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NHPCO data show hospice expanding nationwide, increase in average LOS

Short stays continue to be problem

The most recent data collected by the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, show some positive trends of expansion, with more than one million people receiving hospice care in 2004.

Also, there were 350 additional hospice programs nationwide for a total of 3,650 in 2004, and the average length of stay increased by two days to 57 days in 2004, according to the NHPCO's 2004 National Data Set (NDS).

However, there were some trends that continue to pose challenges for the industry; for example, the median length of stay remained at 22 days in 2004, same as in 2003, and the percentage of hospice patients who died in seven days or less was 35.1 percent, which was very close to the 36.9 percent recorded in 2003.

"The number of short-stay patients is not decreasing," says **Stephen R. Connor**, PhD, vice president, division of access for end-of-life care, research, and international programs for NHPCO.

"It'd be nice if this was a normal curve, but we have a whole bunch at the short end, and then it drops quickly," Connor says.

There are some market forces that could help improve the short-stay numbers and continue to push the average LOS upward, Connor notes.

"One of the things happening is more hospices are using what we think of as open access policies, where they are trying to get patients into hospice while they're still in treatment," Connor explains. "That trend moves the middle group of two-to-three months."

The problem with the short LOS is that it has been driven by the curative treatment restriction in Medicare hospice benefits, Connor says.

"Hospices wait to admit patients until they've discontinued all disease-modifying therapies," he says. "A lot of treatments are very expensive, like chemo, radiation, monitors for congestive heart failure."

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But if hospices could get patients in sooner, then the increased revenue from earlier admission would offset the increased treatment costs, and it would promote better relationships with referral sources, Connor says.

Continuum Hospice Care of Continuum Health Partner in New York, NY, is an example of how well open access policies can benefit hospice referrals.

The hospice has a median LOS of 31 days, fully nine days longer than the national median LOS, and the average LOS is 61 days, says **Carolyn Cassin**, MPA, president and chief executive officer of Continuum Hospice Care.

"We believe we have pushed those numbers up because of open access," Cassin says. "We don't require anyone to give up anything to get into hospice care."

An even better indicator of how well the open access policy has worked is the fact that the hospice has decreased its percentage of people dying

within seven days or less from 31 percent prior to open access to 21 percent now, Cassin says.

"That's the statistic I'm the most proud of in the organization," she says. "We've made it less of a brink-of-death benefit, so open access is working and people don't wait until they've finished chemo or radiation or made that psychological shift in their minds."

Hospice directors should be asking themselves why they have a six-month benefit that is only used for two months on average, Cassin says.

"There should be some general outrage at the federal government or regulatory agencies as to why this benefit isn't utilized," Cassin says.

NHPCO has encouraged open access policies for years, although it should be applied with a balanced approach, Connor says.

"It should be made on a case-by-case basis, with the physician, patient, family, and hospice team trying to understand the patient's goals," Connor says. "And if the goals are palliative, then you should provide the treatment—but you don't want to run your hospice into bankruptcy either, so find whatever balance works for your community."

Hospice LOS has begun to recover from some declining years in the 1990s after the government's Operation Restore Trust compliance investigations, Connor says.

About 15 years ago, the average LOS was 70 days, and then it began to decline after Medicare intermediaries instructed hospice programs to discharge any patients who looked like they might live more than six months, Connor says.

"After Operation Restore Trust, the percentage of 180 days-plus patients had decreased from 15 percent in the early 1990s to about 6 percent in the late 1990s," Connor says.

Although hospices now take it for granted that very few patients will survive the six month benefit period, from a statistical standpoint, having a rate under 10 percent of people living past a predicted six-month survival period means physicians are doing a good job of predicting how long people will live, Connor notes.

At the same time, physicians are making hospice referrals for people with increasingly diverse diagnoses. Fewer than half of the people served by hospice have cancer diagnoses, he says.

In the early 1990s, more than 90 percent of people served by hospice were cancer patients, and according to the 2005 NDS, cancer diagnoses account for 46 percent of hospice admissions.

