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Hospices need to adjust some practices to better serve heart failure patients

Palliative care serves as bridge to hospice

Many patients die of heart failure, but they need not die without hospice services, heart failure experts say. Caring for heart failure patients creates both a challenge and an opportunity for hospices, since heart disease accounts for 30 percent of all deaths, says **Sharol Herr**, BSN, MSEd, RN, CHPN, palliative care nurse clinician and educator at Mount Carmel Health System Palliative Care of Columbus, OH.

"Hospice professionals are the experts in managing symptoms that come about with heart failure," Herr says. "And hospices also have the multidisciplinary team that helps patients and families deal with psychosocial and emotional and spiritual issues that go along with the heart disease process."

The core components of hospice care could provide a positive impact to the heart failure patient population, Herr adds.

But the challenges to increasing heart failure patient referrals to hospice are significant, which is why many programs are emphasizing palliative care as a bridge to hospice care, experts say.

"The palliative medicine people will tell you they believe palliative care begins at the moment of diagnosis," says **Paul J. Hauptman**, MD, professor of internal medicine at Saint Louis University School of Medicine in St. Louis, MO.

"It basically means attention needs to be paid to the patient, the patient's preferences, and to a realization that the disease is a serious one and potentially life threatening," Hauptman says. "Some form of discussion should be made about what patients want out of their therapy and goals and so forth."

Unfortunately, that's now how most health care professionals practice, Hauptman notes.

Medical professionals need to monitor how patients are progressing with the disease and have serious discussions about goals of care with patients and their families, Hauptman adds.

"Only at the very tail end does hospice come into play, and that's in the terminal stages," Hauptman says. "The biggest problem people have is that unlike oncology and oncological diseases, predicting when the end will occur is not that easy."

"Heart failure is such a prevalent disease in this country that if a hospice is not entering into this work then they are not managing a huge segment of the population's needs," says **Mary Ann Gill**, RN, MA, executive director of palliative care services at Mount Carmel Health System in Columbus, OH.

"Sixty percent of all heart disease cases we see in palliative care programs is heart failure," Gill adds.

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Heart failure is the term now accepted to describe the disease, which had been called congestive heart failure, Gill notes.

"We have a hospice that is part of our overarching palliative care program at this health system," Gill says. "And one way we can help one another is if we understand what the research is telling us."

Half of the people who die of heart failure die of a sudden death, and the other half have a slow trajectory toward death, Gill says.

"So you need to prepare your team and resources and response rate to those two potential eventualities," she adds.

Historically, the barrier to having cardiac patients in hospice care is that hospice professionals have had difficulty with the cardiac patient's progression from interventions to palliative care, Herr notes.

For example, hospices tend to shy away from providing cardiac medications along with palliative care medications to heart failure patients, Herr says.

"Hospices tend to make it an all or nothing situation, but there's a much more gray area and transitional area that a hospice can be a part of," Herr adds.

A chart review of a hospice and a literature search of heart failure patients in hospice care showed that more than one-third of these patients were admitted to hospice during their last week of life, says **Cheryl Hoyt Zambroski**, PhD, RN, an assistant professor in the school of nursing at the University of Louisville in Louisville, KY.

One of the reasons why heart failure patients often are referred to hospice so late in their disease is because these patients may tend to have a greater preference for resuscitation than do cancer patients, Zambroski says.

"We don't have a good idea about what is the end-stage heart failure," Zambroski says.

Also, heart failure patients may need active treatment, including pacemakers and other devices and medications that are considered curative, but also could be used to improve the quality of their lives, Zambroski says.

Hospice patients often have a perception that when they go from cardiologist care to hospice care, essentially all the cardiac medications will be stripped from them, Zambroski says.

"I think the perception can make physicians reluctant to refer heart failure patients to hospice care," Zambroski adds.

For example, hospices sometimes are reluctant to offer heart failure patients inotropic medications because of cost concerns since the hospice's per diem reimbursement would have to cover the cost of the drugs, Hauptman says.

"But inotropic drugs can be a very important part of controlling the heart patient's symptoms," Hauptman says.

