Providing the highest quality information for 23 years

Hospital Home Health®

the monthly update for executives and health care professionals

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial Disclosure:
Editor Sheryl Jackson, Managing Editor Jill Robbins, Editorial Group Head Coles McKagen, Board Member Elizabeth Hogue, and Consulting Editor Marcia Reissig report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

MAY 2006
VOL. 23, NO. 5 • (pages 49-60)

Know therapists' concerns when hiring for a home health agency

Recognize emphasis on outcomes and teamwork

Everyone knows the challenge of finding qualified home health nurses, and home health managers have found creative ways to find, train, and retain the good RNs that they do find. With the emphasis on outcomes, the impending arrival of pay-for-performance, and the importance of therapy on outcome improvement, the new challenge for managers is finding and retaining qualified therapists.

Finding the right therapist for home health is similar to finding the right RN, says **Cindy Krafft**, MSPT, COS-C, director of rehabilitation for OSF Home Care in Peoria, IL, and vice president of the home health section of the American Physical Therapy Association. "There are more therapists graduating in recent years; but because home health agencies don't typically take new graduates, we have not been able to tap into this group of candidates," she explains.

While hiring new graduates for home health positions might fill some therapist openings, it is not the answer for most home health agencies, admits Krafft. "A therapist needs one to two years of clinical experience before he or she can go into the field with no direct supervision," she says. One exception to this rule in her agency is a physical therapy assistant who was the primary caregiver for a family member prior to her graduation. "She is used to working on her own and is familiar with working in a home, so she was a good fit for us," she explains.

Another exception also could be therapists for whom physical, occupational or speech therapy is a second career, says **Mary Calys**, MSPT, formerly a rehabilitation supervisor at North Kansas City (MO) Hospital Home Health. "I was a nontraditional student because I had previously been a social worker," she recalls. "I was hired by a home health agency upon graduation and I had no trouble with home health because I was accustomed to working on my own," she explains.

Calys also has hired new graduates for the agency but she does admit that you have to evaluate the new graduate carefully. "I have hired second- or third-year doctoral students and I've hired new graduates who are nontraditional students with previous career experience," she says. "The most important things to look for in a new graduate are a person

who wants to treat the patient in a holistic manner and a person who is seasoned or experienced enough in life not to need daily supervision and coaching," Calys explains. "Remember that a therapist doesn't need to know everything, but does need to know where to go to get the information," she adds.

Therapists don't see HHA as an option

With these few exceptions, the fact that home health agencies don't typically hire new graduates means that managers usually are trying to get therapists to leave more traditional settings.

"Home health is not usually presented to therapists as an option during their education," says Krafft. "They don't perceive it as a full-time opportunity, just as a part-time, occasional opportunity to earn some extra money," she says. "Most therapists believe that home health care has a nursing focus only, and that therapy is not considered a key part of patient care."

One way to educate therapists while they are still in school is to work with local schools to offer internships, suggests Krafft. Even if you won't hire someone immediately after graduation, you get a chance to introduce home health to therapists while they still are open-minded, she explains. "I also talk to as many classes as I can to present a true picture of home health-based therapy and the impact it has on patients' lives."

To address these concerns when you are interviewing potential new hires, be sure you know a therapist's language and focus, suggests Krafft. "Therapists focus on outcomes, so be sure you explain your agency's need for another therapist in terms of improving patient outcomes," she says. Share some of your agency's outcomes with the candidate to show what areas you want to focus on for improvement, Krafft recommends. Talking to the therapist in terms of clinical expertise and outcomes will demonstrate your understanding of therapy's role and your acknowledgement of its importance, she adds. **(See story on p. 51 for other tips on recognizing therapists' importance.)**

Keep in mind that many therapists in traditional settings believe that all home health patients are bed-bound and living in horrible conditions, says Krafft. "It's up to the home health manager to present a more accurate picture of the type of patients who receive therapy," she says. "The chance to spend 45 minutes to one hour one-on-one with a patient is a big attraction, so emphasize the fact that the therapist will get to see the patient for this length of time," she says.

While interviewing candidates, be sure you point out that a home health therapist must be creative and self-motivated, says Calys. "One disadvantage to home health is that you don't have a staff of other therapists around you to brainstorm different ways to help your patient," she admits. That's why it is important to have a rehabilitation supervisor available who can be a source of information, represent therapists on the administrative level, and be a brainstorming partner, she adds. "You need someone on staff who can focus on researching advances in therapy and share that information with the staff," she says.