"When hospices started in the United States,

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the primary diagnosis was cancer because that was far more predictable than other diseases," says **Mary Taverna**, president and chief executive officer of Hospice of Marin & Foundation in Larkspur, CA. Taverna is the 2005-2006 chair of the NHPCO board.

The trend to include different diagnoses is positive, Connor notes.

"We want to encourage this trend because we're serving the people who are dying, and we're less over-represented with cancer patients," Connor says. "Most people die of non-cancerous chronic conditions, including solid organ failure, dementia, senility, congestive heart failure, diabetes, etc."

While every hospice would like to see patients being referred before they have reached the last week of their lives, the fact that these dying patients are being referred at all is good news, Taverna notes.

"It goes along with a greater utilization of patient services," Taverna says. "And it's a matter of educating the medical community that an earlier referral to hospice is better than a late referral."

One of the main reasons why patients are referred so late is because of the discomfort on the part of physicians and some other referral sources to bring up the subject of hospice to patients and families, Taverna says.

"Hospices should work aggressively to better understand timely referral and to better understand how to transition patients from aggressive therapies that are no longer effective to palliative care," Taverna adds.

In many ways, the short-stay referrals are the result of how medical care has improved and changed nationwide, says **David Simpson**, MA, LSW, chief executive officer of the Hospice of Western Reserve in Cleveland, OH.

People who would have been obviously ready for hospice care 15 to 20 years ago are now the beneficiaries of a medical system where there are more interventions available, Simpson says.

"For example, 20 years ago it wouldn't be likely that someone would go through a third round of chemotherapy because chemo way back then was more noxious than it is today," Simpson says. "Overall, it's been improved so much that you propose a second or third round and it's more benign than it would have been."

So those patients who might be in line for a hospice referral have new technology and drug therapies to consider, and this keeps them less

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compatible with hospice care, Simpson says.

The key is to create a health care atmosphere in which conversations about hospice care are comfortable, and referrals are seen as a natural progression in the care continuum, he says. (See story on how hospices can improve LOS and referrals, p. 4.)

The NHPCO NDS also shows increases in for-profit hospice programs, a rise from 29 percent in 2003 to 31 percent in 2004, and a drop in non-profit programs from 67 percent to 63 percent. Government-run programs also increased from 4 percent in 2003 to 6 percent in 2004.

These statistics along with the overall increase in hospice programs may impact the type of care patients receive from hospices, Simpson suggests.

"I'm not so concerned about whether they're for profit or not-for-profit, but I am concerned about how our resources are being allocated into the program in terms of services," Simpson says. "And I think there is greater challenge for a for-profit entity to add things such as art and residential service."

For example, Hospice of Western Reserve has 12 full-time music and art therapists, while most small hospices would have difficulty funding even a part-time music or art therapist, Simpson says.

"My theory is that a community is better served by a consolidation of resources where economies of scale accrue," Simpson says. "So I'm not delighted with the notion that there are 300 more providers." ■

Hospice directors describe strategies for improving hospice referrals and LOS

Normalize hospice is one answer

Everyone in the hospice industry would like to see the current 1.06 million patients served by hospice increase to nearly 2 million, and they'd like to see the average length of stay (LOS) rise from nearly two months to over three or four months.

But how can the industry get from here to that ideal?

"Any societal change takes a couple of things, including a groundswell, a tipping point," says Carolyn Cassin, MPA, president and chief executive officer of Continuum Hospice Care of New York, NY.

"A million people had hospice care last year, and 50 percent of them had it for less than 20 days," Cassin says. "And 36 percent had it for less than seven days."

Perhaps when more Baby Boomers experience hospice care and their families are outraged by late referrals, things will begin to change, Cassin says.

"We have to raise everyone's consciousness, but there's not that level of outrage yet," Cassin says.

Also, physicians and other referral sources have to realize that they might not be the best people to explain hospice services to patients, she says.

"It's just like an organ transplant service, you don't try to explain it yourself," Cassin says. "Health care providers used to explain organ transplants to people, and nobody ever wanted to donate organs."

So providers stopped trying to explain it and let professionals explain organ transplants, and now organ donation is universal, Cassin says.

