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Building residential hospice homes is trend that catches on nationwide

Community involvement is crucial trend that is catching on nationwide

About one in five hospices in the United States operate an inpatient facility or residence, and the number of hospice homes is growing, hospice officials say.

"You do find more folks starting to think about offering a residential facility to serve their communities," says **Jon Radulovic**, spokesman at the National Hospice & Palliative Care Organization (NHPCO) in Alexandria, VA.

"The needs of patients and families at the end of life are sort of changing, and they're more complex than they probably were 30 some years ago when hospice began as a predominantly grassroots movement," Radulovic says.

While the hospice goal remains to keep people at home, challenges arise when patients' symptoms can't be controlled at home or when caregivers are in need of respite assistance, he notes.

Also, hospices increasingly are serving patients with diseases other than cancer, including Alzheimer's disease, heart disease, and combinations of illness, Radulovic says.

"Our statistics show that in 2003, for the first time, end of life patients with a cancer diagnosis dropped below 50% to 49 percent," Radulovic says. "These other serious illnesses can be more complex, and people may have symptoms that are harder to manage at home."

Plus hospice patients with non-cancer diagnoses may not follow as predictable of an end of life trajectory, so their needs will vary, he notes.

"The more comprehensive the range of services a hospice offers, the better equipped it is to meet those evolving needs of dying Americans," Radulovic says. "And having an adequate inpatient facility can be one of those ways to meet those evolving needs."

Another factor contributing to the hospice home trend is the changing nature of American family dynamics, says **Ted Williams**, CFRE, executive director of the Hospice Foundation of Lake and Sumter in

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Tavares, FL, which has plans to break ground in November and December of two residential hospice homes. The foundation has already funded 12-bed hospice home that opened two years ago.

"The family used to take care of their loved ones, and I can remember my own family taking care of my grandparents," Williams says. "But we're double-income families now, and I hate to say it, but we don't have the time."

Also, hospitals used to provide several beds or a wing for hospice units, but fewer hospitals can afford the space, Williams adds.

"In addition, people are living longer, to their 80s or 90s, and the caregiver or spouse may be too frail to consider looking after loved ones even if they'd like to," Williams says.

Also, while many hospice patients want to die at home, others prefer to be removed from the home near the end, says **Donna Shafar, RN**, patient care supervisor for The Villages Hospice Home in The Villages, FL.

So a welcome alternative is a hospice home where the facilities often are new, well-furnished, and comfortable, but have round-the-clock care for residents in their last weeks or days, Shafar notes.

Hospice homes often provide respite care or symptom control for short-term stays of patients who want to remain at home during their end-of-life, but sometimes need additional help, Shafar says.

"We transition patients from the hospital to here," Shafar says. "A lot of times, patients are very sick in the hospital, and they'll come here for a few weeks and maybe then transition to their home."

About 80 percent of the hospice home's referrals come from the hospital, and usually these patients will stay in the home, Shafar adds.

"Clinicians with patients who are very ill and whose life expectancy is very limited try to send them to us so the family can spend quality time with them in our facility, rather than their being in the hospital," Shafar explains.

Residential and inpatient hospice care has been an unmet need for some time, says **Debbie Flippin, RN, MBA, CHPN**, vice president and director of the Kate B. Reynolds Hospice Home of the Hospice and Palliative CareCenter in Winston-Salem, NC. The hospice home, which opened eight years ago with 20 beds, expanded to 30 beds at the end of June, 2005.

"It's been like the 'Field of Dreams,'" Flippin says. "Build it, and they will come."

When the hospice first built the hospice home, administrators had no idea how well it would be supported by the community, but it has stayed at full capacity, Flippin says.

"About 60 percent of our patients come to us having never been in a hospice home care program, and that's a population that would never have been served by hospice without the home," Flippin says.

"Most of the home's patients come from the acute care setting, and while cancer still is the primary diagnosis, the home also sees heart and chronic lung conditions," Flippin adds.