Hospital Home Health® (ISSN# 0884-8998) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Home Health**®, P. O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: ahc.customerservice@thomson.com. World Wide Web: http://www.ahcpub.com. Hours: 8:30-6 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 contact hours per year.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This activity is intended for nurses, mangers, directors, and management involved in hospital-owned home care agencies, including health care professionals involved with home care issues such as end-of-life care, pain management, multicultural issues, elder care, and similar issues. It is in effect for 24 months from the date of publication.

Editor: **Sheryl Jackson**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions
For questions or comments, call **Jill Robbins** at (404) 262-5557.

Even with a rehabilitation supervisor, make sure your therapists are part of a multidisciplinary team that develops and oversees patient care, says Krafft. "The team leader is usually an RN, but if your RNs recognize the importance of therapy and include the therapist in the development of the care plan from the beginning, not only will patient outcomes improve, but retention of the therapy staff will also improve," she says.

When interviewing therapists, remember that many therapists go into physical therapy or occupational therapy with the mindset that they will work with young people recovering from athletic injuries, says Calys. "Few therapists think they will choose to work with geriatric patients so it's important to point out the benefits of working with older patients," she says. "Not only are geriatric patients more fun to work with because of their responsiveness to your help, but therapy has a great impact on the patient's quality of life."

Young therapists like flexibility

Another attractive feature of working in home health is the flexibility of the job, says Calys.

"Therapists with young children like the ability to see their child's play or attend a teacher conference during the day, even when they know that they will be finishing their documentation at night," she says. "All of our therapists use laptops for their documentation, and some staff members finish their documentation during the day, others complete it at night, whichever is best for their personal schedule."

The use of technology for documentation is a great benefit to promote your agency to potential employees, says Calys. "You want to hire people that are computer-literate because it does save time on most visits," she says. An admission will always take the same amount of time, but documentation of subsequent visits or evaluations do take less time with the laptop, Calys adds. "Therapists also like having access to the entire chart so they can see what may have happened on other visits," she adds.

While word-of-mouth is the best way to find qualified therapists, be sure you study competitors' ads for therapists, suggest Krafft. "Signing bonuses are becoming popular now, but that tends to backfire as employees jump from place to place, staying just long enough to keep the bonus," she adds. Recruiters can be helpful if you are looking for therapists in small communities or rural areas, Krafft says. "Recruiters should be the last step because they can be expensive but they do have access to people we won't find in more traditional ways," she explains.

The key to attracting and keeping good therapists is to treat them like professionals, respect their perspective on patient care, and give them a chance to grow, says Calys. "It's taken some time for home health to figure out how therapy fits into home health because therapy has not always been part of a home health agency. Now, we see the value of therapy with an emphasis on outcomes, and working in home health can be very rewarding for a therapist." ■

SOURCES

For more information about recruitment of therapists for home health, contact:

- **Mary Calys**, e-mail: mcalys@gmail.com.
- **Cindy Krafft**, MSPT, COS-C, Director of Rehabilitation, OSF Home Care, 2265 W. Altorfer Drive, Peoria, IL 61615. Telephone: (309) 683-7830. E-mail: cindy.krafft @osfhealthcare.org.

Recognize therapists as part of team to retain staff

Inservices, forms need to address more than nursing

Discovering what attracts and keeps qualified therapists at a home health agency is important for all agencies, and some are doing very well. **Mary Calys**, MSPT, formerly a rehabilitation supervisor at North Kansas City (MO) Hospital Home Health, says therapists don't leave her agency to work for another one, so her efforts to hire therapists during her four years at the agency have been the result of expansion rather than turnover.

While Calys took the position as rehabilitation supervisor of an established department at North Kansas, she faces a different challenge in the position she started in late April at a new agency for which she has to hire an entire therapy staff. "There will be a number of challenges including a need for therapists to be licensed in two states because the agency serves a geographic area that crosses state lines," she says.

Even with the challenges, Calys points out that the basic steps of making sure you respect the therapist's expertise and knowledge still will be important. A few ways to demonstrate your

agency's recognition of therapy as a key part of patient care are:

• **Offer rehab-focused inservices.**

Continuing education is important to therapists so make sure your inservice offerings don't just focus on OASIS or nursing topics, Calys recommends. Offer sessions that cover new evidence-based rehab therapies, new clinical tools for therapists, or other rehab topics in which therapists have expressed an interest, she says.

Not only should therapy educational presentations be open to nurses but make sure your nursing-focused educational sessions are open to therapists who may want to attend, says **Cindy Krafft**, MSPT, COS-C, director of rehabilitation for OSF Home Care in Peoria, IL.