Likewise, doctors should let hospice nurses or social workers explain hospice services to patients, and this likely will improve patients' and families' comfort with the concept, Cassin says.

"Normalize hospice, and make it just another one of the fabulous services that the American health care system has to offer," Cassin says.

There also are specific programs and partner-

ships that hospices can form that will help improve referrals and LOS.

For example, the Hospice of Western Reserve of Cleveland, OH, was involved in an intervention project with an acute care, comprehensive cancer center, says David Simpson, MA, LSW, chief executive officer.

The project, which was part of a study called Project Safe Conduct, involved placing a nurse who is board certified in hospice and palliative care, social worker, and spiritual care counselor in the Ireland Cancer Center of Cleveland, where they met with families when they were diagnosed with advanced lung cancer, Simpson explains.

The project's stated goal was to promote a seamless transition from curative to palliative care for dying patients through the implementation of an integrated care path model and protocols.

"The day patients were diagnosed, they were introduced to the team," Simpson says. "And the team's whole purpose was to guide people through palliative and end-of-life care," Simpson says. "It might sound brutal to say, 'I need to introduce a patient to palliative care,' but it doesn't work that way."

What the team was able to do is talk with people while they still had time to talk, and they could ask them what their concerns are and what their fears were, Simpson explains.

Prior to starting Project Safe Conduct, the average hospice LOS for these patients was 10 days, and after the intervention it had increased to 43 days.¹

Hospice referrals increased from 13 percent to 80 percent due to the intervention, and the hospital admission rate dropped from 3.2 before Project Safe Conduct to 1.05 for the patients enrolled in the program. Also, unplanned hospitalizations and emergency room visits dropped from 6.3 per patient to 3.1 per patient, and average daily medication costs dropped from \$60.90 per patient to \$18.45 per patient.¹

The original project was for three years, and it received \$1.1 million in funding, but after it ended, the cancer center continued to fund the three-person team, and now it's in its third year post-study, Simpson says.

"Our organization has a contract with the cancer center to manage the project, although the Safe Conduct staff are now on the payroll of the cancer center," Simpson says. "The hospice LOS has remained high, and the number of referrals to

hospice remained high.”

From the cancer center’s perspective, the program has been positive, as well, he says.

“Even though we have more people coming into hospice care, the center has had more people coming on to clinical trials, and we don’t know why,” Simpson says. “And the center gets letters from people who thank them for this program.”

Since the study ended, the cancer center has expanded it to include patients with some other types of cancers, Simpson adds. ■

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Mold the shape of hospice visit into best practices model for care

Adjust training for the front lines

One way for hospice managers to ensure their staffs are providing the highest quality care and following best practices is to define the optimal hospice visit and train staff to follow specific guidelines toward achieving that goal.

As a former director of a free-standing hospice, and the current director of clinical and regulatory affairs for the Carolinas Center for Hospice and End of Life Care in Cary, NC, **Susan Balfour**, BA, RN, has given a great deal of thought to how hospice staff could best shape a hospice visit.

“The model I came upon that was the most similar to a hospice visit was the private psychotherapy visit,” Balfour explains. Balfour spoke about the shape of the hospice visit at the Ohio Hospice and Palliative Care Organization conference called, “A Season of Growth with Hospice and Palliative Care,” held Nov. 9-11, 2005, in Columbus, OH.

“What I heard from the field is that the patients are in a crisis, and so we need a long visit,” she says. “In the early days of hospice we believed a good visit was a long visit.”

But now that model no longer works, and it’s more useful to look at the hospice visit as akin to

the 50 minute psychotherapy visit model.

“The therapist comes in and skillfully guides the client into the meat of the work,” Balfour explains. “Within 20 to 25 minutes into the appointment, clients are wallowing in difficult stuff, but then by 40 to 45 minutes, the therapist is shaping that visit so the client is ready to walk out the door at 50 minutes.”

Shaping a visit takes definite skills, and these are what hospices need to teach their staff, Balfour says.

“If an agency wants to change the culture, then visits need to be taught in orientation and should be part of the ongoing competency evaluation and performance evaluation because it’s not something you present once and never present again,” Balfour says.

