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Reorganization: From 'For Sale' to 'Successful' in one year

Clinical teams, multidisciplinary approach part of plan

(Editor's note: This is the first of a two-part article that looks at the successful reorganization of a failing home care agency. This month, we examine the process to identify areas that need improvement and steps taken to address cashflow problems. Next month, we look at tips and suggestions on how to handle staff morale and retention challenges during a transition period.)

Your agency staff are busy, productive, and highly skilled; but you are losing so much money each month, you might be closed down.

That is the situation in which the managers of Gaston Memorial Home Care in Gastonia, NC, found themselves as hospital administrators started asking the question, "Do we want to be in the home care business?"

Two years later, the hospital is not only still in the home health care business, but the agency is well positioned to compete with newcomers to the home health market.

"We were busy with a lot of patients, but we're losing a lot of money," says **Kimber Walters**, MBA, executive director of the agency. "While national reports show that home health can make money, our agency had a history of poor financial performance, and hospital administrators began questioning the wisdom of having a home health agency," she explains.

Walters and her management team started an in-depth review of the agency's operations to determine why they weren't making money and how they could restructure themselves to improve their performance.

"The first thing we did was look at our payers," she says. "We focused on our Medicare patients because they represent a significant portion of our income, but we also examined private payers and our state program." They looked at numbers of clients each payer represented, reimbursement, and cost per visit, Walters adds.

The agency participated in their state's waiver program and did receive patients from the program, she notes. "When we looked closely at the high administrative costs required to participate in the program

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and the level of reimbursement for each episode, we decided that we could not continue to participate," she says.

Withdrawal from the program did not affect a large number of patients but did help the agency by eliminating a service that always lost money, Walters adds.

Once the initial financial review was finished and the waiver program was identified as an obvious target for change, it was necessary to look more closely at operations to decide how to reorganize the agency's processes to improve collections and decrease the cost per visit, she says.

Because a majority of her agency's patients are on Medicare, Walters looked closely at the

process for filing Medicare claims.

"We had an old process in place in which our utilization review staff reviewed all claims prior to sending them to our billing people," Walters explains. While the utilization review staff were able to make sure the claims were coded properly, the Request for Anticipated Payments (RAPs) already had been sent with the original coding within days of the patients' admission. The utilization review did not occur until two weeks after admission, she adds.

"This meant that our RAPs were filed late if we waited on the utilization review, or we had to submit RAP corrections if utilization review discovered incorrect codes on the claims," Walters continues. Both of these situations resulted in delayed payments, she adds.

"We now have our staff split into teams that report to a clinical manager who is an RN," Walters notes.

"Utilization review occurs on the back end of the process so the claims are not delayed, but we have made our clinical managers responsible for the initial review of the OASIS [Outcome and Assessment Information Set] and the coding," she explains. **(For more information on streamlining the OASIS to billing process, see story, p. 99.)**

Look internally to make real changes

One of the reasons that Gaston Memorial Home Care has been able to turn itself around is a willingness to change the organizational culture, says **Ronald H. Clitherow**, MPH, senior management and operations consultant at LarsonAllen Health Care Group in Charlotte, NC.

It is too easy to look externally for reasons that affect your business, but the only way to really change the direction of your organization is to look internally, he says. "Everyone needs to be ready to ask himself or herself if the organization is as good as it can be.

"There are questions that need to be asked within a multidisciplinary group," Clitherow adds. He recommends setting up working lunches at which representatives from different areas can ask each other the following questions:

- "What is my department or group doing that makes your job harder?"
- "What is my department or group not doing that could improve your ability to do your job?"

By paying attention to how one person's

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responsibilities affect the process upstream and downstream, it becomes easier to see what changes are most effective for the entire organization, Clitherow notes.

You have to focus on the work processes and how they interact, he suggests. "Map all of your workflow activities from marketing to intake to admissions to assessment to OASIS and beyond, then get the right people involved to save time and to be accurate in your assessment," Clitherow says.

The right people are not just top managers, he says. Involve the decision makers, but make sure the people who do the job each day are involved as well because they see the actual mistakes or omissions that create problems, Clitherow explains.

