicians have a clear interest in assuring the quality of care rendered by other providers to their patients. Physicians may, therefore, choose to designate in their orders which providers are to render services to their patients to help assure quality of care and manage their risks of liability.

Nonetheless, all providers, including physicians, are required to abide by their patients' right to freedom of choice of providers. There are two sources of this right that apply to physicians:

**1. All patients have a common-law right (based upon court decisions) to control the care provided to them, including who renders it.**

Thus, when patients, regardless of payer source or type of care, voluntarily express preferences for certain providers, their choices must be honored.

**2. Federal statutes of the Medicare and Medicaid Programs guarantee Medicare beneficiaries and Medicaid recipients the right to freedom of choice of providers.**

Medicaid recipients may have waived this right if they participate in waiver programs. When Medicare patients and nonwaiver Medicaid patients voluntarily express preferences for providers, these choices must be honored.

Physicians' orders, based upon quality-of-care concerns for specific providers, should be implemented unless patients express preferences to receive services from different providers. If, however, patients voluntarily express preferences or choose providers other than providers ordered by their attending physicians, patients' choices override physicians' orders and must be honored.

Physicians may then choose whether they want to supervise services and assume the risk of services provided by providers different from those they designated. It is at this point that physicians and their office staff members must be especially cautious. If they try to strong-arm patients into receiving services from providers physicians prefer instead of providers chosen by patients, consent to such services may not be voluntary.

For example, statements by physicians or their employees that the doctor no longer will care for them if they do not accept services from the provider the doctor designated can amount to duress, which invalidates any consent by patients to such services.

Attempts to force patients to accept physicians' choices also have ethical implications. Patients' right to act autonomously may be compromised by the insistence of physicians or staff members.

From a pragmatic point of view, physicians who are serious about quality of care and sound risk management should talk to patients about their preferences for providers before they write orders for specific providers. Patients then will have an opportunity to understand physicians' preferences, to express their own choices, and to resolve any differences between physicians and patients.

Practitioners who deal with physicians who insist on writing orders for specific providers may use a variety of strategies to encourage patients to choose them or physicians to write orders for them instead of other providers. These strategies include pre-op or preadmission visits, use of preferred provider agreements, and use of consulting physician agreements.

Providers who encounter instances in which physicians and their employees put inappropriate pressure on patients to use providers chosen by physicians should document carefully any

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violations of patients' right to freedom of choice. Documentation preferably should be in the form of signed statements from patients. These statements should be forwarded to physicians with a letter from providers or case managers. A word to the wise should be sufficient.

Practitioners encountering physicians who persist in pressuring patients, despite warning letters and documentation from patients, may wish to report violations to both the central and regional offices of the Centers for Medicare & Medicaid Services. Such reports should include documentation from patients.

The competition among post-acute providers continues to heat up. The rights of patients, however, must not be trampled amid the fierce competition among providers. ■

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