To determine which skills were most important for effectively shaping a hospice visit, Balfour spoke with hospice directors, asking them to name the employees whom they’d tag as being really good at conducting visits.

“Then I asked those employees to tell me about how they conducted a visit,” Balfour says. “I asked, ‘What do you do when you approach a visit to plan for it? What do you do during a visit and what happens?’”

For some hospice staff the skills were so second nature that it took a while for them to articulate what they did that was special, Balfour says.

“Then they started to talk about what they did, and I noted all of their comments, and the comments began to fit into four separate areas,” Balfour says.

The four areas are:

- Approaching the visit with focus and attention: “They knew what they were going to do when they got there, and they knew why they were going,” Balfour says.

- Involving team members: “They knew how to involve other team members and were very skilled at getting the social worker and chaplain in there,” she says.

- Knowing boundaries: “They were quite clear about boundary issues,” Balfour says. “They knew there was a clear line and which side they needed to be on.” (See story on teaching staff about boundaries and improving organizational skills, p. 7.)

- Basic organizational skills.

Some hospice staff have difficulty with meeting goals during a hospice visit and typically have problems with one or more of those four areas.

For example, hospice nurses or other staff often do not have a specific plan for a visit, other than knowing that a set number of visits per week has been approved, Balfour says.

“All the nurses should get together and define the steps of the visit and then come back and describe what happens,” Balfour says.

Questions they should ask themselves include these:

- What exactly needs to happen on this visit?
- What happened at the last visit?
- What was planned pre-visit?

In some cases, staff can get off track during the visit and lose their opportunity to provide the best possible care.

Linda Levi, RN, BSN, president of Glory Health Systems in Weaverville, NC, had worked as an accreditation surveyor for the Joint Commission on Accreditation of Healthcare Organization of Oakbrook Terrace, IL, and she sometimes witnessed futile visits.

For example, Levi accompanied one hospice nurse on a visit in which the nurse spent 30 to 40 minutes sitting at a kitchen table while talking with a patient. Finally, the patient complained of pain, and the nurse gave her pain medication, but continued the social visit at the table until the patient asked to lie down.

Even after the patient was resting, the nurse did not begin the nursing assessments, and finally the patient asked the nurse to leave because the patient was too tired to continue the visit, Levi recalls.

“The visit took over an hour, and the nurse never did the assessment,” Levi says. “If there was a purpose to the visit it was not known, and the ironic thing was the nurse had to go back later that week and do the nursing assessment because she didn’t finish her work on that day.”

On another occasion, Levi accompanied a nurse and a social worker to a discharge visit, and Levi asked the nurse how long they would be there. The nurse replied that it would be at least an hour, but when Levi asked the social worker, separately, how long she thought it’d take, the social worker answered, “Maybe 30 minutes.”

The dramatic difference in what they anticipated for the visit was due to the fact that the two team members had not communicated with each other about the visit and what had been accomplished previously, Levi says.

“The nurse thought she would have to do all of this teaching, and the social worker thought it

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was all done,” Levi explains. “So if there was a purpose for the visit, the two were not on the same page of it.”

These kinds of problems can be avoided when hospice staff are trained to focus on their goals for a visit and plan how they’ll carry out their objectives, Balfour suggests.

Every visit has a planned purpose visit with something that the hospice worker can accomplish with the patient and family, Balfour says.

The key is to be conscious of these plans, she adds.

One of the nurses who has best practices in shaping the hospice visit explained to Balfour how she accomplishes an effective and efficient visit. The nurse’s comment was as follows: “I always take a moment in my car to clear my mind, and then when I enter the home it’s with focus and clarity. My full attention is on the patient, and they seem to perceive that.”

If hospice staff aren’t clear about why they’re visiting a patient’s home, then it is easy for the patient and family to distinguish friendly visits from skills and interventions, Levi and Balfour note.

“One social worker said if she made a visit and wasn’t clear within herself then the family would sense that uncertainty, and it would be much more difficult if not impossible to establish the necessary level of trust,” Balfour says.

Likewise, it’s important for hospice staff to know and communicate clearly how their fellow team members will benefit a patient and family. The most effective nurses during visits were skilled at bringing the social worker and other staff into the home when needed, Balfour says.