Once you've mapped all of the workflow activities, set up teams of employees who are responsible for those activities and have them talk through what information is needed for each step, he adds.

Although it may not be feasible to include all employees in these teams, be sure to report findings and recommendations at staff meetings and encourage feedback from all employees, Clitherow suggests.

One advantage of involving a variety of people is that everyone begins to assume responsibility for how their actions affect the bottom line of the agency, Walters notes.

Rather than relying on the way things always have been done, nurses now look for ways to cut costs without cutting quality, she says. "Nurses

Clinical managers ensure accuracy, speed payments

The biggest change made during the reorganization of Gaston Memorial Home Care in Gastonia, NC, was the multidisciplinary team approach in which nurses and therapists report to a clinical manager. Not only is this approach helpful for patient care management, but the streamlined approach makes it possible for the agency to file accurate Request for Anticipated Payments (RAPs) earlier than the old system that relied upon utilization review nurses to approve claims.

Previously, claims were not reviewed for up to two weeks after a patient's admission, so RAPs were delayed or sent with incorrect coding, says **Kimber Walters**, MBA, executive director of the agency.

The new staffing structure now places the responsibility for review of the OASIS (Outcome and Assessment Information Set) by the team's clinical manager who does have the clinical and coding knowledge to evaluate the assessment, she explains.

Once the field nurse or therapist completes the OASIS form on a new patient, the clinical manager reviews it for coding accuracy and identifies any discrepancies in codes that need to be addressed before sending the form to the OASIS clerk, Walters says.

"The OASIS must be completed by the field nurse within 48 hours of admission, then the OASIS clerk is able to take the form that has been reviewed by the clinical manager and generate the RAP within five days," she explains.

"We still have utilization review double-check the

claim, but that is done on the back end of the process after the clinical people have reviewed the form." Because coding is reviewed by the clinical manager upfront, there are fewer corrections to the RAPs, and payments are more timely, Walters adds.

One of the key reasons the new process runs smoothly is the clinical manager's direct contact with the field staff, she explains. When a utilization review nurse found a discrepancy or a missing code, she would call the field nurse and ask for an explanation.

"Because the utilization review nurse was not the field nurse's supervisor, there was less urgency to call back immediately," Walters says. "Now it's the nurse's boss calling to ask for information, so responses are much quicker."

That process also gives them an opportunity to identify trends in coding mistakes and further educate the nurses, she adds.

"The manager can immediately talk with the nurse to correct mistakes so that the nurse doesn't unknowingly continue to code the next several days' worth of OASIS forms incorrectly," Walters says.

Not only is there one-on-one teaching occurring when the manager is talking with the nurse about why one code is used as opposed to another, but if the same mistake is made by several nurses, the agency has a chance to offer further training to all nurses, she explains.

The interaction between the clinical managers and the field nurses has improved the entire process of assessment, coding, and OASIS completion, Walters notes.

"We've learned that you can't solve financial problems without including the clinical staff in the solution," she adds. ■

suggest different dressings for wound care that don't require daily visits to change the dressing so we are able to cut the number of visits without reducing care," Walters says.

Hospital-based agencies have a special challenge when the hospital administration directs departments to cut costs, Clitherow points out.

"Too many times, the hospital expects cost cutting to include a reduction of FTEs [full-time equivalent positions]," he explains.

"Reducing FTEs in the hospital setting can be effective because patient volume is set by the number of beds, patient care services can be centralized, and overhead costs don't fluctuate based on location of patients," Clitherow notes.

"A home care agency cannot easily cut field nurses and still provide the same care to the same number of patients," he notes. "At the same time, a home care agency cannot conduct a marketing campaign to increase the number of patients without the flexibility of adding nurses to care for those patients."

An important part of the home care manager's job is to educate hospital administration on the necessity to increase some expenses to increase income, Clitherow says.

Knowing what your costs are and how an increase in patients affects expense and income is critical if you are going to educate others, he adds.

Two years after hospital administrators wondered if they should be in the home care business, the answer today is "yes," Walters says.

"Luckily, our hospital administrators realized that it took us a long time to reach our low point and that it will take time to complete our turnaround, so we were not given an unrealistic deadline such as six months," she explains.

