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Special Report: Improving Diversity in Hospice Care

This is the first in a two-part series about how hospices lack diversity in their staff and patients. Next month, in part two: how different organizations tackled the diversity issue and improved their patient base among minority communities.

Researcher has data showing surprisingly negative views of hospice among minorities

Researcher suggests barrier breakers

Despite national and various regional focuses on improving minority access to hospice, many challenges remain, hospice diversity experts say.

The National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA, first assembled a task force on access to care of minorities and people of color in the late 1980s, and NHPCO began addressing the issue at annual conferences in the early 1990s, says Fay A. Burrs, RN, BSN, director of access and diversity at NHPCO.

While the national organization's attention to the issue has helped improve minority access to hospice, African Americans account for roughly 9 percent of hospice patients, which is less than their 12.4 percent representation in the United States, Burrs says. (See NHPCO chart on hospice patients, p. 18.)

For the Latino/Hispanic population, hospice use is even rarer with Hispanics accounting for only 4.3 percent of hospice patients, while the minority group accounts for 12.8 percent of the U.S. population, Burrs adds.

"So we still are vastly underserved when we look at the racial and minority mixture," Burrs says.

A variety of barriers have prevented some African Americans and

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other minorities from seeking hospice care, a hospice researcher says.

There are at least five major barriers within hospice that impact the access to hospice care by minorities, says Dona Reese, PhD, MSW, assistant professor in the School of Social Work at the University of Arkansas in Fayetteville, AR.

First as a hospice social worker and later as a hospice researcher, Reese became interested in the topic of hospice care and cultural differences back in the 1990's.

"In 1990, I found that the African Americans who were in hospice care tended to be young and have AIDS," Reese says. "At that time we had AIDS patients dying in hospice, and those patients didn't have good social support and were different from what you'd expect if you knew some information about the African American culture."

When Reese interviewed African American ministers about the AIDS patients, she often was

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Editor: **Melinda Young**, (864) 241-4449.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).

Editorial Group Head: Lee Landenberger, (404) 262-5483, (lee.landenberger@thomson.com).

Associate Managing Editor: **Leslie Hamlin**, (404) 262-5416, (leslie.hamlin@thomson.com).

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told that hospice was all that the dying young men had since they weren't hooked into the African American community and its traditional church-based support system.

Later, Reese's research found that the vast majority of staff, volunteers, and patients in hospice care are white.¹

Her research has identified a variety of individual, family, cultural, and religious barriers, including:

- denial;
- lack of understanding of hospice philosophy;
- private personality;
- lack of ability to care for patient in the home;
- home visits seen as intrusion;
- taboo regarding discussing death;
- "We are to take care of our own;"
- role of extended family in caring for patient;
- most people want curative care and don't want to give up;
- hospice programs are threat to religious leaders;

- religious beliefs influence treatment choice.²

However, there are barriers that are specific to hospices, including fear of harm, misconceptions, and lack of diversity among hospice staff, she says.

"My results showed that 94 percent of staff were white and non-Hispanic, and 96 percent of volunteers were white and non-Hispanic," Reese says. "That's shocking because that's one of the major barriers to having a diverse hospice group —being approached by an all-white hospice."

Especially racial and cultural groups that have experienced past discrimination and oppression are fearful when approached by white health care providers, Reese adds.

"We did a study in a rural area in a Southeastern state and interviewed African Americans who have used or not used hospice services," Reese says. "And some who had not used hospice had never even gone to a doctor because of a fear of the white health care system."

Reese says there also is a perception among some African Americans that when they're dying white people will show up at their door for the first time in their lives and tell them to sign an agreement that says, "If you're heart stops beating, we will not resuscitate you."

Real or imagined, the fears are based on their own negative experiences in the health care system, including affordability and access issues, or on the experiences of people they know, she says.

The negative information often is inaccurate.

For example, one person interviewed by researchers said, "Hospice will kill you." The person had heard about how hospice uses strong medications such as morphine and had heard about palliative care that may involve the withholding of nutrition, and so the person was afraid that a hospice would use these means to kill patients, Reese says.

Empowerment is the major issue, Reese says.

"The major theme I picked up on was they wanted to be empowered to care for their patients themselves in their homes," Reese says. "They were afraid the hospice staff would come in and take over."

In the cases of African Americans who accepted hospice care, the major reason they gave for using hospice services was that they had a doctor they trusted who had introduced hospice staff to them, Reese says.