When Hauptman has referred a heart failure patient to hospice care and prescribed inotropic drugs for the patient, the hospices have objected, saying that inotropic drugs are for acute treatment of heart failure, he notes.

"But we say, 'Yes, in some cases, but in many cases the patient feels better,'" Hauptman says.

Hospices can provide a tremendous financial benefit, as well as convenience, to their heart failure patients by covering the heart medications, Herr notes.

It will help keep the patients stable because they will receive follow-up by hospice staff on a predictable basis, Herr says.

"Many times patients prior to hospice care have not been stable, but they end up becoming stable because of that oversight," Herr adds.

Sometimes a heart failure patient's poor compliance with medications is the result of an inability to pay for the drugs, Herr notes.

"Hospice can play a role in terms of helping to coordinate or monitor the availability and appropriate use of medication," Herr says.

Hospice staff also might learn how to better understand a heart failure patient's prognosis by watching the patient's weight and abdominal girth, which may provide clues about kidney function, Gill says.

Also, water retention may negatively impact quality of life, so the hospice and palliative care approach might be to help the patient reduce water retention through a low salt diet, for instance, in order to improve the patient's comfort, Gill says.

"Our message is that you can't be cavalier in the hospice environment about things that appear to be about disease management, because they might also impact a patient's comfort," Gill adds.

Clinicians often find that heart failure patients' progression is unpredictable, Gill says.

"They can look very stable and sometimes die very unexpectedly," Gill explains. "Others can look like they're at the end of their life and continue to live with a little stable management."

Another problem with referring heart failure patients to hospice care is that too few hospitals have palliative care services, which could serve as a bridge to hospice services, Hauptman says.

At a recent conference with cardiac physicians, Hauptman asked informally how many people worked at hospitals with palliative care services, and only about 30 percent answered "yes."

"It's important to have access to a palliative care team," Hauptman says.

The future of care for heart failure patients likely involves bringing a palliative care approach to the acute care setting, Zambroski says. (See article about palliative care program, p. 52.)

"I think people are going to be really open to the palliative care approach in that we can deliver excellent and outstanding symptom management, palliative and multidisciplinary care, and all those things outside the hospice label," Zambroski says.

The idea is to use the multidisciplinary approach that has been lacking in the acute care setting, she adds.

"The problem is: Who is going to pay for it? This is not an era when you can have services provided when there's little if any reimbursement," Hauptman says.

One solution to increasing earlier hospice referrals of heart failure patients is for more research

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to be done on the best practices for patients with end-stage heart failure, Hauptman says.

The default best practice is to use the oncological model, which involves morphine and other narcotics and which focuses on pain management, Hauptman says.

The problem is that the oncological model doesn't focus much on dyspnea, he says.

"There's not enough information available for understanding how heart patients actually die," Hauptman says. "If we knew better the mode of death, we could focus our treatments better."

Also, hospice physicians need more education on how patients with heart failure die, Hauptman says. ■

Ohio health care system is palliative care leader

Hospices can go through training program

Mount Carmel Health System in Columbus, OH, was one of the first health systems to recognize the national need for having palliative care integrated into the health care for heart failure and other patients.

"Mount Carmel proposed the palliative care leadership concept to Robert Wood Johnson Foundation [of Princeton, NJ]," says **Mary Ann Gill**, RN, MA, executive director of palliative care services at Mount Carmel. Mount Carmel Health System Palliative Care Service is one of the Center to Advance Palliative Care (CAPC)-designated Palliative Care Leadership Centers. Mount Carmel Health System has three acute care hospitals with a total of 1,048 beds, a college of nursing, a residency program, a home health agency, a hospice, and other services.

The Mount Carmel Health System Palliative Care Service includes three hospital-based palliative care programs.

"We started in 1997 with the palliative care process," Gill says.

The health system's palliative care program worked so well that other health systems took notice. Palliative care officials received many requests from other health care systems that wanted to see their model up close, but they were so busy keeping up with palliative care patients that they couldn't provide mentoring services to other organizations, Gill notes.