The reorganization took one year, and they are in the second year of improving, Walters adds. "We are not losing money anymore, and we are seeing positive increases in our bottom line," she says.

The challenge is the number of new agencies that have entered their market, Walters admits.

While hospital-based agencies generally don't have the marketing dollars available to them that private agencies have, her agency is better positioned to handle competition as a result of the reorganization, she adds.

Previously, there was no interaction between departments, Walters says. "Now we are more creative in our approach to our jobs, and agency leaders challenge each other to review current

practices and look for better ways to handle responsibilities," she says.

"The most positive part of the reorganization is that clinical and financial employees talk with other and collaborate on projects that benefit the agency and patients," Walters adds.

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HIPAA Q & A

[Editor's note: This column addresses specific questions related to implementation of the Health Insurance Portability and Accountability Act (HIPAA). If you have questions, please send them to Sheryl Jackson, Hospital Home Health, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsjackson@bellsouth.net.]

Question: How do I decide who has access to electronic personal health information (EPHI) or personal health information (PHI)?

Answer: "Because of the minimum necessary rule, an employee's access to EPHI or PHI will be driven by what their job is," says **Robert W. Markette Jr.**, an Indianapolis attorney.

For example, an employee who is responsible for billing is going to need access to the patient's name, address, insurance/Medicare/Medicaid information, diagnosis, and any other information required to complete the claims submission, he says.

An employee who schedules home health visits will need to know only the patient's name, contact information, general insurance information, and the reason for admission to home health, Markette points out.

Complete information about the patient's diagnosis is not needed by this employee, he

says. "The real issue that drives the decision of how much access to grant the employee is what information must this employee have to perform their job," Markette notes. "Many home health agencies determine minimum informational needs based upon job description."

Each job description is used as the basis for a description of minimum PHI needs; then, when an employee is hired or placed into a position, he or she is given access based upon the position, he explains.

Question: What type of background check do I need to conduct on the employee before giving access to EPHI or PHI?

Answer: "There is not a clear rule on background checks for HIPAA purposes," Markette says.

"As a matter of practice, many states require home health care providers to perform at least limited background checks of their employees, and these states prohibit individuals with certain convictions from providing services," he adds.

The Department of Health and Human Services (HHS) has said that the need for and extent of a screening process will be based upon an assessment of risk, cost, benefit, and feasibility, as well as an evaluation of other protective measures in place, Markette explains.

"This means that each home health agency will need to assess its own screening needs based upon its risk assessment, he says. "The only thing HHS has been clear about is that background checks are not mandatory under HIPAA."

However, screening employees before giving them access to EPHI does give an agency reassurance that you do know who is handling your patient's information, Markette adds.

Question: What steps need to be taken when terminating an employee to ensure that access to EPHI is terminated?

Answer: "When terminating an employee or when an employee resigns, the home health agency should take steps to close every potential point of access the former employee might use to access EPHI or PHI," Markette recommends.

For example, the employee should return any and all keys and identification badges, and any accounts the employee had on company computers should be closed, he says.

"If the employee had access to passwords on accounts that will not be closed, the passwords should be changed," Markette adds.

If the nurse or administrative employee was given a company computer to work remotely from home or to use in the field, retrieve that computer, he notes.

If the employee worked remotely from home using his or her own computer, you need to consider how to ensure the employee does not have EPHI on a home computer, Markette says.

"One way to plan your termination procedures is to review what you do when an employee is hired," he suggests.

When an employee is hired or changes positions within the company, he or she is provided with access to the facility, to computers, and to certain information, Markette points out. Use a checklist format to list these actions when hired, and then use the same checklist to make sure each step is "undone" when the employee is terminated, he recommends.

"If all of the original steps are undone, then the access should be closed," Markette says. "In order for this to be truly effective, it is imperative that the employer adequately document the access provided to each employee and the means provided to the employee to obtain access."

One other area of concern is a lack of communication within the company, Markette notes. Some companies, when preparing for HIPAA, discovered that when an employee left the company, the proper individuals were not always notified, he says.