“This gets into scripting as a concept, having words ready for situations where you know they are going to be repeated, so you have the script as

a tool at your disposal to use when needed,” Balfour says. “Some nurses we talked to shared with us the kinds of words they use.”

For example, one nurse told Balfour that she would say, “I can see that you’re having problems. Let’s sit down and talk about it for a few minutes, and then let me call the social worker.”

By introducing the need for a social worker to make a visit in this way, the nurse showed the family that she cared about the problem and provided as much support as she could, but ultimately would ask someone to help the family who was better equipped to do so, Levi explains.

“I think it’s important that this nurse identified the concern by saying, ‘I see you’re having problems,’ but didn’t discount it or ignore it,” Levi says. “She acknowledged it and acknowledged her own limitations, and that’s better than just saying, ‘Let me call the social worker.’”

By handling the situation in this way the nurse is supporting her team and her team members’ particular skills sets, Levi adds.

“We say the visit is the patient’s experience and the family’s memory,” Levi notes. “It’s the clinical and medical and social interaction, but from what you leave with the patient and family it’s pretty special.” ■

Help hospice staff develop better boundaries and organizational skills

Is action therapeutic or not?

While any type of home health work makes it more challenging to recognize and respect boundaries, it is particularly challenging for hospice workers who see people at the most intimate and difficult time in their lives.

“The assumption is that ‘I’m here as a hospice professional, so I have a carte blanc because death and dying is an intimate experience,’” says Susan Balfour, BA, RN, director of clinical and regulatory affairs for the Carolinas Center for Hospice and End of Life Care in Cary, NC.

So hospice staff might assume that because they are taking care of a patient at this time, it is all right to be personally involved with the patient and family, Balfour notes.

“But we’ve had patients and families give feedback about how they, frankly, find it very much an imposition, and sometimes they don’t know enough to say, ‘You need to leave’ or ‘That’s not appropriate,’” Balfour says.

Sometimes there are situations where hospice aides are telling patients about their own problems, and this clearly is not appropriate, says Linda Levi, RN, BSN, president of Glory Health Systems in Weaverville, NC.

Balfour spoke with a hospice social worker about boundaries, and the woman’s comment was as follows: “If you’re taking your own stuff into the home, there had better be a therapeutic reason.”

What hospice staff sometimes forget is that people are trained to be polite and make guests feel welcome, so even if they’re uncomfortable with a hospice worker’s visit, they won’t ask the person to leave or try to correct the person’s behavior, Balfour says.

One person who had experienced hospice visits told Balfour: “Just because the hospice staff share the intimacy of death with us as a family does not give them the right to become intimately involved with our affairs.”

So if hospice workers’ actions or words are not therapeutic, they don’t need to do or say it, Levi says.

“Therapeutic doesn’t necessarily bring healing, but it certainly means doing no harm and promoting the wellness of that situation,” Levi explains.

Hospice managers should teach staff to look at all of their actions through the filter of therapeutic, Levi suggests.

Another strategy for helping staff learn boundaries is to promote the use of the team as a boundaries safety net, Levi says.

“You can go to your team members and acknowledge with them what the situation is and what you’re doing and get some feedback,” Levi says. “Don’t go out there as the Lone Ranger and just do things.”

For example, at one hospice an aide wanted to bring a small gift to a hospice family member. It was an inexpensive figurine she found at a garage sale, but the team let her know that it would be better if the gift were given through the entire team so the family and patient wouldn’t construe the gift as meaning that the aide cared about them, but the rest of the team did not, Levi says.

Also, there was another situation in which a

hospice nurse took a sausage biscuit to a patient each time she made a visit, Balfour recalls.

"Then one time another staff member came for the visit, and the patient was mad because that person didn't bring the sausage biscuit," Balfour says.

While the nurse's actions were altruistic, they had crossed the boundary, she notes.

"People rarely identify whether they've stepped over boundaries," Balfour says. "Nature is such that we can be over there and not realize we've crossed a bridge that we shouldn't have crossed."