"They would meet with them personally and reassure the family and patient that the hospice staff would not take over or do anything that the caregiver did not give them permission to do," Reese says. "That was very important, and they thought they could trust the hospice staff because the doctor they trusted had recommended the hospice."

Reese's research has also shown that African American ministers and many people in the African American community believe that the hospice philosophy of accepting one's death would be seen as a lack of faith.

"They believe God will perform a miracle, and that's what they're praying for, so to accept their death would be an alien point of view," Reese says.

Although the problems with access to hospice services among African Americans are long-standing, the same issue is becoming an even bigger problem among Hispanic populations, according to Reese's research.

"We had an 800 percent increase of Hispanics in our community in the last few years, and our hospices aren't serving them," Reese says. "It's not that they haven't tried, but I think hospices need a lot of guidance on how to do this."

NHPCO is developing a diversity toolkit for hospices and organizations that would like to improve hospice access to minorities, Burrs says. (See sample guidelines from toolkit, p. 16.)

"The toolkit has all of the components that people need to address the issue organizationally, personally, and with specific focus and features on end-of-life care and what we're charged to

NHPCO's suggestions for a successful diversity plan

The National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA, is developing a diversity toolkit to assist hospices with their efforts to diversify their patient population.

The preview toolkit includes these suggestions of measures to increase the success of an agency's diversity plan:

1. Know your community. Who are the respected leaders? What are the community's strengths and needs? Go to the community for answers.

2. Be cautious in rolling out a mandatory cultural competence initiative. That could lead to resentment, poor adherence to policies and superficial responses by staff. Instead, gradually infuse cultural proficiency into the organization's culture.

3. Employ a manager of cultural proficiency to emphasize and help organize the commitment to diversity throughout the organization.

4. Establish a cultural diversity advisory board that includes representatives from the organization as well as the community to help guide the delivery of culturally competent care.

do," Burrs says. "Phase II of that project is to take all that information and then provide a template, a curriculum to give the organization a step-by-step process for unfolding this diversity initiative at their organization."

A 130-page preview version of the toolkit, which is expected to be made public next year, includes checklists, charts, definitions, and tips for identifying barriers and overcoming them. (See diversity plan suggestions from toolkit, p. 16.)

Also, various hospices and hospice organizations around the country have worked with NHPCO to address diversity issues. One such effort is the Opening Doors Project of Hospice Minnesota of St. Paul, MN.

"Several years ago, Hospice Minnesota was very aware that multicultural and minority populations in Minnesota and also, throughout the country in general, were not receiving and were not aware of end-of-life services for family mem-

Need More Information?

- ◆ **Fay Burrs**, RN, BSN, Director of Access and Diversity, National Hospice & Palliative Care Organization, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314. Email: fburrs@nhpc.org.
- ◆ **Barbara Greene**, MPH, Multicultural and Diversity Consultant, Custom Health Consultants, 1417 Fairmount Ave., St. Paul, MN 55105. Telephone: (651) 690-5526. Email: barbara-greene@comcast.net.
- ◆ **Dona Reese**, PhD, MSW, Assistant Professor, School of Social Work, University of Arkansas, 106 Academic Support Bdg., Fayetteville, AR 72701. Email: reese@uark.edu.

bers," says Barbara Greene, MPH, a multicultural and diversity consultant with Custom Health Consultants of St. Paul, and also program director/multicultural consultant with Hospice Minnesota, the state hospice organization that represents about 70 hospices in the state.

Hospice Minnesota conducted a statewide survey of hospice organizations, asking them how much they served minority or multicultural families and patients, including the Hmong community, which is one of the largest in the country, Greene says.

"For the most part we found great work needed to be done," Greene says. "While a few hospices had bilingual staff and were knowledgeable in how to use interpreters and were aware of a diversity of beliefs around end-of-life and communications patterns, most hospices had not gone down this path before."

The hospices were very interested in learning how they could provide culturally proficient services for multilingual communities, Greene notes.

"So over the last three years, we have looked at this issue, and my role is to help guide and facilitate and bring together hospices throughout Minnesota to improve their cultural proficiency on end of life care," she says.

The hospice organization has provided training at seminars, workshops, special events, and conferences and has had a variety of hospice materials translated into the Spanish and Hmong languages, including

patient and family information that can be distributed in those communities, Greene says.

Fourteen hospices in Minnesota have joined to be part of a pilot project in which they work together on multicultural end-of-life issues, Greene notes.