"In many cases, the human resources department failed to notify the information technology department, and this resulted in computer accounts remaining active for up to six months after an employee had left," Markette explains. "This is a major security concern, so home health agencies need to make sure they have a process in place to communicate with all departments upon an employee's termination."

A home care agency's termination procedure should be the same whether the employee leaves voluntarily or is terminated, because it will eliminate the possibility of confusion, he says.

"Furthermore, the procedures should result in all points of access being closed as quickly as possible," Markette adds.

[For more information on the security rule, contact:

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LegalEase

Understanding Laws, Rules, Regulations

Carelessness has a price in abuse investigations

By Elizabeth E. Hogue, Esq.
Burtonsville, MD

Many providers generally are familiar with prohibitions against fraud and abuse in the Medicare and Medicaid programs, including Medicaid waiver programs. Fraud involving billing for services that were never actually provided may be especially familiar.

But there are at least two common misconceptions about fraud and abuse.

First, government enforcers must prove intent to show that providers engaged in fraud, but many providers do not understand what the government can use to show intent. Most providers certainly understand that if they submit claims for care that was never provided to patients, they had intent and engaged in fraud. But providers also must understand court decisions have found that if enforcers can prove that providers knew or should have known of a pattern of fraudulent conduct, enforcers may conclude they had intent.

Other court decisions say that when providers show reckless disregard for a pattern of fraudulent conduct, regulators can show intent necessary to prove fraud.

When providers grasp these crucial standards, it is clear they must become vigilant to prevent patterns of fraud and abuse. This is necessary to prevent government enforcers from concluding that they had intent necessary to prove fraud and/or abuse.

Many providers also do not understand that every health care practitioner, regardless of position, is personally responsible for fraud and abuse compliance. It is extremely tempting to think that fraud and abuse compliance is management's responsibility or the exclusive job of the administrator or the organization's compliance officer under a Medicare/Medicaid fraud and abuse compliance program.

But the Office of the Inspector General (OIG) of

the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, is quite clear that every provider has personal, individual responsibility for fraud and abuse compliance. The OIG has taken this position because the OIG realizes that the problem of fraud and abuse will never be resolved until every provider takes individual responsibility for it.

This point is illustrated by fraud charges brought against a home health agency in Florida. Enforcers took action against both upper management and a number of individual staff nurses allegedly involved in billing for visits that they never made, among other possible fraudulent practices.

When providers understand these two basic points, they are well along the road to active participation in fraud and abuse compliance efforts.

Providers must remember that fraud and abuse compliance now is a permanent part of the health care landscape across the nation.

Compliance is not a fad that will blow over or disappear in a few months. Providers must be prepared to actively work to prevent or correct fraud and abuse for as long as they work in the health care industry.

(More information about the fraud and abuse implications of consulting arrangements with referring physicians is available in Medicare/Medicaid Fraud and Abuse: A Practical Guide for Providers. Send a check for \$30 — including shipping and handling — to Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866.) ■

Improve end-of-life care training for social workers

Topics include pain, spiritual, cultural issues

The hospice industry in recent years has worked with medical and nursing schools to improve their students' training in end-of-life care, but such education still is needed for social workers, who commonly find themselves inadequately prepared for the issues confronting them with dying patients, experts say.

Only 31% of social workers recently surveyed said they thought the end-of-life training they received at their college was adequate for the job they went to immediately following graduation,

says **Mary Raymer**, MSW, ACSW, who was an investigator in the study, which was conducted as part of a Soros Foundation of New York City grant to assess social workers' educational needs for end-of-life care. Raymer also is president of Raymer Psychotherapy and Consultation Services in Acme, MI.

"People in the trenches don't feel like they're getting what they need to deal with people at the end of life," Raymer says. "The social workers surveyed identified that what they need most urgently are things like ethics, specific psychological and social needs of patients and families, spirituality, and cultural relevancy."

Raymer and co-investigator Ellen L. Csikai, MSW, MPH, PHD, used the survey results to guide their development of end-of-life care curriculum for social workers. The result was the Social Work End-of-Life Education Project, a two-day educational seminar.