"So we proposed a concept of mentoring and having financial support from grants to do that, and eventually we created the concept of the leadership center," Gill explains. "So far we have trained 102 programs from 37 states over a three-year-period that will end in July, 2006."

Mount Carmel Health System Palliative Care Service consists of a 17-bed acute palliative care unit in each of the three hospitals, and it includes the Mount Carmel Hospice. The hospital-based palliative care program has served more than 7,000 patients since 1997, according to a page on the CAPC Web site at www.capc.org.

Palliative Care Leadership Centers, including Mount Carmel's, provide a two-day training session that exposes attendees to all aspects of building a successful palliative care program. The centers also offer one year of mentoring services after the training has been completed.

There are six Palliative Care Leadership Centers, which provide training and mentoring services to other health care professionals.

The cost is $1,750 per team, which includes up to four people, from an institution, or $1,500 per team, if one of the four people includes a hospital finance person.

Palliative care and hospices are natural partners in the care of patients with chronic illnesses.

For example, hospice and palliative care staff should be prepared to teach families how to deal with a patient's symptom exacerbation, says **Sharol Herr**, BSN, MSEd, RN, CHPN, palliative care nurse clinician and educator at Mount Carmel Health System Palliative Care of Columbus, OH.

Mount Carmel Health System cares for many patients with chronic diseases, Gill says.

"They enter first through the emergency room and use a lot of hospital resources, often spending more time in the hospital than what the hospital is paid to serve them," Gill says.

With a palliative care program, a health system can train patients and families to improve their chronic disease management, and it can prepare them for the possibility of hospice care, Gill explains.

While it might appear that hospital systems could provide this training and preparation without having a palliative care program, it typically does not happen, Herr notes.

"You would expect there would be discussions about patients and their wishes in terms of their advanced disease process and how they're not going to recover from it," Herr says.

But this doesn't always happen in acute care hospitals, Herr says.

Palliative care and hospice programs have an expertise in end-of-life and advanced disease management that sometimes is lacking in other hospital environments, Herr adds.

Palliative care staff, like hospice staff, are comfortable initiating patient discussions about advance directives and care planning and asking questions about resuscitation and the burdens of treatment, Herr explains.

"That's not something typically done in the acute care world to the same degree," Herr says.

For example, the palliative care team is well trained in working with heart failure patients.

"One thing we do is evaluate patients who have heart failure," Herr says. "When heart failure patients start to return to the hospital frequently, requiring acute care, then that tells us we need to be looking at the plan that's in place for them, and we also need a continuum of care."

Patients with heart failure might require a higher level of vigilance and interaction between the hospice staff and the cardiologist or physician, Herr adds.

"The patient will need closer monitoring to prevent exacerbation of symptoms," Herr says.

Palliative care staff and hospice staff also should be prepared to teach patients about self-monitoring, even if they already have received some instruction, Gill says.

"Patients who have heart disease are fairly accustomed to doing self-monitoring, but they may not do it well," Gill says.

Sometimes the instructions patients might receive in the acute care hospital are not as appropriate for the hospice care program, Gill notes.

"For example, when patients leave the hospital, the hospitals are held accountable for specific discharge instructions for these patients, including things like weight monitoring, follow-up appointments, medications taken on certain diets, activity levels, and smoking cessation, and what to do if symptoms worsen," Gill explains. "But smoking cessation for a patient in a hospice program probably won't be as much of a priority."

One thing both palliative care and hospice care do is consider the patient's perspective, choices, and priorities.

"Maybe the person only has a short amount of time left and he wants to smoke," Gill says. "You have to think about it from their point of view."

There are benefits to a hospice when a parent health system forms a palliative care program, Gill says.

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"I personally think that the concept of partnering and creating a link to the hospital will do nothing but enhance the hospice's ability to be a part of the mainstream health care in a different way than we have been in the past," Gill says.

"We've found that hospitals are very unaware of the complexity of hospice work in the community, and the hospices are not always aware of the complexity of chronic diseases and how chronic diseases burden the resources of a hospital," Gill says. "Together these entities can actually benefit both sides of that continuum."

Also, palliative care physicians in a hospital will partner with other physicians and be able to explain to their colleagues why it might appropriate for a particular patient to be referred to hospice care, Herr says.