"This year we're going to have some very targeted training sessions for hospices on the use of interpreters at the end-of-life," Greene says. "It's a very critical need."

At the organization's Web site at www.hospicemn.org, there are diversity materials posted, including brochures and pamphlets that have been translated into other languages, Greene says.

"It's an ongoing priority of Hospice Minnesota and their board of directors, and I guess we're finding it's of great national interest," Greene says.

"I think people who choose to work in the field of hospice are some of the most sensitive and dedicated people," Burrs says.

"We keep hearing from hospice staff that they want to diversify and do it right, but they don't have the resources to do so," Burrs adds. "So the diversity toolkit is a response to hospices wanting to do the right thing."

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NHPCO diversity toolkit offers these ideas for building trust and improving diversity

Spend time in community you want to reach

The National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, has developed a diversity toolkit designed to help hospice organizations with their efforts to improve diversity among their patient base.

A preview look at the toolkit, which will be published within the next year, provides these suggestions for how hospice staff can build trust and

develop a relationship in a minority or culturally diverse community.

- Recognize that diversity exists.
- Obtain a broader current understanding of diversity.
- Develop a desire to learn about other cultures, races, and religions.
- Listen and learn from those who are different.
- Respect the dignity of the person.

Demonstrate respect for people as unique individuals, with their culture, race, or religion as just one factor that contributes to their uniqueness.

- Develop compassion.
- Learn to be present.
- Adhere to ethical principles and practices.
- Become informed—taking better advantage of available diversity resources.
- Don't assume anything.
- Ask and clarify as you seek to understand.
- Do not expect all members of one cultural group or family system to behave the same way.
- Appreciate that each person's cultural, racial, and religious values are deeply ingrained.
- Refrain from making assumptions and generalizations about a group of people.
- Be willing to modify health care delivery in keeping with the patient's cultural, racial, or religious preferences.
- Do not take others' behavior personally. Their reactions to you may have less to do with you than to factors such as your age or gender. (For example, some cultures do not accept females taking care of males). ■

Conduct a self-audit of hospice program to identify risk areas

Expert offers guide to effective compliance

It's been more than six years since the Office of Inspector General (OIG) published its compliance program guidance for hospices, listing 28 areas in which hospices are particularly vulnerable to fraud and abuse.

Still, many hospice directors and staff are unfamiliar with these areas and could use some assistance in developing effective corporate compliance programs, an expert notes.

"In my experience, hospices that have an effective compliance program tend to be

stronger hospices," says Heather P. Wilson, PhD, president of Weatherbee Resources Inc., a company that provides compliance consulting and other services, of Yarmouth Port, MA. Wilson is the co-chair of the regulatory subcommittee at the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, and the leader of the education work group at NHPCO.

"When we get a call from a hospice program that's in trouble we ask if they have a compliance program, and if they don't we help them set up one because it protects them in so many ways," Wilson says. "If the government sees they have a viable corporate compliance program it can help mitigate some of the penalties that might otherwise accrue for what has happened."

Wilson was the primary author of the corporate compliance program toolkit published by NHPCO in 2000. The toolkit includes information about conducting audits and monitoring a hospice program to make certain it's in compliance with the regulations, Wilson says.

While many of the risk areas are similar to those for home health agencies, others are hospice-specific, Wilson says.

"Some of the risk areas are related to marketing, and others are related to billing, and a number of them are related to the provision of hospice care in nursing homes," Wilson says. "The remainder are specifically focused on the Medicare Conditions of Participation [COPs]."

Wilson provides this short guide to what hospices can do to reduce compliance risk:

1. Set the scope of an auditing/monitoring program.

Hospices should determine which areas will be monitored on an ongoing basis and determine the frequency of audits and who will conduct the audit, Wilson says.

"Who has the best level of competency in terms of what needs to be looked at?" Wilson says. "Most hospices will have to do it internally, so who are going to be the best people to do it?"

The audit protocol might focus on these areas:

- Trouble areas for the hospice;
- OIG's corporate risk areas;
- Substandard care areas;
- Compliance with Medicare COP;
- Patient admission.

"The most significant risk area is the one of

admitting patients to hospice who are not terminally ill," Wilson says.

"Many hospices call us because they've had claim denials or are under focused medical review by a fiscal intermediary," Wilson explains. "It comes down to continued eligibility for the person with hospice care and the eligibility for the level of care that they're billed for."