Regional hospices, hospitals, and universities have sponsored the seminar at sites across the country. The seminar, which initially was a one-day presentation, also has been provided at conferences sponsored by the National Hospice and Palliative Care Organization in Alexandria, VA, Raymer says.

"It's been well-received. There's a definite need out there." The seminar costs \$3,000 for the three faculty, plus travel and miscellaneous expenses, she adds.

"Our current wish is to be provided some funding so we can create a train-the-trainers model, so there will be more faculty to take the curriculum on the road," Raymer says.

"Our goal is to inspire critical thinking and get people to ask the right questions so assessment and interventions are on target," she notes. "We want people to recognize that working in end-of-life care really is a specialty and requires a unique knowledge base that is applied to help people reach their full potential."

The program's curriculum includes information about pain and physical symptoms, as well as many other aspects of end-of-life care. (**See story on project's pain, grief, and psychology symptoms education for social workers, p. 105.**)

Here's a look at some of the other major topics covered by the educational project:

✓ **Cultural awareness**

How a person experiences pain also is subject to societal rules and pressures, says **Terry Altilio**, LMSW, social work coordinator in the department of pain medicine and palliative care at Beth

Israel Medical Center in New York City. Altilio is one of the project's instructors.

"We grow up in cultures and societies that have rules about how we handle pain," she says. "Do we suffer it? Do we pay attention to it? Do we go on with our lives? Sometimes, we don't understand each other in terms of how pain gets expressed."

One patient might experience several different cultural influences, notes **Amanda L. Sutton**, LCSW, senior program coordinator of End of Life Palliative and Bereavement Services for CancerCare also in New York City. Sutton also is an instructor for the project.

"People don't belong to one culture; they belong to many, and it's our job as social workers to identify which culture they identify with the most, because that will impact their decision making," she points out.

"Are they most influenced by the fact they are a person from Laos, or are they most influenced by their gender or the role of being a breadwinner or a mother in a family?" Sutton asks.

You have to understand the patient's influences before you can understand why the patient is making certain decisions, she says.

"A lot of times, team members will look to us and say, 'Why is the person or family behaving this way?'" Sutton notes.

"But if you stop and ask the right questions, you might find out that the person who is refusing treatment is doing so because the small financial resources he has would be best served by giving them to his family members who live with him then by using them to live a short period of time," she adds.

Workplace issues

Another cultural aspect to pain involves the workplace, Sutton says.

Institutional culture has an impact on how decisions are made, how resources are allocated, and how a social worker might align him- or herself to become optimally effective, she explains.

"How do you become aware of your colleagues' culture and speak with them in a way that they understand?" Sutton says.

"Nurses and doctors are bottom-line people, who are used to fixing problems," she notes, as an example. "So, sometimes, when we want to raise certain issues, we need to do it in a language that will be best understood by our colleagues."

✓ **Grief and bereavement**

Many people still view grief and bereavement through a 1970's lens, using the stage theories, Raymer says.

"Grief is really a developmental and ongoing process," she explains.

Also, social workers and other hospice staff need to be aware of the children and adolescents who are involved in a patient's end of life and who are grieving in different ways than are the adults, Sutton says.

"One thing we try to do at the education session is ask, 'How many of you work with kids?' and we get one or two hands raised," she adds. "Then I say, 'All of you work with kids because you have all these patients who have concerns about children, who are dealing with their illness and end of life.'"

Developmentally, children understand grief differently than adults, Sutton notes.

For instance, children might have disenfranchised grief, which is a grief that is not socially sanctioned, she says.

"A lot of people say that kids and teens who don't grieve in the same way as adults are not grieving as much," Sutton explains. "But kids may have very intense feelings one minute, and in the next minute, they run out and play; then two days later, they want to talk about it."

Social workers and hospice staff need to educate parents about how to handle it when kids finally do bring up their own grief, she says.

Don't forget spiritual aspect

✓ Spiritual assessment

Hospice social workers sometimes fear getting involved in turf warfare and will leave the spiritual realm to the chaplain, but this would be a mistake, Sutton notes.

"I think a lot of times people will talk to us and speak about spiritual issues," she says. "We as trained active listeners need to acknowledge those moments and engage the client in exploration of the issues."