NHPCO's data show that about 52 percent of hospice homes are freestanding, while 19 percent are in hospitals and 5 percent are in nursing homes. Also, the data indicate that 43 percent provide acute and general inpatient care as well as residential and routine care, while 34 percent provide acute care and 23 percent provide residential care.¹ ■

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Reference

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Hospices in two states add hospice home beds to better serve their communities

Here's a look at new hospice home projects

Hospices from coast to coast are expanding or building new hospice homes as part of a trend of providing inpatient or residential care to end-of-life patients.

Here's a look at two hospice's involvement in building or expanding residential hospice beds:

* **The Villages Hospice House in The Villages, FL:** Lake County in Florida is one of the state's fastest growing areas, as it is a bedroom community of Orlando and Disney World.

Also, the area increasingly hosts year-round residents, who are replacing the "snow birds," says **Ted Williams**, CFRE, executive director of the Hospice Foundation of Lake and Sumter in Tavares, FL.

So when the Hospice of Lake and Sumter in Tavares, FL, was offered free land for the purpose of building hospice homes, a foundation was formed and the money was raised, Williams says.

"When you have something with community involvement and community commitment, plus the land up front, that's telling us they want us to be there, and there's a need to be met," Williams says.

The hospice has had a small hospice home facility in Tavares since 1987, but with the donated land, the Hospice Foundation of Lake and Sumter was able to raise more than \$3 million to build a 12 bed hospice home and its \$400,000 serenity center in The Villages, Williams says.

In July, 2005, the hospice received a first runner-up award for The Villages Hospice House at the Florida Medical Business newspaper's 16th annual Golden Stethoscope awards dinner in Fort Lauderdale, FL.

The home is located within a 55 years-plus

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development community that has nearly 100,000 residents, a shopping center, a bowling alley, a hospital, and its own zip code, Williams says.

Although the hospice home is located within The Villages, it is open to anyone, regardless of their ability to pay its sliding scale room and board charge, Williams notes.

The 2-year-old facility has a private rooms, each with a lanai, which is a screened-in back porch, says **Donna Shafar**, RN, patient care supervisor of The Villages Hospice House.

Patients' beds can be rolled outside, where a fan on the porch will keep them comfortable, Shafar says.

Rooms also have personal computers on wheels so patients can play computer games or access the Internet and email, and there are DVD players in each room, along with pull-out beds and refrigerators, Shafar adds.

"We have a lobby area that would look like a family room, very comfortable and open with several couches and two round tables so families can eat lunch or dinner there," Shafar says.

A more private room contains a plasma screen television, and behind it is an office for family members who have to do work, including using a computer or fax machine, while they are staying with their loved one, she adds.

The hospice home operates with 15 nurses, 10-12 nursing aides, a patient care supervisor, a regional team manager, a housekeeper, a chief executive officer, and a part-time chef, Shafar says.

Plus there are many trained volunteers, including cooks, servers, and greeters, she adds.

The average length of stay is 14 days, and while the home's residents may receive some Medicare or other payer reimbursement, it also relies on community contributions, Shafar says.

The foundation's plans include breaking ground in November, 2005, on an eight-bed hospice home, and in December on a 10-bed hospice home. All four hospice homes will be within a 30-mile radius, Williams says.

"I'm running a 5.5 million capital campaign and have raised half of it so far," Williams says. "The campaign has been underway for less than a year."

Also, future plans might include fundraising for endowments that would cover unreimbursed operational expenses at the homes, and there probably will be expansions down the road, Williams adds.

Each of the newer homes could be expanded, with The Villages Hospice Home having the space to add 36 additional beds in 12-bed units, Williams explains.

*** Kate B. Reynolds Hospice Home in Winston-Salem, NC:** The hospice home opened with 20 beds eight years ago, and in June of 2005 it was expanded to 30 beds, says **Debbie Flippin**, RN, MBA, CHPN, vice president and director of the Kate B. Reynolds Hospice Home, Hospice and Palliative CareCenter in Winston-Salem, NC.

The hospice also has built an education and counseling center at the hospice home site, Flippin says.

Patients admitted to the home have either inpatient or residential needs. Inpatient beds are for patients typically seen in an acute care hospital, Flippin says.