"I've seen agencies schedule nursing inservices for which therapists were told that they didn't need to come." While therapists and nurses may not have an interest in a topic being presented for the other group, don't exclude them, she says. The best way to keep everyone working as a team is not to segregate them, she adds.

• **Don't make therapists use nursing forms.**

Look carefully at the forms your agency uses to see if you are a nurse-oriented agency as opposed to a clinician-oriented agency, suggests Krafft. "Remember that most therapists think of home health as a nursing-dominated field," she says. "If all of your forms have a line that says 'nurse signature,' you are reinforcing that perception." Change signature lines to say "clinician signature" to show your respect for non-nursing clinicians, Krafft adds. ■

Therapies use light, suction to speed wound healing

Improve outcomes with cost-effective techniques

New technologies for wound care in the home decrease the amount of time needed for treatment and improve patient outcomes, while helping home health agencies manage costs more effectively.

The Centers for Medicare & Medicaid Services has approved two negative pressure wound therapy systems for reimbursement in home health settings. Both treatments rely on suction applied to wounds to reduce excess fluid in the wound, improve blood flow to the wound to improve healing, and to pull wound edges together.

"Suction is suction," says **Randy MacDonald**, RN, CWN, a wound care specialist with Arkansas Home Medical in Hot Springs. "The major difference between the two systems is the type of dressing used," he says. The V.A.C. System, manufactured by Kinetic Concepts in San Antonio, uses a foam dressing that must be applied three times a week, he says. The Versatile 1 Wound Vacuum System manufactured by BlueSky Medical in La Costa, CA, uses an antimicrobial gauze dressing that is changed two times a week, he explains. **(See resource box, p. 53, for vendor contact information.)**

"My experience is that home health nurses are accustomed to using wet to dry gauze dressings and find the BlueSky system easier to use," says MacDonald. "I also like the fact that a dressing change only requires two visits per week.

"A typical wound care patient reimbursement is $1,444 per episode," he continues. "For a home health agency to make money, nurses cannot visit patients every day to change dressings, so it is important for negative pressure wound therapy to be considered," he points out. His agency has chosen to use the BlueSky system but he says many agencies have used the Kinetic Concepts product successfully.

"Education is simple and nurses or family caregivers can easily learn how to use the system," says MacDonald. "There is minimal drainage with this treatment and the gauze bandage doesn't stick to the wound."

There are a few things to keep in mind when considering a negative pressure wound therapy system, he cautions. "If the dressing is disrupted, a nurse needs to come to the home to reapply because to be effective and to reduce the risk of infection, the product should not be off the wound more than two hours during treatment," he says.

Also, MacDonald points out that there are some situations in which negative pressure wound therapy should not be used:

- tumors or active cancer in the wound;
- gross infection;
- 30% of wound tissue is necrotic.

The treatment is very effective for pressure ulcers, trauma wounds, and surgical wounds, says MacDonald. "Negative pressure wound therapy is really a home run for home health agencies," he says. "Not only does Medicare reimburse for the treatment, but the agency is able to reduce visits and improve outcomes."

Another form of treatment for wounds is

looked at as some sort of voodoo by physicians and nurses initially, admits **Sharon Burt**, RN, CWOCN, coordinator for wound, ostomy, and Anodyne treatments at Physician's Home Health Care in Colorado Springs, CO. Monochromatic infrared photo energy (MIRE) can be used to cause red blood cells within the wound to release nitrous oxide, which acts as a vasodilator, she explains. "This increases blood flow, which speeds healing."

The light treatment also encourages the growth of collagen so that scarring is minimized, Burt says. "An added benefit is the reduction of pain," she adds.

Burt uses the therapy system manufactured by Anodyne Therapy in Tampa, FL. "There are four pads with 60 diodes to each pad, and they are sized so that you can place them easily anywhere on the body," she explains. Light from the pads penetrates about 5 cm and begins to affect the wound in just a few treatments, Burt adds.

"For most wounds, you begin treating the tunnel first. Then as the tunnel heals, you move the pads to heal the rest of the wound," she says. The effect can be dramatic, especially with diabetic patients with poor circulation that makes wound care difficult, Burt says. "One of my patients with peripheral neuropathy as a result of diabetes had a wound that would not heal after 16 months of treatment with a variety of treatments," she says. "After six weeks of MIRE, the wound had healed completely."

Because there is no electrical current or deep heat associated with MIRE treatment, it is safe to use on patients with pacemakers, metal pins or screws and defribillators, says Burt.