Also, patients and their families often are more comfortable talking with the social worker about spiritual challenges or any shame they may be feeling, Sutton explains.

"Like if they are at the end of life and they feel betrayed by God and are ashamed of those feelings, they may have some spiritual suffering because of that," she says. "If somebody were to say to me, 'I feel tremendously ashamed because right now I hate God because I'm dying of cancer,'

I would look at those issues the same way as if they were saying they hated their mother."

In other words, a social worker would help the person seek a better understanding of his or her feelings by asking these kinds of questions:

- Do you think God is punishing you?
- What have you done to make you feel worthy of punishment?

"These questions help to break down those complex feelings, and then you can problem solve and do a reality test, and all of those things are part of social work," Sutton says.

Also, social workers often can help resolve family rifts that occur when the patient's spiritual feelings are not in concert with his or her family's spiritual feelings, she notes.

"It's important to explore their views of the afterlife, because if somebody's in tremendous crisis before they die, then probably it will come up with the caregivers during the bereavement process," Sutton says. "Crisis moments are good opportunities to change values, and that's another piece we do."

Social workers can find out whether spiritual issues will play some role in the patient's and family's end-of-life care by asking them these open-ended questions, she suggests:

- What gives your life meaning?
- What gives you a sense of purpose?
- What values do you have?
- How did you get those values?
- Who were the people who were great role models for you?
- Why were they great role models?
- What makes your life worth living?
- How do you spend your time?
- Do you find yourself being reflective in the day?
- Where do you seek pleasure?

"All of those can be elements of spirituality," Sutton explains. "Through that process their thoughts on God comes out."

✓ Secondary trauma/self-care

Social workers may be well aware of the emotional ramifications of working with end-of-life care patients and families, she says.

But the problem is that social workers sometimes are the very people other members of the staff go to for help when they're experiencing burnout, so their emotional load is even heavier, Sutton suggests.

"Social workers first have to help themselves," she continues. "We talk about practical ways to help yourself in terms of rituals you do to

separate your life from your work.”

It may be as simple a device as changing your shoes or listening to relaxing music on the ride home, Sutton says.

“Give yourself direct transitions so you’re not taking work home with you,” she advises.

Otherwise, it may be very hard to separate work life from home life because social workers are very invested in their clients; and they naturally will think about a patient who is dying while they are home fixing dinner, Sutton explains.

“Also, social workers often are the only social worker on a team, so they work in isolation,” she says. “It’s very helpful to have multidisciplinary team meetings and meet regularly with other social workers to process what various experiences have been.”

The education project has a networking component built into it, so social workers can share their concerns and burdens with their peers, Sutton adds.

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Educate social workers about pain and grief

Social workers can play role in pain management

While nurses and physicians have their roles to play in palliative care of dying patients, social workers also have a responsibility for assisting in pain management, experts say.

Social workers need to know more about pain and palliative care because of hospice work as well as work in hospitals that often includes care for people who have life-threatening illnesses, says **Terry Altilio**, LMSW, social work coordinator in the department of pain medicine and palliative care at Beth Israel Medical Center in New York City.

“Most people see pain as involving physical symptoms, but pain can be very complicated, and so it’s not only a physical event,” she says. “It has emotions attached to it and thoughts and beliefs and expectations that can be very distressing to patients and families.”

Part of a social worker’s role is to look at human beings from a multidimensional perspective, Altilio notes.

“When somebody is experiencing serious pain or other symptoms, it becomes important in addition to treating the physical aspect to understand what the symbolism of those symptoms are in their lives,” she explains. “For some, it’s a physical experience; for some, it’s redemptive; and for some, it’s a sign of abandonment by God.”

So it’s important to look at the emotions and beliefs that surround the experience of pain when someone has a life-threatening illness, Altilio points out.

This perspective is an easy one for social workers to adapt since they are trained to look at multidimensional care, she says.

“I teach social workers to extend their skills to pain and symptom management,” Altilio says.

Social workers also can be instrumental in helping patients alleviate pain and suffering through cognitive behavioral interventions, including relaxation techniques, she explains.