"The other piece is that the palliative care physicians are able to have difficult discussions with patients and families, so they share the weight of transitioning this patient to hospice care," Herr adds. ■

Using a social worker for admissions increases hospice's LOS, referrals

Multiple benefits result from program

A Missouri hospice has discovered that it is cost-effective, efficient, and it improves length of stay (LOS) and referrals to have a social worker serve as an admissions coordinator.

Option Care-Missouri River Hospice of Columbia, MO, decided to implement a program

in which a social worker would serve as admissions coordinator as a nursing shortage impacted the Midwest, says **Denise Swenson**, MSW, LCSW, admissions coordinator.

"Our hospice's director looked at ways we could utilize different roles so that we could maximize the use of nurses in direct patient care," Swenson says. "When nurses were doing admissions it would take two visits and sometimes three visits before the families were comfortable accepting hospice services."

This was inefficient and left hospice patients with less time in which to benefit from the holistic approach to hospice services, she notes.

Since the hospice began to use a social worker in the role of admissions coordinator, the benefits have been multiple:

1. It saves money. The social worker's salary is on average $5 per hour less than hospice nurses, so the hospice has experienced a cost savings, Swenson says.

"Last year, I did 600 introductions to hospice, so it was about $3,000 less last year to send me to do the introductions than it would be to send a nurse," Swenson says.

Another $2,800 was saved in the admissions process. Of the 600 people who heard the hospice introduction, 560 were admitted, and the admission process takes another hour, which again saves money when the social worker is the one doing the admission, Swenson adds.

2. It saves time. "It also saves time," Swenson says. "When nurses were conducting the introduction and admissions, and then if they had to do a nursing assessment too, it would take them about three hours."

When an MSW does the introduction and admissions, it will take 1.5 to 2 hours, depending on the family's questions, she says.

The nursing assessment still will need to be done when patients are admitted, she notes.

But in cases where the family does not accept hospice services, the nurse's time is not used needlessly, Swenson says.

3. Staffing efficiency and productivity are improved. Prior to the change, when nurses would do admissions, it would interrupt their day and they couldn't schedule their visits efficiently, Swenson says.

"Now, the RNs can focus on direct patient care, which is the greatest utilization of their time," Swenson says. "Nurses know where they will be visiting patients and can more efficiently manage mileage and drive time."

Also, nurses can schedule chart documentation days, Swenson says.

"When someone is dedicated in the role of hospice admissions, it frees everyone else to schedule their day more efficiently," Swenson says.

Swenson's own time is scheduled to be efficient for both the hospice and patients. Since there are very few referrals on Fridays and many families would like her to visit during the evening hours, she typically works four 10-hour days, Monday through Thursday.

"This schedule accommodates families very nicely, because if they want to see me at 7 p.m., that's not a problem," Swenson says.

4. LOS and overall admissions are up. The hospice's LOS has improved since switching to having a social worker serve as admissions coordinator. In 2001, the agency's median LOS was 16.5 days, Swenson says.

In 2005, the median LOS was 22 days, she adds.

The change in LOS occurred almost immediately as the LOS rose to 21 days by the end of 2002, Swenson says.

Increasing it still further has proven more challenging because the hospice's admissions also have increased, which includes many admissions in which patients receive hospice care for seven days or less, Swenson notes.

5. There are psychosocial benefits. "Also, there have been real and significant benefits to utilizing the MSW over nurse from the psychosocial aspects," Swenson says.

While nurses are trained to focus on the physical aspects of patient care, the social worker looks at both the patient and everyone in the patient's life, Swenson says.

"A great amount of what hospice offers is intended to support the caregiver and family, as well," Swenson notes. "So when the social worker goes out on an admission visit, the social worker is looking at what everyone needs in this experience."

This is why patients who are visited by the social worker at introduction are more likely to accept hospice services sooner than they did when nurses were making the first visit, Swenson explains.

Also, the social worker at admissions will help the family focus on volunteer and other hospice services, showing patients what the hospice can do to help them, she adds.