Even with the high degree of patient safety, there are precautions, she warns. Superficial burns can occur if you don't carefully assess the area to be treated and set the energy settings appropriately. The other potential complication is hypoglycemia, she says. "Patients with diabetes should eat before their treatments and monitor blood sugar levels following treatments to adjust their insulin," she adds. Anodyne pads should not be placed over or near the womb of a pregnant woman and should not be used over an active malignancy, Burt explains.

While Medicare does not reimburse for Anodyne treatments for wound care not associated with peripheral neuropathy, Burt's agency chose to purchase units for wound care patients. "We do not charge the patient for our use of this therapy while they are our wound care patient," she says. "We absorb the cost because it helps us control our costs in terms of fewer visits, less complications, and better outcomes for our patients."

The treatments can be administered by nurses or therapists with minimal training, so there is no need to add staff, says Burt. The machine is so easy to use that some patients who have peripheral neuropathy have purchased their own machines to treat their condition after their discharge from home care.

"While peripheral neuropathy cannot be cured, MIRE does restore sensation with regular treatments," she explains. The cost of a four-pad machine designed for frequent, clinical use is about $3,000, and the cost of an eight-pad machine designed for health care providers is $6,300, says Burt. Because Medicare will pay for some of the cost of a machine designed for patients' private use, a patient might pay about $500 for a four-pad machine intended for home use, she adds.

Although physicians are skeptical when the treatment is first suggested, Burt says they are pleased with the results. "The outcomes are dramatic, the patient is happy, and 80% of our physicians now readily accept our recommendation for this treatment," she says. ■

SOURCES AND RESOURCES

For more information about wound care treatments, contact:

- **Sharon Burt**, RN, CWOCN, Coordinator, Wound, Ostomy, and Anodyne Treatments, Physician's Home Health Care, 5085 List Drive, Suite 200, Colorado Springs, CO 80919. Phone: (719) 531-9585. E-mail: sburt@phhc.com.
- **Randy MacDonald** RN, CWN, Wound Care Specialist, Arkansas Home Medical, 104 Hillcrest Street, Hot Springs, AK 71901. Phone: (501) 993-5380. E-mail: steamyh20@sbcglobal.net.

For product information, contact:

- **Anodyne Therapy System**, 13570 Wright Circle, Tampa, FL 33626. Phone: (800) 521-6664 or (813) 342-4432. Fax: (800) 496-8323 or (813) 342-4417. Web site: www.anodynetherapy.com.
- **BlueSky Medical**, Versatile 1 Wound Vacuum System, 6965 El Camino Real, Suite 105-602, La Costa, CA 92009. Phone: (760) 727-1477. Fax: (760) 727-0236. Web site: www.blueskymedical.com.
- **Kinetic Concepts**, V.A.C. System, 8023 Vantage Drive, San Antonio, TX 78230-4726. Phone: (800) 275-4524. Web site: www.kci1.com.

Coping skills intervention reduces caregivers' stress

Intervention requires three brief sessions

New research shows that a three-session educational intervention with caregivers of cancer patients in hospice can significantly improve the caregivers' quality of life and reduce burdens related to the patients' symptoms and duties.[1]

Investigators adapted a psycho-educational intervention used in stress research, called Brief COPE, to use for hospice cancer patients, says **Susan McMillan**, PhD, ARNP, Lyall & Beatrice Thompson professor of oncology quality-of-life nursing at the University of South Florida College of Nursing in Tampa, FL.[1,2]

"We realized that the difference in hospice and other cancer patients is by the time they get to hospice they are very ill and fragile and weak," she says. "So we couldn't use an intervention of self-care practices as you might do with healthier patients."

Instead, the intervention is designed for the caregivers since most hospice care in the United States takes place at home, McMillan adds. "Hospices support family caregivers, so our intervention was designed to support, aid, train, and help the family caregiver," she says.

COPE is an acronym that describes the intervention as follows:

- **C for Creativity:** "We want the caregiver to be creative in managing the symptoms," McMillan says.
- **O for Optimism:** "We want caregivers to believe they can manage the symptoms," she says. "We find a lot of situations where people believe pain cannot be relieved, and so they give up and don't try."
- **P for Planning:** Caregivers need to plan around events that might cause symptoms, such as pain and shortness of breath, and help patients better cope with them, she says. "For instance, if the family is going to have a get-together, then plan the pain medication around that event so the patient can be comfortable for most of the event."
- **E for Expert:** When in doubt, caregivers should consult expert sources, such as hospice staff and the COPE manual that they're given, McMillan says.