However, when a boundary is breached within a highly functioning team, it can be recognized and resolved, Balfour says.

Some cues hospice staff should ask to help them recognize boundaries are these, Levi says:

- Does the action benefit me rather than the patient?
- How is the action viewed from the perspective of the patient's family?
- Does this patient mean something special to me?

"If you start treating someone special in some way from all the different patients, then you know you have a boundary issue," Levi says. "We try to give cues and use team support to bounce things off and get some balance, but the bottom line is 'Who does this benefit—me or the patient?'"

Another analogy for maintaining boundaries is to think of it as like a tennis match, Balfour says.

"Hospice staff talk with family members about their lives and kids," Balfour says. "But a skill we need to teach our staff is for the front-line folks to get that ball back over the net and back into the patient's and family's court because it's all about them and not about us at all."

Organizational skills also needed

Nurses who conduct the most effective hospice visits also have better organizational skills, which some might say are more nature than nurture, these still can be learned, Balfour says.

"You should set up a structure that includes those organizational steps that someone would take automatically, and then you assist and evaluate them," Balfour suggests.

Levi recommends hospice managers follow these tips on improving staff's organizational skills:

- Look at what tasks need to take place to

make up a visit.

- Note what a hospice worker needs to do to get ready for a visit.
- Outline how they will conduct patient care, collect supplies, complete forms, etc.
- Explain what actually will be done on a hospice visit.
- Describe how a hospice worker will introduce him/herself, including saying what he/she will be doing in the home.
- Script how the hospice worker will explain what will occur on future visits.
- Provide context for the visit and post-visit phase of care.
- Show what happens when there's a change in the plan of care.
- Break down the visit into steps and phases, explaining what needs to be done at each.
- Help nurses and staff develop their own visit protocol, including what takes place, what are time savers, what can be done differently, how to do documentation, and identifying which tasks can be completed ahead of time.

"As a hospice director, I always had a couple of staff members who were chasing down documentation," Balfour says. "Some agencies have solved that because of laptop computers."

But for those who have difficulty with documentation, one good strategy to follow is what one nurse described to Balfour: "I start the charting in the home, and it helps my patient and family see that I'm taking everything seriously."

One way for a hospice manager to monitor staff's organizational skills is by teaching staff to debrief and ask themselves these questions, Levi suggests:

- Was the purpose of the visit achieved?
- Were my and the patient's/family's expectations met?
- What organizational skills did I use?
- Did I identify the plans for the next visit?

Another way to look at the importance of organizational skills in hospice work is for hospice staff to keep in mind that the last thing most hospice families and patients need is change, Levi says.

They already are experiencing a big change, and what they need from hospice is consistency, which is what a well-organized team can provide, Levi explains.

"The gift we can give to patients and families is if our visits are consistent," Levi says. "They really need that feeling that if their nurse is not visiting them that day, then someone else will

come in who will do things pretty much the same way and within the same time frame.” ■

Minister gives clues to turning problems into patient relationship successes

Here are some best practices

Each hospice and each hospice employee will have moments when patient care fails to achieve all goals or when an unanticipated problem arises.

So the question is not how to prevent these events, but how to make the best of them, says **Robert C. Miller**, BA, Mdiv, a Lutheran minister and vice president of clinical development and ethics for VITAS Healthcare Corp. of Miami, FL.

“We know that certain patients have problems, like those in a lot of pain or who have shortness of breath or at risk of bleeding,” Miller says. “Those are the ones who call us a lot, and so we should focus on those patients as much as we can to find a way for them to have confidence in their provider.”

Hospice workers should read and adopt the philosophy imparted in the book *Healing Words: The Power of Apology in Medicine*, written by Michael Woods, MD, and Jason Star, and published by Doctors in Touch in April, 2004, Miller says.

“The book is written for doctors and focuses on the physician-patient relationship when something goes wrong,” Miller says. “But if people have this difficult relationship with physicians sometimes, then there is something we can generalize out of that to help us in hospice.”

Most of the time when a patient sues a doctor it hasn't been just one event that causes the lawsuit, it's typically a problematic relationship and series of events, Miller says.