In one situation, Swenson met with a family in which both the patient and caregiver were elderly and had health problems.

"The initial plan was for the wife, who was the patient, to go home from the hospital and be cared for by her husband," Swenson says. "But her husband didn't know how he was going to take care of her because he couldn't take care of himself, and other family members were not volunteering to provide services in their home or to take Mom and Dad home with them."

So Swenson spent time talking with the family about a feasible and safe plan, and with her assistance, the family decided that the best step would be to place the wife in a nursing home, where she would receive her end-of-life care.

"Sometimes the most loving thing to do is to allow the patient to have health care professionals available 24 hours around the clock to do all the nursing and health care things that families aren't trained to do," Swenson says.

"So it really does help from a psychosocial and emotional perspective to have that social worker in there from the very beginning, supporting the family, as well as the patient," Swenson says.

6. Patient referrals have increased. "Because we have someone dedicated in the role of hospice admissions, we are able to respond to every hospice referral within 12 hours," Swenson says. "And every hospice introduction is conducted within 24 hours, unless the family specifically requests that we wait until other family members are available."

Each admission is consistent. Swenson uses an outline at each admission, saying the same thing each time.

"I also do an initial assessment of what equipment needs they might have, and I notify the team when the patient has psychosocial or spiritual needs or when the patient is out of medicine," Swenson explains. "So when the nurse goes out to do the nursing assessment, she already has an idea of what she's walking into."

Physicians are very pleased with the prompt response to their referrals, Swenson says.

In 2003, there were 370 hospice introductions with 350 admissions, compared with 600 introductions and 560 admissions in 2005, Swenson says.

"I don't know how much of that increase is attributable to the social worker in the role, but the physicians we work with strongly support our model of delivery of services," Swenson says.

Also, the nursing assessments have been made more efficient because each of the hospice's offices has a clinical coordinator with an RN degree who conducts the nursing assessment, following the admissions coordinator's visit, Swenson says.

7. The admissions coordinator also can serve as community liaison. "We have designated as part of the responsibilities of this role that I do all of the community education programs and speak at clubs, organizations, agencies, and nursing homes," Swenson says. "I also speak at national health care and long term care conferences about hospice services." ■

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Shooting for the top 10%? Monitor results, implement best practices

While the parameters for pay for performance are not yet set, experts agree that monitoring and improving your performance in Home Health Compare will get you ready for the changes in the payment process.

Just looking at your numbers isn't enough for an agency to succeed. You must have a process in place and you must be willing to adopt best practices to make changes, says **Robert Fazzi**, Ed.D, president and CEO of Fazzi Associates, a benchmarking and consulting company in Northampton, MA. "The National Home Health Hospitalization Reduction Study identifies best practices to reduce hospitalization, but how do we accelerate adoption of best practices to affect the national home health hospitalization rate of 28%?" he asks.

There are home health agencies that are addressing different Home Health Compare items and doing well, Fazzi says. There are more than 2,400 agencies in the top 10% for at least one Home Health Compare measure; but the numbers drop to only nine agencies in the top

10% for nine out of 10 measures, and there are no agencies that are in the top 10% for all measures, he says.

While reaching the top 10% for all measures might not be practical for all agencies based upon services they provide and populations they serve, the identification of areas in which best practices can create improvement is important, says **Lazelle E. Benefield**, PhD, RN, professor in gerontological nursing at the University of Oklahoma Health Sciences Center in Oklahoma City.

"The benefit of implementation of best practices is improved patient outcomes," she says. When outcomes are improved, the agency's fiscal management improves because staff members are providing the most effective care, she adds. "Also, staff satisfaction may improve because an environment in which best practices can be implemented will further the professional role of the staff."

Addressing all Home Health Compare measurements is overwhelming, so the staff members at VNA of Rhode Island in Lincoln choose two outcomes to focus upon each year, says **Patricia Fleming**, RN, chief clinical officer for the agency.

"We don't just focus upon Home Health Compare; we look at all outcomes measured by OBQI," she says. The outcomes chosen for performance improvement efforts are not necessarily the outcomes that represent the lowest scores; instead they represent areas in which real improvements can be made that will affect a large group of patients, she says.