Another risk area is when hospices bill for a higher level of care than is necessary, Wilson says.

"If you don't have documentation in your records, you could be at risk for billing for a higher level of care than is necessary," she says.

2. Include standard compliance components.

"In setting up an auditing and monitoring protocol for a corporate compliance program, audit for risk areas, but also audit for effectiveness of the compliance program," Wilson suggests.

The standard components of a compliance program are the standards of conduct, she says.

"What standards of conduct emphasize is an organization's commitment to conduct business in an ethical manner," Wilson says. "We recommend they adopt NHPCO's code of ethics because these are essentially the same thing."

It's not enough for a hospice to say that it has accepted NHPCO's code of conduct, however, she says.

"The code of conduct should be visible and posted in a prominent location with staff training material," Wilson says.

3. Customize a compliance manual.

Also, it's not helpful to purchase a compliance manual or toolkit and then let it gather dust on a bookshelf, Wilson says.

"I've actually seen it in my consulting work where a program purchased our manual and just photocopies the policies and procedures and doesn't customize them to their own organization," Wilson says. "So that doesn't work—the manuals are intended to be helpful, but not the actual program."

A staff person should be designated to work on the tool kit or compliance manual, and, ideally, a compliance officer and compliance committee should be established, Wilson says.

While it's okay to use NHPCO's code of ethics, which is strong and touch on all aspects of hospice ethics, it's equally important to read them and internalize them, making them an organization's own code, Wilson explains.

4. Develop policies and procedures.

"In the toolkit we provide sample policies and procedures that are needed," Wilson says.

"You need to look at policies and procedures for each of the components of a corporate compliance program and for each of the risk areas," she says. "Also, address each risk area in terms of how you deal with those risk areas."

The risk areas are the 28 listed by the OIG. (See table of OIG hospice risk areas, p. 20.)

The toolkit provides samples of policies and procedures and suggestions about different components to be included, Wilson notes.

5. Find the ideal person to be a compliance officer.

"Basically, it happens in hospice all the time

Characteristics of patients served by hospice

The National Hospice and Palliative Care Organization of Alexandra, VA, lists these characteristics of hospice patients, according to 2003 data of 950,000 estimated patients served that year:

- 54 percent of hospice patients were female;
- 46 percent of hospice patients were male;
- 63 percent were 75 years of age or older;
- 81.2 percent of hospice patients were white or Caucasian, not including Hispanic or Latino whites;
- 9 percent of hospice patients were black or African American;
- 4.3 percent of hospice patients were Hispanic or Latino;
- 0.9 percent of hospice patients were Asian or Hawaiian/Pacific Islander;
- 4.6 percent of hospice patients were classified as multiracial or "another race."

*Expressions and gestures may not mean what you assume they do.

that you go into work one morning and your job description has changed," Wilson says. "All of a sudden you're the HIPAA officer or the compliance officer."

While big hospice chains can afford to have a specific position designated to the role of compliance officer, smaller hospice programs have to find an employee who can fill that role while performing other tasks, as well, Wilson says.

"The point of it is to have a focal point of accountability for the compliance program, and it should be someone who has the authority in the organization and who is well-regarded," Wilson says.

The person could be a clinical manager, clinical director, nurse manager, or have some other position, she adds.

"It really is a matter of looking at your organization and deciding who is the most appropriate person to take on that responsibility," Wilson says.

6. Educate staff effectively.

"You can't have an effective compliance program if the staff don't know it exists," Wilson says.

"The training should be an initial training when the compliance program is rolled out and an annual inservice, as well as being included in new staff orientation," Wilson says.

Part of the training, which might take 45 minutes to an hour, should include an introduction to the compliance officer and information that is included in the employee handbook about compliance, she adds.

7. Establish a reporting mechanism.

The staff should know that there is a reporting mechanism in which they can report compliance concerns, Wilson says.

"This can help deal with whistleblower issues," Wilson says.

For example, if a hospice has a disgruntled employee who brings a lawsuit against the hospice program, then some of the damage could be mitigated by the hospice having a reporting mechanism, Wilson says.

The mechanism should give staff a way to call about potential fraud or abuse without fearing retaliation, and they should be adequately trained on how to use it, she says.

It could be a toll-free number for fraud and abuse that is established by an outside contractor, she says.

Need More Information?