“So if you have a patient who has a problematic relationship with a health care provider and not just with a hospice, then focus on that patient proactively,” Miller says.

For physicians, three minutes can make the difference between being sued and not being sued, Miller notes.

“A study quoted in the book shows that physicians who spend just a few more minutes in an office visit with a patient end up getting sued less frequently, and it's literally three minutes difference,” Miller says.

What hospice workers need to ask themselves is what they can do to help patients feel like they aren't going to abandon them and are truly present with them, Miller says.

The key is to know how to turn a service failure into an opportunity to improve a provider-patient relationship, Miller says.

“Whenever there's a service failure, you should do everything you can to involve the physicians who referred the patient,” Miller says. “We might ask the medical director to be in contact with the attending physician for guidance.”

Someone needs to proactively contact the doctor to let him or her know there has been a problem so the doctor doesn't hear about it from patients, Miller says.

“Our relationship with the attending physician is probably the most critical relationship in terms of their feeling comfortable in making referrals,” Miller says.

Another way to handle service failures is to have a forensic quality assurance program, such as a forensic utilization review meeting in which the appropriate staff will look at a case to try to determine what went wrong, Miller suggests.

“They should look at the chart, look at what was there and whether there was something that should have been done differently in that situation,” Miller says. “They can pick the chart apart and think about it on a broader scale, such as if it happened one time was there something that could be learned to prevent it from happening again?”

Woods' book focuses on apology because this is a powerful tool in working with patients and families, Miller says.

Despite what risk management specialists will say, health care providers should apologize when needed, he says.

“It's only one step in terms of what you need to do overall, but people need to know there's a human being on the other side of the phone,” Miller says. “They need to know that we're really sorry that this happened, and we shouldn't be afraid to say so.”

Some law firms even have a corporate apology program in which major corporations save

themselves millions of dollars annually by apologizing in writing to the individuals who were harmed by their products.

Miller makes an analogy of the power of apology to a broken arm that has healed properly, calling it "stronger in broken places."

"It's a reference to the novel *Farewell to Arms*, in which Ernest Hemingway talks about how a bone that is broken is unlikely to break again in the same place because it's actually stronger than it was," Miller says. "The human spirit grows stronger in the places where it was broken."

When hospice workers have a relationship with a patient and family and the trust is broken, possibly because of a mistake or because the service failed to meet the patient's expectations, then that's when the bond is broken, Miller explains.

"So what we want to do is recover in a way that makes our relationship with them grow stronger, providing a catharsis," Miller says.

Miller has seen this phenomenon regarding apology at work in his own experience: "My wife just had surgery and had a hysterectomy," Miller explains. "She bled internally, and it was rough for about 24 hours."

The doctor came back to see her several times that day and was apologetic for what she was going through, Miller recalls.

"He was obviously very concerned and very calming and talked about what we would do and that really made all the difference for us," Miller says. "We didn't feel like we were alone in that experience."

Another tactic for dealing with service failures is to respond immediately and respond in person whenever possible, Miller says.

"One typical way of handling a complaint is to go out and investigate it and then call the family," Miller says. "Our practice is to not investigate it because that could take 24 hours, and meantime the family is wondering why no one is calling them."

Instead, a hospice should show the patient and family that someone will help them and care about what they're going through, Miller says.

"You have to foster the kind of environment where people feel comfortable volunteering their mistakes, saying, 'This situation didn't go as well as I would have wanted it to go, and you can help me handle this in the future better,'" Miller suggests.

Need More Information?

- **Robert C. Miller**, BA, Mdiv, Vice President of Clinical Development and Ethics, VITAS Healthcare Corp., 100 S. Biscayne Blvd., Miami, FL 33131.

At VITAS Healthcare, this type of environment is fostered at team meetings where each meeting includes a few minutes for education, Miller says.

Customer service also is a main focus during the educational segment of the meetings, he says.

"We're trying to help the manager encourage these kinds of conversations to happen," Miller says.

"One big stumbling area for hospice people is if we treat a complaint as though it's ineffective coping, saying, 'They are not coping well; they are anxious and grieving,'" Miller says. "When in fact there might be things that are really critical for this individual and we don't listen for that."