"They generally have a short-term need for symptom management," Flippin says. "The residential beds are for someone who either does not have a home or does not have a caregiving system that allows the person to stay at home."

The average length of stay for the combined levels of care is nine days, Flippin says.

Rooms are larger than the typical hospital room and all are singles with bathrooms. The initial 20 bedrooms had a large window seat that could be used as a makeshift bed for caregivers, Flippin says.

"We have roll-away cots available and a recliner that folds flat to make a bed, and we encourage caregivers to stay," Flippin says. "We also have family rooms on each wing, and we

have a sun porch on each wing."

Each room has a small desk table and computer and phone hook-ups.

About 75 to 80 employees, both full and part-time, staff the hospice home, Flippin says.

The hospice decided to build a hospice home after deciding that it was difficult to provide a continuum of care for patients who moved between acute care, the home, and long-term care facilities, Flippin explains.

"Our patients were getting lost in the system, and as hard as we tried to have a continuum of care, we found it didn't always happen," Flippin says. "Even simple things like finding parking for family members were difficult."

After two years of meetings, including joint meetings with local hospitals, the hospice decided a hospice home was the best way to meet the needs of patients who had short-term acute management needs, Flippin says.

"Both hospitals started with giving us a one million dollar loan to start the capital campaign," she adds

Initially, the capital campaign raised \$2.2 million for the hospice home, and the cost of the addition was \$1.7 million, Flippin says.

Although the home remained at full capacity since it opened, it took a while for the hospice to convince the state, which requires certificates of need, that there was need for additional beds, Flippin says.

The hospice home charges \$120 per day on a sliding income scale, and private insurance will reimburse some costs with the community fundraising covering deficits, Flippin says.

"We have several fundraisers a year and a fair number of memorials left to us," she says. ■

Improve staff's bedside manner with comprehensive tuck-in program

Reduce off-hour calls, improve team work

Sometimes a hospice's client satisfaction and staffing problems stem from repeated and often unnecessary off-hour calls by patients and families.

A Colorado hospice has addressed this issue by starting a "tuck-in" program that includes

additional staff training and scheduling changes.

The Hospice of Metro Denver in Denver, CO, identified several problems in the past year, including a disappointing client (77.69 percent) satisfaction score on a family evaluation survey, says **JoAnne Foulk**, RN, CHPN, clinical manager for the nursing home Northwest team of the hospice.

As a result, hospice managers began to look at all patient data to identify the nurses who were what they called “the best tucker-inners,” or the nurses who had the fewest weekend and evening calls from patients, Foulk says.

“We got these nurses together and tried to figure out what they did that was different from what the other nurses were doing, and we came up with a list,” Foulk explains. “Then we presented the data we received to the home staff.”

Hospice managers held four mandatory meetings for nurses and will expand the education to social workers, certified nursing assistants, and other staff, Foulk says.

The chief items on the list were communication, clinical skills, and pathophysiology, including how well nurses understand what is going on with a particular patient’s disease process, Foulk notes.

“Clinically, what we found was we had a lot of calls about leaking Foley catheters and people running out of diapers,” Foulk says. “It was simple stuff, including medications and people not knowing they had medication in the refrigerator that could help them with pain control or nausea and vomiting.”

The nurses knew how the client’s could take care of these mostly minor issues, but for some reason they weren’t doing a good job of communicating what they knew about the patient comfort packs and how these could help the patients, Foulk says.

So the hospice began to teach nurses how to improve their communication skills, including how to sit down with a patient and family member, who are still shocked by the recent knowledge that the patient will not recover, and answer their questions and concerns, Foulk explains.

“We have to reassure the patient and family that everything is going to be okay and that we’ll be there for them and they are capable of doing what needs to be done for their loved one,” Foulk says. “We want to increase the family and patient’s confidence, their understanding of the disease process, and their understanding of medications being used.”

Hospice managers teach nurses to bring in all of these details right from the start of meeting with patients, but this information also has to be reinforced many times because the family may only digest about one-tenth of the information at the beginning, Foulk says.

The more patients and families hear instructions repeated, the easier it is for them to deal with that piece, says **Maureen Pangle**, RN, ND, CNS, clinical manager.