◆ **Heather P. Wilson**, PhD, President, Weatherbee Resources Inc., 161 Main St., Yarmouth Port, MA 02675. Telephone: (508) 375-0098. Email: hwilson@weatherbeeresources.com.

"It doesn't have to be a hotline number," Wilson says. "You could do a suggestion box or provide the contact information of the compliance officer, as well."

8. Establish consequences and corrective actions.

When problems or noncompliance issues are discovered, there should be a protocol for disciplinary action, Wilson says.

"What you need is a policy and procedure that says a hospice employee would be disciplined for noncompliance with regulations or violating the organization's standards of conduct, code of ethics," Wilson says. "Let people know these violations are serious and there are consequences for not adhering to the compliance program."

When an audit finds problems within the hospice, it's important to demonstrate that the management will do everything necessary to correct it, Wilson says.

"If a hospice receives an overpayment, it should immediately pay it back," she says.

Also, if a compliance problem is discovered the hospice should consider retaining an attorney to assist in any governmental communication, Wilson suggests.

"What I find is that hospices are so scrupulous and so intense on doing the right things that they over-do it," she says. "They just need to be protective of themselves and their organization, so when they find something wrong their legal counsel can help them with disclosing it."

Most of the fraud and abuse problems committed by hospices are due to a lack of understanding or knowledge of regulations, Wilson adds.

Or, as it says in the planning guide, "Challenges abound, but perhaps the most threatening of these challenges is complacency."

Too often in smaller communities, there is

The OIG's hospice risk areas

1. Uninformed consent to elect the Medicare Hospice Benefit;
2. Admitting patients to hospice care who are not terminally ill;
3. Arrangement with another health care provider who a hospice knows is submitting claims for services already covered by the Medicare Hospice Benefit;
4. Under-utilization;
5. Falsified medical records or plans of care;
6. Untimely and/or forged physician certifications on plans of care;
7. Inadequate or incomplete services rendered by the Interdisciplinary Group;
8. Insufficient oversight of patients, in particular, those patients receiving more than six consecutive months of hospice care;
9. Hospice incentives to actual or potential referral sources;
10. Overlap in the services that a nursing home provides, which results in insufficient care provided by the hospice to a nursing home resident;
11. Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately-paid professionals;
12. Providing hospice services in a nursing home before a written agreement has been finalized, if required;
13. Billing for a higher level of care than was necessary;
14. Knowingly billing for inadequate or substandard care;
15. Pressure on a patient to revoke the Medicare hospice benefit when the patient is still eligible for and desires care, but the care has become too expensive for the hospice to deliver;
16. Billing for hospice care provided by unqualified or unlicensed clinical personnel;
17. False dating of amendments to medical records;
18. High-pressure marketing of hospice care to ineligible beneficiaries;
19. Improper patient solicitation activities, such as "patient charting;"
20. Inadequate management and oversight of subcontracted services, which results in improper billing;
21. Sales commissions based upon length of stay in hospice;
22. Deficient coordination of volunteers;
23. Improper indication of the location where hospice services were delivered;
24. Failure to comply with applicable requirements for verbal orders for hospice services;
25. Non-response to late hospice referrals by physicians;
26. Knowing misuse of provider certification numbers, which results in improper billing;
27. Failure to adhere to hospice licensing requirements and Medicare Conditions of Participation;
28. Knowing failure to return overpayments made by federal health care programs.

no single voice for hospitals and they end up being left out of the local emergency planning committee. Wise advises hospitals to set aside their competitive nature and ensure they have a role in communitywide planning.

The Joint Commission developed the guide in partnership with the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University. It also convened two

expert roundtable meetings in 2004.

Wise notes these lessons learned from past disasters:

- Hospitals must be able to stand alone for at least 48 to 72 hours.
- Hospitals must take care of the personal needs of their staff.
- Maintaining a communications system is crucial.

Even if you make it on your own, you need contact with the outside world. Hospitals need an emergency communications system, says Wise.

For example, after Sept. 11, New York hospitals developed an 800 MHz phone system that would connect hospitals and the Emergency Operations Center. The closed-circuit system would not be affected by overloading on the public circuit. The phone system worked well during the Northeast blackout in 2003. ■

Preceptors can improve retention of new nurses

Individualized programs create better results

Anew job can be overwhelming no matter what industry you may choose, but when the new job is in home care, saying that the job is overwhelming may be an understatement.