The manual is in a 3-inch binder, and its sections are written in an accessible style so caregivers can easily refer to chapters of particular interest when they have questions or problems, she explains. **(See sample from COPE manual, p. 55.)**

Investigators added a chapter on constipation to the COPE manual, McMillan notes.

"Whenever you manage a patient's care with opioids, you almost always cause constipation, so it's foolish to think you'll manage pain and ignore constipation," she says. "It's an underassessed problem throughout the health care arena."

After modifying the intervention for the hospice caregiver, investigators began to test it to see if it would be effective and immediately translatable to the bedside, McMillan says.

When designing the study with the intervention group and the group that received standard care, researchers decided to add a third arm that would receive standard care plus three extra visits in the home, McMillan says.

"As we were designing the study, we thought the intervention group might benefit from the extra attention," she explains. "Maybe just the effect of the time was what we were measuring, so we added a second control group that we called attention control."

The results showed that the COPE intervention group of caregivers had a significantly better quality of life than both the standard care group and the standard care plus extra time group, McMillan says.

"The intervention group experienced less stress from the patients' symptoms," she says. "Our randomized scheme worked, and it was the training we gave the caregivers that made the difference."

Also, the study found that the COPE intervention decreased the burden related to patients' symptoms and caregiving tasks, meaning the caregivers were better able to tolerate patients' pain and constipation or the personal care tasks.[1]

The study findings suggest that COPE intervention is a way to improve caregivers' well-being and enhance existing hospice care.[1]

Typically, cancer patients do not stay in hospice care for long, so the intervention was designed to be presented with three visits in nine days, McMillan says.

Registered nurses provided the intervention visits, and the first one was conducted within the first two to three days of admission, the second was on days 5 or 6, and the third was on days 7 to 9, she says.

The study enrolled only patients who had at

Caregiver manual offers tips on caring for cancer patients

Researchers created a simple, three-visit intervention to assist caregivers of cancer patients in hospice because of advanced cancer. Part of the intervention includes a manual from the American College of Physicians called the "Home Care Guide for Advanced Cancer."

The revised manual includes tips that caregivers can use to help relieve their family member's pain, shortness of breath, and other symptoms. In the chapter on cancer pain, there are tips on ways to relieve pain resulting from cancer. Also included in this section are suggestions for managing the more common side effects of pain medicine. The excerpt below provides a sample look of the tips on managing these side effects:

• Prevent constipation with stool softeners and laxatives.

Narcotics are dehydrating. They take water from the stool, which results in constipation. Stool softeners are pills that put the water back in, making the stool softer and easier to pass. Some people take one or two stool softeners in the morning and one or two at bedtime to prevent the problem.

If stool softeners and laxatives do not work and the patient has not had a bowel movement in two or three days, give a product that is purely a laxative, such as Milk of Magnesia. You also may have to increase the number of stool softeners and stimulants taken each day. One Dulcolax rectal suppository every day can be very helpful. Problems with constipation mean that you need the help of hospice workers. If your family does not have help from a hospice, call the pain clinic or hospital and ask for a referral. These staff members know how to solve problems of constipation and pain, and they will help you with many aspects of caring at home for someone who has advanced cancer.

• Relieve a dry mouth with crushed ice, hard candy, and frequent rinses with water or products that do not contain alcohol.

• Relieve painful, dry nasal passages by humidifying the air or breathing in moisture from a sink full of warm water.

• Avoid an upset stomach by taking medicine with food or antacids unless instructed otherwise.

• Expect drowsiness for a few days when pain medicine is started or increased.

If sleepiness increases just after starting or increasing pain medicine, wait about three days. Sometimes sleepiness occurs because a person is finally getting relief from his or her pain and needs to catch up on missed rest, or the body just needs time to adjust to new medicines or doses. ■

least two of three main symptoms, including pain, shortness of breath, and constipation, McMillan says.

The interventions basically were implemented in this way:

• **First visit:** The RN introduced herself and spoke about the COPE approach, explaining what each letter in the acronym stands for, McMillan says.

"Then we focused on one of the patient's symptoms, letting the caregiver decide which was the priority symptom," she says. "We taught the caregiver how to do the COPE intervention, and gave the caregiver homework about the second symptom."

The first session lasted about 45 minutes, although initially it was supposed to be 1½ hours long, McMillan notes.

"We cut the time in half because of the caregiver's attention span," she says.

Also, the intervention's first approach was to show caregivers a short video demonstrating the COPE method, but investigators quickly found that patients didn't have the patience to sit through the video and then concentrate afterwards on what the nurse had to say, McMillan says.

"So we piloted the first 25 patients with the video, and then eliminated it and, instead, had the RN go through the intervention, using the COPE book," she says.