She reviews agency outcome data on a regular basis, and produces reports that show trends and comparisons of her agency to national averages, enabling staff members to identify areas for improvement. Improvement areas are chosen in June, then staff members on the performance improvement team develop strategies to implement them. Staff education on the new processes and strategies for the selected areas occurs in July and August. "We are currently working on improving urinary incontinence and improving the status of surgical wounds," she says.

"We are fortunate to have a certified wound, ostomy, and continence nurse on our staff," Fleming points out. "As our in-house expert, she has given inservice classes on identification and staging of wounds," she says. By making sure that staff members understand different types of wounds, they can better choose treatments for the wound, she adds.

"We also want our nurses to better identify patients who may have continence problems," says Fleming. Staff education that offers tips on how to better assess the patient are important, she says. "Patients are not likely to tell you they are incontinent because they assume it is part of growing older and because they are embarrassed," she points out. Nurses need to be on the lookout for diapers in the trash, as well as the smell of urine on clothes or in the house, she suggests. Once a nurse confirms that the patient is incontinent, exercises and medications that can help are discussed, she adds.

Once the staff education has been conducted, outcomes for the selected performance improvement areas are shared at staff meetings and posted on bulletin boards in all agency offices, says Fleming. "Our staff drive these improvement projects, so it is important that we keep them up to date on our progress," she says. "It is also a good way to pat everyone on the back for a job well done." ■

Customer service key to patient satisfaction

Respond to complaints, utilize survey trends

Anyone who works in retail knows that customer satisfaction is the key to repeat business, leading to a more successful financial future.

Customer satisfaction also is just as important to a home health agency's successful future, according to home health managers who have focused on improving their own agencies' patient satisfaction programs.

A continuous staff education awareness program, inservices to better prepare staff members to handle complaints from patients, and hiring the right staff members for the job all contributed to the Press Ganey Compass Award won by Mercy Homecare in Cadillac, MI, for a significant improvement in patient satisfaction scores, says **Maureen Hayes**, RN, professional service manager of the agency.

"All staff members worked together to make customer service a part of our agency's culture," explains Hayes. "Customer service became a part of every meeting's agenda, all new employee orientations, and inservices that

were designed to help employees address patient's individual concerns," she says.

Because staff morale affects the level of customer service you can provide, some processes and staff positions were restructured to better use staff members' talents, says Hayes. "We focused on hiring the right people for each job, whether it was a case manager or a physical therapist," she says. "By making sure the employee is handling a job for which he or she is best prepared, we improved everyone's enthusiasm because no one felt like they were overwhelmed or forced to cover for someone else," she says.

After reviewing patient concerns on satisfactions surveys, Hayes' agency discovered a trend in dissatisfaction with physical therapist availability. "We added physical therapists to our staff to better meet patients' needs and satisfaction scores for that service increased," she says.

While patient satisfaction scores and comments are discussed at all staff meetings, and posted for all staff members to read, Mercy Homecare emphasizes the importance of customer service by developing customer service competencies that must be met for each position.

Along with spelling out what customer service activities each person must demonstrate in their job, inservices that teach each staff member how to handle complaints were also developed, says Hayes. "We teach everyone how to accept the complaint and listen carefully, then we tell him or her how to refer the complaint for resolution," she adds.

Mercy Homecare's process spells out the staff members' responsibility to report a complaint to a supervisor, case manager or other appropriate staff member to make sure the complaint is not ignored or lost in a shuffle of paperwork, says Hayes. "We make it clear that reporting a complaint is an important part of providing care to that patient," she adds. "We don't make it a punitive process, we make it a learning process," she says.

High return rate means accurate data

When reviewing your patients' satisfaction with your service, the real challenge is to make sure you get a good return rate on your surveys, says **Karen Marshall Thompson**, RN, MS, administrator of Southern Ohio Medical Center Home Health Services in Portsmouth. "You need at least a 25% return rate to ensure reliable data," she says. "We increased our return rate by addressing the survey to a specific person," she explains. While it does take a little extra effort to personalize each letter with a survey, return rates do go up because patients like the personal touch and it doesn't make them feel like they are just part of a mass mailing, she explains.