Traditional orientation programs don't always take into account the myriad details that a home care nurse needs to know to both succeed in the job and to be happy with it, so two agencies are handling new employee orientation with preceptors.

Since her agency started the preceptor program four years ago, new nurse retention has been higher and employee satisfaction has increased as well, says **Suzanne Van Loon**, RNC, BSN, MPH, director of clinical services at VNA of Somerset Hills in Bernardsville, NJ. "Our new hires have been split 50/50, with half of the nurses having home health experience and half of the nurses not having home health experience," she says. "Our three-month orientation program gives all new nurses a chance to adjust both to our agency and to home health if this is a new field for them," she explains.

The preceptor's responsibilities are to introduce the new employee to the different protocols and processes of the agency, assess the new employee's learning needs through discussion and observation, and plan the new employee's learning experience, says Van Loon. "Because the preceptor spends so much time with the new employee during the first four weeks, her case load is reduced," she says.

At first, the new employee will make visits with the preceptor, but she will also spend

time with other agency employees, she points out. "New employees spend days with our clinical director, our quality improvement director, rehab employees, OASIS coordinator, intake employees, our respite department manager, and our nursing secretary," she explains. "This gives each new employee a real understanding of all of the agency's activities and introduces key people that she will need to know," she adds.

Even though the preceptor and the new employee are not together every day once the orientation period begins, they have regular progress meetings, along with the new employee's supervisor, to review what has been learned and to identify areas that may need to be enhanced, such as computer skills or OASIS training, explains Van Loon. The training is designed to meet the individual's needs, not a timeframe, she adds.

"It is a very positive relationship that develops," she says. "It is non-threatening and it makes it easy for the new employee to ask questions without worrying that admitting a lack of knowledge may result in a poor review," she adds. While the orientation period is defined as three months, the preceptor relationship can be informally extended as needed, she says.

"We select case managers to serve as preceptors," says **Vikki Prochaska**, RN, MSN, CNAA, director of home care at Kenosha Visiting Nurse Association in Kenosha, WI. The first week of training, the new nurse spends time learning the computer system and OASIS entry, she says. "The next two weeks, the new nurse works with her preceptor, visiting patients, completing documentation, and talking about agency operations," she says. After two weeks with her preceptor, the new nurse will spend the next few weeks visiting patients with a variety of other nurses, she says.

"We like for a new nurse to see how a variety of nurses handle patient visits and paperwork because everyone develops their own way to do the job and you can learn something different from each nurse," she explains. The new employee does stay in contact with her preceptor and the preceptor reviews the new employee's progress.

Prochaska's program is 90 days and comprised of orientation and evaluation, but it is very individualized, with different nurses progressing at

different paces, she says. "It is important to tailor the training to the nurse's experience and ability so that the job doesn't overwhelm and frustrate the new employee," she explains.

Selecting the right employee to serve as a preceptor is just as important as selecting the right nurse to hire as a home health nurse. "We require that our preceptors have a minimum of two years' nursing experience and at least one year of home health experience," says Van Loon. "We also want someone who loves being in the field and is very organized with a natural talent for teaching," she adds.

"I look for preceptors who consistently do their job the right way, without taking a lot of shortcuts," says Prochaska. "While everyone develops shortcuts as they learn their job, it is important for a new nurse to learn every step of the process the correct way so that mistakes can be easily found and fixed," she explains. "Preceptors also have to be ready to become the new nurse's best friend during a trying period of her life," she adds.

"We also encourage our preceptors and our new employees to let us know if personality conflicts do arise," says Prochaska. While she tries to match preceptors and new employees on the basis of personality as well as skills, there may be times that the new employee needs to move to a different preceptor, she says. A move from one preceptor to another does not reflect upon the skills or ability of either the preceptor or the new employee, it is strictly a personality issue, she emphasizes.

"A preceptor who is very confident may seem intimidating to a nurse who is less assertive, so the new nurse will feel free to ask questions of, and learn more from, another preceptor with a different personality," she explains.

A reduced workload for preceptors does mean an increased workload for other nurses, but every one in the agency appreciates the value of a preceptor-based orientation, says Van Loon. While the individual training and orientation may seem costly as first, the real savings is seen in the retention of new employees, instead of a revolving door of nurses who stay less than three months, she adds.

Not only does this approach to orientation solve retention problems, but it also is a recruiting plus, Van Loon points out. "Nurses who are new to home health are relieved to find out that they will have one person, other than a supervisor or manager, to whom they can go with their questions," she says.