• **Second visit:** This session focused on the second symptom that concerned the caregiver, going over the homework assignment. Then the nurse briefly would go over the information from the first session, McMillan says.

This session lasts 30 minutes and includes an assignment regarding the third symptom.

• **Third visit:** This visit focuses on the third symptom, recapping the information provided for the second symptom.

Also, since this is the last visit, part of the half-hour session includes a closure process to make certain the caregiver understands that this particular nurse won't be returning to the home, McMillan says.

The study's COPE intervention is immediately translatable for hospices with cancer patients, and there already have been requests for the

SOURCE

For more information about reducing stress in caregivers, contact:

- **Susan McMillan**, PhD, ARNP, Lyall & Beatrice Thompson Professor of Oncology, Quality of Life Nursing, University of South Florida College of Nursing, MDC Box 22, 12901 Bruce B. Downs Blvd., Tampa, FL 33612. E-mail: smcmilla@hsc.usf.edu.

COPE manual from hospices around the world, McMillan says.

Eventually, the entire intervention and manual will be available electronically so that it might be easily sent to anyone who requests it, she adds.

"We manualized this intervention so that we could share it with other investigators or other hospices that asked for it," McMillan says. ■

References

1. McMillan SC, et al. Impact of coping skills intervention with family caregivers of hospice patients with cancer: A randomized clinical trial. *Cancer* 2006; 106:214-222.

2. Carver CS. You want to measure coping but your protocol's too long: Consider the brief COPE. *Int J Behav Med* 1997; 4:92-100. ■

Patients deserve info on quality-of-care cases

Regulations prohibit sharing of details

Medicare recipients who have a complaint about their quality of care have a means of reporting their complaints — but it's unlikely they will find out the details of investigations of their complaints, according to the American Health Quality Association (AHQA), which has launched an effort to enact major reforms in the complaints system.

The Centers for Medicare & Medicaid Services (CMS) investigates complaints by Medicare beneficiaries about quality of care by contracting with quality improvement organizations (QIOs) in each state to actually conduct the investigations. However, CMS prohibits QIOs from telling the complainants details of investigations involving physicians without permission from those physicians. Without permission, QIOs can only tell complainants whether their complaint was confirmed; they cannot reveal what went wrong or why.

AHQA, which represents the national network of QIOs, is proposing that QIOs inform beneficiaries of findings, launch a national campaign to promote more timely and direct patient feedback to providers, and help providers correct confirmed problems reported by consumers.

AHQA: Tell beneficiaries what happens

According to CMS, QIOs have two methods of resolving clinical quality-of-care beneficiary complaints: medical record review and mediation.

When a case is reviewed for quality issues, one of two determinations is made — either "no substantial improvement opportunities are identified," or "care could have been better."

The Medicare patient is not given details uncovered by the QIO. In cases where it is deemed that care could have been better, the QIO reviewer determines if care was "grossly and flagrantly unacceptable," failed to follow accepted guidelines or usual practice, or could reasonably have been expected to be better. Again, while CMS permits complainants to be kept informed as to the progress of the sometimes months-long investigation, no specifics involving physicians are disclosed.

Cases for which no improvement opportunities are identified or where better care could have been expected can be considered for mediation if the person filing the complaint wants to pursue mediation. Due to the serious implications of cases in which care was grossly or flagrantly unacceptable, or where care failed to follow accepted guidelines or usual practice, those cases are not eligible for handling through mediation.

Medical record review is the traditional option to resolve a quality-of-care complaint under Medicare. When the QIO receives a written complaint about the quality of services received by a Medicare beneficiary, a doctor of matching specialty will review the medical record. When the review is complete, the QIO notifies the complainant of the final disposition of the complaint.

AHQA is proposing that the findings of QIO investigations of complaints be given to Medicare beneficiaries who file complaints, along with information about actions taken to prevent the problem from recurring. The proposal would make QIO findings in complaint investigations inadmissible as evidence in malpractice suits.

"This approach strikes a proper balance," says **David Schulke**, AHQA executive vice president. "It isn't just Medicare that must appreciate that

SOURCE/RESOURCES

For more information about improving patients' quality of care, contact:

- **Jonathan Sugarman**, MD, MPH, CEO Qualis Health, P.O. Box 33400, Seattle, WA 98133. Phone: (206) 364-9700.
- **American Health Quality Association**, 1155 21st St. N.W., Suite 202, Washington, DC 20036. Phone: (202) 331-5790. Web site: www.ahqa.org.
- **The Sorry Works! Coalition**, P.O. Box 531, Glen Carbon, IL 62034. Phone: (618) 559-8168. Web site: www.sorryworks.net.

consumer concerns are important indicators of quality breakdowns. Providers, too, must learn to actively welcome consumer concerns, and take timely action to improve care so there is no need to bring in the QIO."