Another simple way to increase survey return rates is to make sure that you have the patient's correct address, Thompson points out. "We often get their primary address for insurance purposes, but sometimes a patient might stay with family members during the home health episode or they might move during or immediately after we provide care," she explains. "All of our nurses know to communicate with the business office so that surveys will be mailed to the correct location," she adds.

"Keep your survey short," suggests Thompson. "We have a one-page survey that is succinct and easy to complete, and we include a postage-paid return envelope," she says. By keeping it simple, you further increase the chances the survey will be returned, she explains.

Once you get the surveys back in your office, look for trends in order to prioritize areas you need to improve, recommends Thompson. "People are generally satisfied with home health care but we are always looking for ways to improve because we are in a very competitive market," she says.

"Our patients think that their ability to reach us 24 hours each day is very important and when we noticed some ratings in this area that were not as high as we wanted, we looked at how we handled evenings and weekends," says Thompson. "We had always used an outside answering service for on-call and we tried a number of different services but we always had problems with missed calls or delays in getting messages to nurses," she says.

Thompson found the answer to her on-call answering service dilemma with her hospital's switchboard. "We analyzed the number of calls we actually received on weekends and evenings and we showed that the extra number of calls for the home health nurses would not result in a need for more switchboard operators and would not affect the operators' ability to handle hospital calls," she says. "Our home health phone line now rolls over to the

hospital switchboard operator after-hours and the operator will take messages and page nurses," she explains.

"We discovered that the hospital switchboard operators were perfect for this task because they are trained for customer service, they are accustomed to anxious callers, they know how to stay calm, and they are used to paging people," explains Thompson. "Our patients and our nurses are very happy with this change, which did improve our ability to respond to patients 24 hours a day," she adds.

At Mercy Homecare, patient satisfaction has improved because customer service has become an integral part of the agency's culture, says Hayes. The change didn't happen overnight but it can be accomplished, she says. "Just keep talking about customer service, don't make it a once a year topic for a meeting, make customer service a standing agenda item for every meeting that occurs in the agency." ■

Courtesy and smiles project good image

Effective telephone etiquette necessary

People who choose home health care as their profession are caring, people-oriented professionals, but home health managers should not assume that being caring and friendly always results in the best customer service, say experts interviewed by *Hospital Home Health*.

The patient's perception of the quality of care begins with the first telephone contact, points out **Karen Marshall Thompson**, RN, MS, administrator of Southern Ohio Medical Center Home Health Services in Portsmouth. "We train all of our employees on telephone customer service and we teach everyone to answer the phone with a smile," she says. Even though the caller cannot see the smile, there is a difference in the tone of your "hello" when you are smiling, she points out.

"We do provide some scripts for employees to follow when answering questions and we teach key words to use in telephone conversations that show the caller that we are listening to them and we want to help them," says Thompson. The most effective thing staff members learn in telephone etiquette training is to close every call by asking, "Is there anything else I can help you with today?" she says.

"Patients are often surprised by this question because it shows that we are not trying to rush them so we can move on to something else and that we are willing to spend time with them to handle their question," Thompson points out. "It is a great way to end a telephone call because the patient feels good when the call ends," she adds.

When employees do receive complaints, it is important that they know how to handle them, points out **Maureen Hayes**, RN, professional service manager of Mercy Homecare in Cadillac, MI. "We teach everyone that a concern or complaint from a patient is an opportunity for us to improve, not a reason for us to become defensive," she says. "It is important that every patient concern or complaint be reported to a supervisor or manager so that we can identify trends and find ways to address complaints," she says.

Employees need to feel comfortable reporting complaints and that means they have to know that there are no repercussions for reports, says Hayes. Even if a complaint appears to be directed at an employee, such as a nurse arriving late for a visit, there may be factors beyond the nurse's control, such as traffic at that time of day, which can be addressed by a revision of the schedule, she points out.