Social justice is another aspect of pain management, Altilio notes.

“Pain is undertreated in minorities and the elderly and in women, so there are social justice issues that pervade this topic,” she says.

Also, political issues, minority health care issues, and many other aspects of pain management make it an amazingly rich topic for social work clinicians, Altilio says.

It’s important to note that a patient can have pain, but not have suffering, and vice versa, she says.

“You can have pain from running a marathon, and it’s not attached to suffering; it’s attached to celebration,” Altilio continues.

Alternately, a patient who is in hospice care because of a chronic lung disease or some other illnesses might not experience any pain but does have suffering because of the loss of freedom, mobility, and the prospect of death, she explains.

Dying patients can experience depression and anxiety without experiencing pain, Altilio notes.

“You can have depression that is a consequence of out-of-control pain,” she says. “Sometimes, if you manage a patient’s pain well enough, the

patient's mood improves enormously, and the patient is able to sleep and engage in the world in a different way."

Other times, end-of-life patients who have psychological symptoms may need to be treated with antidepressants or other medication, Altilio says.

Another symptom that can be problematic is delirium, because end-of-life patients can become delirious for a variety of reasons, she says.

"It robs people of the quality of life they could have together in the setting of a serious illness," Altilio explains. "Some deliriums are treatable, and some are not, and some are part of the dying process."

It's very important to help patients who have delirium return to a more normal cognitive state so they can be in touch with their families in a way that is meaningful for them, she adds.

Relaxation techniques and other cognitive behavioral interventions may help patients cope with pain, Altilio says. "Cognitive behavioral interventions are designed to intervene in the relationship between mind, body, and your emotions. There are many different areas of living that are wonderful demonstrations of the relationship between emotions, mind, and body, and one of those is fear. If you can conjure up a fearful thought in your mind, then you can create a physiological reaction," she continues.

Health care providers can help a person who is in pain learn to change their thoughts and experience of that pain through such methods as hypnosis, Altilio explains.

"You use interventions and techniques they are most able to accept and try to teach it to them and help them understand it in a way that makes sense to them," she says. "You can tap into people's ability to use their mind and emotions because it can influence how they experience their body and pain."

Another area of end-of-life care in which social workers can help involves grief and psychological symptoms.

Very few medical professionals have received training in differentiating grief from depression, says **Mary Raymer**, MSW, ACSW, president of Raymer Psychotherapy and Consultation

Services in Acme, MI. "So often a patient's receiving treatment for depression when the person is grieving normally, or vice versa," she says.

There are many differences, but the biggest is that in depression, the symptomology is persistent and pervasive; and in grief, the symptoms waxes and wanes, Raymer says.

"A person may experience a heavy bout of sadness and then something will lift him up, and he starts to feel good, and then something will hit him, and he feels sadness again," she explains. "In depression, the heaviness is persistent and pervasive."

Also, self-destructive thoughts are transient in people who are grieving, but again, are pervasive in those who are experiencing depression, adds Raymer.

"Someone can be happy, but not successfully if depressed, and closeness with other people is reassuring when someone is grieving," she says. "When someone is depressed, he tends to isolate from others."

People who are grieving do not need psychotherapy, but they do need validation, Raymer notes. "They need people who believe in their ability; they need connectedness, and particularly for the social work role, people need good information and education that is accurate about what grief is and suggestions of healthy changes that will help them cope with the grief," she explains.

"For depressed patients, social workers need to screen them for the type of depression and assist in providing an appropriate treatment so the person can begin to grieve, because when you're depressed, you can't grieve," Raymer adds.

While there are many known strategies for helping hospice patients and their families cope with grief, social workers and other hospice staff are less well versed in how to help children cope with grief when someone they love is dying in hospice care, says **Amanda L. Sutton**, LCSW, senior program coordinator for CancerCare of New York City.

"Kids talk in their own language, and it's our role to speak with them in a language they speak in," she says. "We do this in play, activities, art, or music."

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It's not the same as when hospice staff work with adults and let them sit in silence as the social worker or hospice staff wait for the person to speak about what concerns them, Sutton notes.