"The role of the Medicare QIO program should be to protect the entire population of Medicare beneficiaries, and to support improvement of America's health care system," says **Jonathan Sugarman,** MD, AHQA past president and the CEO of Qualis Health, a QIO in Seattle.

"Unfortunately, the current Medicare beneficiary complaint system as regulated by CMS has not been implemented in a manner that focuses on rapid resolution of disputes and systematic improvements in care, and has not kept up with our evolving understanding of quality improvement."

For example, Sugarman points out, CMS does not regularly analyze and report the specific types of quality-of-care concerns that are identified by QIOs, depriving QIOs the opportunity to share data on the quality complaints confirmed nationwide.

"AHQA's proposal encourages increased transparency to complainants, remediation of systems problems, and prompt referral to appropriate authorities when willful and reckless actions are identified, and it also supports prompt and candid communication between patients and practitioners when complaints arise," Sugarman adds.

AHQA's call to reform the beneficiary complaint program follows the association's adoption in 2005 of a new policy to assure that all QIOs conform to the highest standards for business practices, governance, and public accountability. The new code of conduct — formally adopted by more than two-thirds of QIOs — sets standards for board and executive compensation, diversity, travel expenses, and conflicts of interest.

To implement AHQA's proposals for reform of the beneficiary complaint process, Congress will need to revise the law governing operation of the QIO program. Responding to beneficiary complaints is a small part of current QIO initiatives, which focus mainly on proactive efforts to improve care by providing technical assistance to hospitals, physicians, nursing homes, and home health agencies. Congress will examine how to modernize the QIO program after receiving a report on the program from the Institute of Medicine.

Some efforts at reducing medical errors and contentious malpractice lawsuits hinge on getting information into the hands of those who believe they have suffered a breach in quality of care, not in withholding that information. The Sorry Works! Coalition has been successful in getting several states to pass legislation urging health care providers and hospitals to openly investigate allegations of medical errors, and to share their findings with complainants.

Theorizing that many lawsuits arise out of frustration over not receiving answers about what happened or assurances that measures are taken to prevent repeat occurrences, Sorry Works! and efforts like it work to educate health care providers that openly addressing errors — or allegations of error — can do more to ensure a good outcome than a room full of lawyers. Like the AHQA proposal, Sorry Works! plans contain protections for physicians and other providers so that the information shared cannot be used against them in malpractice actions. ■

LegalEase

Understanding Laws, Rules, Regulations

Liability of MCOs for contracted services

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

Many providers and case managers remain concerned about low rates paid for services by managed care organizations (MCOs) and the effect of these rates on the quality of care rendered by providers.

In a recent case, an appellate court decided that MCOs have a duty of care not to contract with organizations that they know or should have known would provide deficient care. In addition, MCOs have a duty not to set payment rates in their contracts so low that they are likely to result in the provision of substandard services to patients.

In other words, MCOs may be held liable for the actions of their contractors, including organizations that provide case management and utilization review services and providers who render care to patients, especially when rates are so low that they encourage substandard care.

In *Pagarigan v. Aetna U.S. Healthcare of California Inc.*, Johnnie Pagarigan died while she was a patient in a nursing home. Her family claimed in a subsequent lawsuit that the care Pagarigan received in the nursing home was substandard. She became malnourished, dehydrated, developed a huge pressure sore on her lower back, and a severe infection and abscess at the site of the gastric tube insertion. Her abdomen became protuberant and discolored.

Despite the nature of her condition, she was not transferred to a hospital for several months. By the time she was hospitalized, her condition could not be effectively treated.

Pagarigan's family claimed that she was not transferred from the nursing home to a hospital for economic reasons. As long as Pagarigan remained in the nursing home, her care was paid for by the Medicaid or MediCal program, as it is called in California. But if she was hospitalized, Aetna was responsible to pay for her care.

The court in this case decided that MCOs have a duty of due care when contracting with health care providers who render services directly to patients and who provide other services on behalf of MCOs such as case management and utilization services. They must choose contractors who render appropriate care or decisions. MCOs also have a duty to avoid executing contracts with providers and other organizations containing terms, especially low levels of payments, which may require or encourage substandard care.