"We remind nurses that many of our patients are anxiously awaiting the visit as a social experience, as well as a health care visit," points out Thompson. "Our nurses call the evening before the visit to confirm a time so that the patient knows when we plan to be at their home," she says. "If a nurse does have a visit run longer than normal or if the nurse is running ahead of schedule, he or she will call patients to let them know of the change in schedule," she says.

The telephone calls demonstrate that nurses do respect their patients' time, says Thompson. "If the nurse is late and the patient has heard nothing, the patient assumes that his or her visit has been forgotten," she says. "Once a nurse realizes that he or she is going to be late, it just takes a few minutes to call patients to reassure them that they are not forgotten." ■

Use of non-solicitation, non-compete agreements

By Elizabeth E. Hogue, Esq
Elizabeth is an editorial board member for Hospital Home Health.

Competition among providers for referrals can be fierce. Managers are increasingly concerned about employees and independent contractors who leave organizations and take patients with them.

Providers have used a variety of strategies to combat the loss of patients to other providers when former employees or contractors take patients with them, including: non-solicitation agreements and non-compete agreements.

Non-solicitation agreements frequently require employees and independent contractors to agree not to solicit patients who currently receive services from the company at the time the relationship terminates. They may also prohibit former employees and independent contractors from soliciting employees and independent contractors of companies at the time relationships end to work elsewhere.

Of course, the difficulty with non-solicitation agreements is that it may be problematic to prove that "solicitation" occurred. Former employees and independent contractors may claim, for example, that patients who switched companies did so on their own without any encouragement from them, much less any solicitation.

Nonetheless, it may be helpful to ask employees and independent contractors to sign non-solicitation agreements because it may deter them from engaging in attempts to get patients and staff to change companies.

In view of the potential limitations of non-solicitation agreements, providers have also utilized non-compete agreements. These agreements may, for example, prohibit employees and independent contractors from working for other providers of similar services within a specific geographic area for a specified period of time. Or they may prohibit them from providing services to patients that they cared for at the agency for a specified period of time after the relationship with the agency ends.

Many providers recognize that the terms of non-compete agreements must be reasonable. What is reasonable is likely to be determined by a mediator, arbitrator or a judge in the courtroom. But, generally speaking, if the terms of non-compete agreements amount to deprivation of the ability to earn a living, they will be considered unreasonable.

With regard to non-compete agreements it is also important for providers to be meticulous about getting these agreements signed before they hire employees as opposed to after they have already been employed. It is important to get non-compete agreements signed before staff members are employed because the courts in some areas of the country have ruled that non-compete agreements with existing employees are unenforceable.

The crucial issue for many courts seems to be whether or not employees receive something called consideration in exchange for signing a non-compete agreement.

With regard to employees who sign agreements before they are hired, the consideration is clearly getting the job.

Employees who were asked to sign non-compete agreements after they are already employed have successfully argued in court that there was no consideration for the agreement, so they are unenforceable. Of course, employees asked to sign non-competes can always quit their jobs. But some former employees have claimed that they could not realistically do so. Since signing a non-compete agreement did not guarantee continued employment, it was unfair, without consideration and, therefore, unenforceable.

On the contrary, other courts have concluded that when existing employees sign non-compete agreements and continue to be employed, their continued employment was consideration for signing non-compete agreements. After all, employers could have fired them if they refused to sign the non-compete agreements.

What should providers do in response to the different conclusions reached by courts in various jurisdictions about these issues?

• Asking employees to sign non-compete agreements as a prerequisite to hiring them may increase the likelihood that non-compete agreements will be enforced.

• Providers should ask current employees to sign non-compete agreements before potential problems with a continued employment relationship are encountered, the company contemplates layoffs, etc. To the extent that employment continues after employees sign non-compete agreements, they are more likely to be enforced.

• Enforcement of non-compete agreements is a rapidly changing area of law. Managers should periodically review their agreements and any applicable state statutes and regulations and make amendments to them as needed to help ensure enforcement.

Competition among providers continues to heat up. Providers cannot afford to lose patients to others when staff members leave to work elsewhere. All reasonable steps must be taken to ensure that patients are not lost, including the use of non-solicitation and non-compete agreements. ■

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