"This removes a lot of their anxiety about working in a new field and makes them look forward to learning a new job," she adds.

A preceptor-based orientation also addresses the fact that home health care cannot be learned in a classroom, says Van Loon. She explains, "The only way to learn home health is to do it. This approach gives new nurses a chance to do home care in a safe, supervised environment." ■

Four tips to protect your agency's employees

Protecting employees as they travel throughout the area and into many different types of situations often means giving them trainings and tools that can help them avoid, or escape, a dangerous situation. Conversations with home health nurses and aides, as well as review of incidents that have occurred, help you discover what issues need to be addressed, explains **Carrie Krueger, RN, BSN**, clinical director of home care services at Cincinnati Children's Hospital Medical Center.

Some of the changes or enhancements to her agency's protocol for visits include:

1. Use a duress signal.

A code word or phrase that is known by all staff members is used when a nurse believes he or she may be in a potentially dangerous situation. "The nurse tells the family that a page must be returned, then he or she calls the office," says Krueger. "The staff person who answers the call and hears the duress signal calls the police," she explains. It is important that the nurse give the location by saying, "I'm at [patient's name] home on [street name]" so the office staff member answering the phone knows the exact location. "It is also important that the office staff member taking the call stay on the phone with the nurse until the police arrive," she points out. If it is not possible to stay on the phone, the nurse should leave the cell phone on and in his or her pocket so others can hear what is going on, Krueger continues.

2. Communicate location.

"A nurse should make sure that someone knows where she or he is going at all times," Krueger points out. "During the weekday, it

is easy because we have staff in the office and it is easy to check in with each other," she says.

"Nurses who go out in the evenings and on weekends need to make sure a family member knows where they are going and how long it should be until they return," Krueger suggests. "Family members should also have a list of contact numbers for managers and supervisors in the agency if the nurse doesn't return on time and can't be reached," she adds.

3. Establish good relationship with police.

Although the nurses no longer rely upon police escorts for visits into high-risk areas, agency schedulers regularly check in with police in the different districts when a new patient with an address that is in an area that might be high risk is referred to the agency. By talking with a specific, designated contact, the scheduler is able to determine if the location is considered high risk and requires that the nurse have an escort from the protective services group at the hospital, says Krueger.

4. Don't schedule some visits in evening.

"If the patient is located in a known high-risk area, we don't schedule night visits," Krueger says. If the patient needs care at 11 p.m., have them go to the emergency department, she adds. ■

CMS takes steps to ease emergency

The Centers for Medicare and Medicaid Services (CMS) relaxed some rules and requirements for home health agencies that provide care to patients who were relocated as a result of Hurricane Katrina.

The first step taken was to reassure agencies that the normal burden of documentation is waived and the presumption of eligibility should be made for all patients who were evacuated to neighboring states where no

health records exist and no proof of coverage can be presented.

Other changes that will help home health agencies include:

- Home health agencies that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricane Katrina, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud or abuse occurred.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid.
- Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.
- Normal prior authorization and out-of-network requirements also will be waived for enrollees of Medicare, Medicaid, or State Children's Health Program managed care plans.
- Normal licensing requirements for doctors, nurses, and other health care professionals, including home health personnel, who cross state lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their home state.
- Certain privacy requirements of Health Insurance Portability and Accountability Act will be waived so that health care providers can talk to family members about a patient's condition even if that patient is unable to grant that permission to the provider. ■

Fixed performance areas for random surveys announced

Although the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) begins unannounced surveys for all organizations in 2006, it does not mean that random unannounced surveys will end.

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Because random unannounced surveys are one way that the Joint Commission can demonstrate that organizations remain in compliance with its standards throughout the three-year accreditation cycle, random unannounced surveys will continue to be performed, even after January 2006.

"The Joint Commission will continue to conduct unannounced surveys on a 5% random sample of accredited organizations every year through 2008," says **Mark Forstneger**, spokesperson for JCAHO. These random unannounced surveys are conducted nine to 30 months following the organization's accreditation date.

The 2006 fixed performance areas for home care are: assessment and care/service, patient safety, and information management.

In addition to the fixed performance areas, organizations selected for random unannounced surveys will be surveyed on variable components that are specific to the organization being surveyed.

For more information about random unannounced surveys, contact Kevin Hickey, director of the Management Support Unit, Joint Commission, at khickey@jcaho.org. ■

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