“Nurses need to help them deal with their loved one,” Pangle adds.

As part of the nursing education, Foulk asked nurses to imagine that they were the only nurse on call every night and on weekends, and if they were called at 2 a.m. they’d have to travel the hospice’s service area, spanning 50 miles across. Then, if they were that only nurse, what would they do to prepare patients and families for all possible small emergencies?

This scenario worked for **Maryjean Blair**, RN, CHPN, primary care nurse at the hospice, because she has done work on weekends, Blair says.

“So I started thinking about my patients and what could happen tonight and in the next few days,” Blair says. “I started to get a feel for where a family was and whether they could take in all of the information.”

As a result, Blair began to go through the medications in the comfort pack and try to get families and patients comfortable with these, particularly toward the end of the week.

“I’d try to prepare them for a tuck-in for the weekend, and I always remembered JoAnne’s

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words of how you're the only nurse out there, and so I'd try to think broader about what could happen and what would help the families prepare," Blair says.

The additional nurse education focused on teaching nurses how to anticipate and plan for the next step, Pangle explains.

"They know the disease process and can't exactly predict what's going to happen, but they know basic things that will happen down the road," Pangle says. "So we try to get nurses to think about what will happen at week one, two, and three, if we get that far."

Blair soon discovered that her additional time spent educating patients and families was working.

"As soon as I started doing this reinforcing and teaching, I would hear on voice mail messages that when someone did call in, the family had more awareness of what to do," Blair says. "Patients started calling less, and from the feedback I knew they knew what to do."

From the initial nursing focus groups, managers learned that nurses who did best with tuck-in were great motivators, says **Julie Isaacson, RN, MSN, NP-C**, palliative care consultant.

"Whether the family was coping well or not, whether they understood what was going on or not, the nurses were motivating the families and giving them confidence," Isaacson says.

The most successful tuck-in nurses were telling families that they were doing a great job, really helping their family and loved one, Isaacson says.

"This gave the family more confidence that if something did happen after hours they wouldn't freak out, but would remain calm and think about what they could do," Isaacson says.

Fouk encouraged nurses to write instructions down for families, leaving some written record that families could refer to.

This also served the purpose of keeping different shifts of caregivers well informed, she notes.

"Keep in mind that a lot of caregivers during the week may not be the caregiver on the weekend, so it's important to have something written down," Fouk says. "We have a packet that's left in the home, and nurses can leave notes in that packet."

Another aspect to the nursing education is to encourage nurses to learn more about their families and customize their communication

style to fit a particular family, Pangle says.

"So if you have a caregiver who has poor eyesight, maybe you could put the information on a poster board, whereas for another family, you can keep a running notebook of things," Pangle explains.

"The nurses in the original focus group were comfortable with communicating with patients, including talking about death and dying issues," Pangle says. "They could have hard conversations and really be able to listen."

So much of the tuck-in problems go back to communication difficulties because the hospice already was taking care of all of the patient's physical needs, including medication, Fouk says.

Still, it was important for nurses to attend to the details of making certain patients had enough medicine, diapers, and other items to get them through the weekend, whether the patient was at home or in a nursing home or assisted living facility, Fouk says.

This might mean the hospice nurse would have to communicate with the nursing home nurse to make certain everything was in order, she adds.

"You'd be surprised at how many phone calls were about people running out of diapers, which they could buy at a drug store, but they expected us to have them there if they were in a nursing home or assisted living facility," Fouk says. "It's our responsibility to make sure they have them there as a back-up, and sometimes, they can't leave, so you just want to have all your ducks in a row."

After the training, managers conducted evaluations and found that the majority of staff found the education to be helpful, Isaacson says.

"We had a few outliers who were disgruntled that it was mandatory or who felt it was only needed for newer nurses, but we also had seasoned nurses who found it helpful to review the information," Isaacson says.

After feedback from the first training session, managers altered it to provide more discussion in the second session, Isaacson says.

Finally, the additional training stresses team work, Fouk says.