For instance, there might be a patient who complains because the home health aide is 15 minutes late two times in a row, Miller says.

Instead of attributing his complaint to his inability to cope with his illness, the hospice staff should take his complaint seriously and find a solution, he says.

At a workshop Miller held on this topic, one hospice employee provided an ideal solution to this problem: "She had a caregiver who was an engineer, and every time the home health aide was a couple of minutes late he'd be on the phone with her supervisor," Miller recalls.

So the supervisor asked the home health aide to call her when she was running late, and the supervisor would then call the caregiver and talk with him for the five minutes it took for the aide to arrive at his home, Miller says.

"She'd talk on the phone with him about the weather or whatever, waiting until the aide arrived, and then he'd say, 'I have to go because the home health aide is at the door,'" Miller says.

The idea is to create an environment in which people feel comfortable talking about mistakes, Miller says.

"It's finding that balance between making sure we foster the right kind of environment where people are comfortable talking about things and holding people accountable for what we expect from them," Miller says. "Our main goal is that when a mistake happens we do everything we can to make sure it doesn't happen again for that family and any family." ■

Should you have your own malpractice insurance?

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

Licensed practitioners of all types who are employees of health care providers are often covered by malpractice insurance that is paid for by their employers. Employees who are covered by their employers, however, wonder whether they should also purchase their own malpractice insurance.

Below are some of the pros and cons of purchasing your own malpractice insurance coverage.

You should purchase and maintain your own malpractice insurance coverage because:

1.) When claims are filed in which you may be involved, your employer's insurance company will assign legal counsel to defend the claims. Legal counsel assigned by your employer's insurance company clearly represents your employer, not necessarily you. In fact, if legal counsel determines that the actions you took are outside the scope of your employment, your employer's insurance company may decide that there is no coverage for the claims filed against you. Under these circumstances, the only insurance you have may be the coverage you purchase yourself.

2.) In some instances, multiple claims may be filed against the same provider, including you. These multiple claims may exceed the limits of liability of your employer's insurance policies. Once again, the only coverage you

may have may be the coverage you purchase and maintain yourself.

3.) Almost all practitioners have assets that should be protected, even though most practitioners are not accustomed to thinking of themselves as deep pockets. These assets often include wages from employment, a home, automobiles, savings, stocks and bonds, etc. The only way to help ensure protection of these assets is to purchase and maintain your own insurance policy.

4.) Malpractice insurance is relatively inexpensive for most types of practitioners, except for some advanced practitioners, such as nurse midwives. It is readily available through professional associations at a reasonable cost.

5.) If you purchase your own malpractice insurance and a claim is filed against you, your insurer will assign legal counsel. Unlike counsel assigned by your employer's insurance company, legal counsel assigned by your insurer owes allegiance only to you. You will have legal counsel who is solidly in your corner and who can, if necessary, counter arguments made by your employer's insurer that your employer's policy should not cover you.

6.) It is untrue that if you have your own malpractice coverage you are more likely to be sued. In most instances, patients and their families have no way of obtaining information about whether or not you have malpractice insurance before they file lawsuits. Even after lawsuits are filed, rules governing discovery may prohibit attorneys for patients and their families from getting information about whether you have malpractice insurance and, if so, the amount of coverage, etc.

You should not purchase and maintain your own malpractice insurance coverage because:

1.) Employers, especially large institutions and organizations, may not want their employees to have their own malpractice insurance. It may be time-consuming for everyone involved if your insurer assigns legal counsel in addition to counsel from your employer's insurer. The attorneys may disagree about your liability or it may be difficult for them to communicate effectively and to get on the same page

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regarding your best interests.

The bottom line, however, is that purchasing and maintaining your own malpractice insurance will provide peace of mind at a relatively low cost. As indicated above, the potential benefits far outweigh possible difficulties of having your own coverage. Having your own malpractice insurance in our litigious society may now constitute an important aspect of professional practice. ■

[To obtain more information about professional liability in a book entitled Legal Liability, send a check for \$30.00 that includes shipping and handling made out to Elizabeth E. Hogue, Esq., 15118

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