And it's not necessary for hospice providers to pretend to be cool when they're working with teenagers, because what the teens need most is to see the provider as a consistent adult in their lives, she says.

Here are some practical suggestions for helping children and teenagers cope with grief:

- "If the parent or another loved one is dying, kids can be involved in the process as far as how their lives are going to be changed, such as who is going to take them to school," Sutton says. "They can make decisions like that."

It's important to give children age-appropriate responsibilities, but to not burden them with too much responsibility where they might feel overwhelmed or inadequate, she adds.

- Also, the parents often are so identified with being parents that if they are dying, they'll want to cram in their parenting at the end, Sutton says.

"But be sensitive to the fact that the child can only do so much," she advises. "So have the parents express themselves in a way that's titrated for the child, such as doing some videotaping or letter writing over a period of time."

- Educate parents about normal developmental problems vs. situations intensified by grief, Sutton says.

For example, a child might skip school because he is afraid that if he leaves his parent at home then the parent will die, she explains. "So the child is truant not because he is a bad kid, but because he's trying to preserve that parent's life. We tell parents what's going on with the child so they'll understand why the child is acting the way he's acting." ■

BINDERS AVAILABLE

HOSPITAL HOME HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail ahc.binders@thomson.com. Please be sure to include the name of the newsletter, the subscriber number and your full address.

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NEWS BRIEFS

After Oct. 1, CMS to return noncompliant transactions

The Centers for Medicare & Medicaid Services (CMS) has announced electronic claims that are noncompliant with the Health Insurance Portability and Accountability Act (HIPAA) will not be processed after Oct. 1, 2005.

CMS will process these claims prior to Oct. 1, but after that date, noncompliant claims will be returned to providers for resubmission as compliant claims.

This action ends a portion of a CMS' HIPAA contingency plan in effect since Oct. 16, 2003, under which Medicare continued accepting non-compliant electronic claims after the deadline. ▼

JCAHO expectations for 2006 patient safety goals

Organizations accredited by the Joint Commission on the Accreditation of Healthcare Organizations can see detailed implementation expectations for the 2006 National Patient Safety Goals on the Joint Commission web site.

Two new goals that must be implemented by January 2006 include a standard approach for handoff communications and implementation of a fall reduction program. (For more on 2006 patient safety goals, see "JCAHO announces 2006 patient safety goals," *Hospital Home Health*, July 2005, p. 76.)

To meet the new goal regarding handoff communications, implementation expectations include:

- Limit interruptions during communications.
- Present up-to-date information.
- Verify information.
- Provide an opportunity for the receiver to review information and ask questions of the giver.

Meeting the fall reduction program requirement should include consultation with a

pharmacist who can identify medications most likely to affect a home care patient's risk for falls.

To see a complete list of implementation expectations, go to www.jcaho.org. Under "Top Spots," choose "National Patient Safety Goals and FAQs," and scroll down to "2006 Implementation Expectations." ■

CE questions

This concludes the CE semesters. A CE evaluation form has been included with this issue. **Please fill out and return in the envelope provided.**

21. What was one of the first steps taken by Gaston Memorial Home Care to address their negative bottom line, according to Kimber Walters, MBA, executive director of the agency?
 - A. Staff were cut by one-fourth.
 - B. Marketing dollars were increased to attract more patients.
 - C. Specialty services were added.
 - D. The agency withdrew from a payer program with high administrative costs.
22. Immediate notification of what department upon an employee's termination is a major security concern for home health agencies, according to Robert W. Markette Jr.?
 - A. payroll
 - B. information technology
 - C. clinical departments with which the employee interacted
 - D. all departments within the agency
23. Under Office of Inspector General guidelines, health care providers are responsible for fraud and abuse only if the illegal activities are intentional.
 - A. true
 - B. false
24. According to a recent survey, what percentage of social workers felt the end-of-life training they received in college was adequate for the job they went to immediately following graduation.
 - A. 11%
 - B. 31%
 - C. 51%
 - D. 71%

Answer Key: 21. D; 22. D; 23. B; 24. B

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CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **After completing this semester's activity with this issue, you must complete the evaluation form and return it in the reply envelope provided to receive a certificate of completion.** ■