"When we go into a home people see individuals," Fouk says. "But we want to stress that each member of the team exchanges information about the patient, and the family needs to know that." ■

Grief camp reaches children suffering silently from a loss

Hospice runs it with contributions

West Georgia Hospice in LaGrange, GA, decided eight years ago to answer the common questions clients and community members would ask about how to deal with children who've experienced a loss.

The hospice conducted a survey of school counselors and found that most had not received grief education, and the school nurses also weren't receiving grief training, says **Cathy Wiggins, RN, CHPN**, director of the hospice.

"Death and dying issues had not reached the counseling agenda of people in schools," Wiggins says. "One of the questions we asked counselors is 'Would you recognize symptoms of grief in a child?'"

The counselors answered "No," so the hospice decided to offer basic grief education for counselors in the school system, teaching them that grief symptoms among children commonly include bedwetting, acting out in school, and multiple colds or absences due to illnesses, Wiggins recalls.

Following up the grief education for school teachers and counselors, the hospice has provided a workshop on art therapy for grief and how teachers can use drawings and other types of art forms to have children express their grief, Wiggins says.

"We had a specialist teach that in a day-long seminar, and we had sponsors for it," Wiggins notes. "We had about 50 participants, and we'll do something like that again this year."

Also, the hospice will send out a social worker and bereavement coordinator whenever there's a death in the school, she adds.

After forming this relationship with local schools, the hospice expanded on the collaboration by starting a summer grief camp for children, ages six to 16, Wiggins says.

School teachers, social workers, hospice staff, and other trained volunteers work at the camp, which has expanded from an overnight stay to three days and two nights for up to 60 children. The camp has served more than 350 children so

far, and 90 volunteers work at the weekend camp each year, Wiggins says.

"It's about 4,500 volunteer hours, and we have everything donated, so no child has to pay for anything," Wiggins explains.

For example, use of the camp is donated by the local sheriff's department, which uses it for their drug awareness program, and all of the camp meals are donated, Wiggins says.

Children are referred through their schools, hospice clients, or the community in a five-county area, and they're signed up on a first-come, first-serve basis, although the camp hasn't had to turn anyone away because of lack of space yet, Wiggins says.

They have diverse backgrounds, but all are children who've experienced the loss of someone who was very important in their lives, Wiggins says.

Parents are given a booklet that explains what activities will take place at the camp, and the coordinator meets with parents to let them know more about the experience, Wiggins says.

Here's how the camp experience works:

*** Children meet in groups:** Typically, the children are afraid or nervous when they arrive at the camp because they have been told it's a grief camp, Wiggins says.

So counselors begin to divide the children into groups of eight to 10, based on their age, and these groups will continue to meet in four sessions over the course of the three days, Wiggins says.

"They meet with the group counselor or leader, and each one of those sessions deals with some type of loss," Wiggins says. "First of all, they talk about change, how change is an important part of their lives; then they talk about loss and feelings and memories."

Grief sessions are led by teachers and social workers trained in grief counseling.

"We teach them that it's okay to cry, and it's okay to talk to someone about your loss, and it's okay to be angry," Wiggins says. "So we teach them healthier ways to deal with anger."

*** Grief counseling is followed by fun activities:** Young adult volunteers lead the children in relay races in the evenings and storytelling in the cabins at night, Wiggins says.

"On Saturday, we have swimming and horseback riding," Wiggins says. "There are people who bring horses to the camp each year."

If a child is acting out or having a difficult time during either the grief sessions or group activi-

ties, then some adult will take the child aside for one-on-one time to walk and discuss what's bothering them, Wiggins says.

"Maybe they'll throw rocks in the lake and get the child to talk during that activity," Wiggins says.

*** Arts and craft time also provides grief assistance:** The camp has a "memory room" in which children can create a pillow as an expression of their memory of their loved one, Wiggins says.

The pillows have pictures of butterflies on the front, as the theme of the camp is the metamorphosis of the caterpillar to the butterfly, Wiggins adds.

"The idea is the child comes in apprehensive and is learning to deal with grief, and hopefully the child will leave as a butterfly, gaining relief with his or her feelings," Wiggins explains.

On the alternate side of the pillow children will draw a happy memory of their loved one.

"We have had everything from a picture of a child's dad's truck, showing how the dad helped the child change the gear, or a picture of a person who loves playing music on the guitar," Wiggins says.

Another memory craft involves creating collage in which the child cuts out magazine pictures that remind him or her of the deceased loved one, Wiggins says.

And one of the craft activities that Wiggins personally has used to remember someone in her own life is the creation of a memory bracelet.

"They can make a bracelet with a person's name on it, and the name is whatever they called that person, whether it's Paw-Paw, Daddy, Joe, Mama, whatever," Wiggins says. "It is extremely powerful to put that bracelet on."

Other therapeutic arts and crafts activities include making a mask of what the child is feeling that day or making a memory box for mementos of the deceased loved one, Wiggins says.

*** Closing activities continue grief therapy:** "On Sunday, the kids do a little presentation of what they liked, and then we have a memorial service that afternoon on the baseball field," Wiggins says.

"One activity is the child writes a card to the loved one, saying what the child wanted to say but never was able to," Wiggins says. "Then the coordinator calls out the child's name and the name of the child's loved one and ties the card to a balloon."

The child then lets the balloon go, Wiggins

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says.

"It's very impressive when the children let the balloons go," Wiggins adds.

However, that is not the grand finale of the weekend. One more surprise is in order for children as the hospice buys dormant butterflies, individually packaged in envelopes, with one butterfly going to each child, Wiggins says.

A Georgian company sells and ships the butterflies, and the hospice purchases them with donations, Wiggins adds.

These are kept in envelopes in the refrigerator until 45 minutes before the butterfly ceremony, and then they are released into the hot Georgian sky, where they'll hover momentarily near the children who released them and then fly into the sky, Wiggins says.

"We talk about metamorphosis, so this makes a nice transition," Wiggins says. "And the children where white t-shirts featuring a yellow caterpillar and smiley face."

All of these extra details are donated from churches and small donors, as are buckets of insect repellent and sunscreen for the camp children, Wiggins says.

Some children have contacted the hospice after the camp, demonstrating how important it was in their lives, Wiggins notes.

For example, one eight or nine-year-old child contacted the hospice a few weeks after the camp to ask for a balloon to give his grandmother so she could release it in memory of his grandfather who had died, she says.

"A year after our first camp, an 11-year-old boy called and asked to speak with the social worker who had been his counselor," Wiggins recalls. "The boy had lost his mother and was living with his grandmother, and while at the camp the counselor said that he could call the hospice any time he needed to talk with someone."

So the boy remembered this and a year later called to speak with the counselor because his grandmother had been taken to the hospital and was put on dialysis, and he feared she would die, Wiggins says.

“Also, school counselors tell us there’s a huge difference in behavior among the children who come to the camp,” Wiggins adds. “The camp has had the cooperation and collaboration of the school system, and that’s really made it more successful.” ■

Celebrate World Hospice and Palliative Care Day— October 8

Hospices from Tifton, OH, to Timbuktu will celebrate World Hospice and Palliative Care Day on Saturday, Oct. 8, 2005.

Developed in association with Voices for Hospices, the National Hospice and Palliative Care Organization (NHPCO), and other hospice and palliative care organizations worldwide, the new day of celebration will feature a variety of global and local events.

NHPCO will send its members a Fall Engagement Toolkit with recommendations for events to host in honor of the world hospice day.

Also, there will be a national event in Washington, DC, on Oct. 8, called "Soul of Africa," in which faith communities and hospices will be brought together to highlight the need for hospice and palliative care in sub-Saharan Africa due to the AIDS pandemic. NHPCO will co-sponsor the event with the Foundation for Hospices in Sub-Saharan Africa (FHSSA).

Hospices are encouraged to host an event that will raise funds for FHSSA.

To learn more about these events, hospice staff can visit the World Hospice and Palliative Care Day Web site at www.worldday.org and www.fhssa.org or email Fay Burrs at fburrs@nhpco.org. ■

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 timelier, 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. ■

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 posi-

tion, 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. ■

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." ■

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.

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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

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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. ■

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