First, health care providers and other entities that contract with MCOs may be tempted to conclude that they have no liability for substandard care if they are paid low rates. On the contrary, the Pagarigan case makes it clear that the direct providers of services share liability for substandard care with MCOs. So providers and other types of organizations that provide services on behalf of MCOs cannot avoid liability for poor quality of services because the rates MCOs pay are low.

Don't trade volume for low reimbursement

The bottom line is, of course, that providers of services to MCOs should not contract with them for rates that do not permit them to provide appropriate care. Providers must be very careful to avoid trading volume of patients for reimbursement that is so low that they cannot possibly provide care consistent with applicable national standards. The risks of low rates and resulting poor quality of care cannot be shifted to MCOs but the risks can be shared with them.

It may be helpful to utilize this point in negotiations with MCOs. This court decision should put MCOs on notice that they should provide reimbursement to all of their contractors at levels that are likely to support quality of care.

But if rates are inadequate, the best course of action may be to refuse to contract at all. In fact, the more providers that refuse to contract with MCOs, the more likely it may be that MCOs will offer higher rates.

Providers must be very careful, however, to avoid possible antitrust violations. When providers or others who provide services on behalf of MCOs get together and decide to refuse to provide services unless rates are raised, they may violate state and federal antitrust laws. Specifically, this conduct may constitute so called "group boycotts," which are usually determined to be illegal.

Providers and case managers are once again grappling with problematic relationships with MCOs. Recognition of potential liabilities should provide MCOs with incentives to provide reasonable payments. If not, providers and others have a clear obligation to avoid being squeezed between low rates of payment and applicable standards of care. ■

Comply with JCAHO's goal to label all medications

Many organizations are not in compliance

The JCAHO's National Patient Safety Goal requiring all medications to be labeled sounds simple enough, but it's proving to be difficult for many organizations. "I think the biggest challenges for an organization center around the back table labeling of syringes and containers," says **Susan Mellott**, PhD, RN, CLNC, CPHQ, FNAHQ, CEO of Houston-based Mellott & Associates. "While the operative areas may be already doing this, this has not always been occurring outside of those areas."

Even within the operative areas, staff may not have been labeling syringes or basins that contain normal saline or other nonmedication fluids, says Mellott. "I am sure that a clarification will be coming out stating that any procedure area will have to comply with this goal. If there is not such a clarification at this time, organizations would be well advised to implement this goal in the nonperioperative settings, as it is really best practice," she says.

Newly revised requirements for the safety goal have been changed to make them more consistent with the requirements in Medication Management standard MM.4.30. The new requirements are as follows:

- Labels include drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in fewer than 24 hours.
- All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

The revision deletes a previous requirement to include on the label the initials of the person preparing the medication or solution and the date of preparation. Neither of these items is required under MM.4.30 and, after review by the Sentinel Event Advisory Group, it was determined that they provide "no additional safety to the preparation and labeling process," according to a JCAHO announcement.

Inventory the types of fluids and medications used during procedures and then obtain preprinted labels for these solutions, recommends Mellott. "There could be a standard set for the facility and specialty labels for areas that require more labels than the common ones, such as the cardiac catheterization lab," she says. "The organization should then monitor for compliance after implementation." ■

SOURCE

For more information about JCAHO's Safety Goals, contact:

- **Susan Mellott**, Mellott & Associates, 5322 W. Bellfort Suite 208, Houston, TX 77035. Telephone: (713) 726-9919. Fax: (713) 726-9964. E-mail: mellott @mellott andassociates.com.

NEWS BRIEFS

Folk remedies popular among older rural residents

Researchers at Wake Forest University School of Medicine in Winston-Salem, NC, have found that alternative medicine is just as popular in rural areas as in urban ones.[1]

The difference between the two areas is that older, rural residents of North Carolina are more likely to use folk remedies, such as vitamins, Epsom salts, or a vinegar "tonic," rather than massage therapy, acupuncture or herbal medicines.

The study surveyed 701 diabetic patients to determine how many were using folk or home remedies to treat their condition. Study participants reported that they are not using alternative therapies to treat chronic conditions, such as diabetes, but are using home remedies to treat sore throats, headaches, and injuries.

More than half (52%) of the respondents used food home remedies (honey, lemon, and garlic), and 57% used other home remedies (tobacco, Epsom salts, and salves). Vitamins were used by 45% of the study participants and minerals were used by 17%. Only 6% used herbs to treat themselves.

Blacks and Native Americans were more likely to use home remedies than whites. Eighty-one percent of black participants and 76% of Native

American participants reported using home remedies.

Researchers point out the importance of home health providers understanding all of the remedies patients might use to make sure that patients understand the reason for different prescribed treatments and their potential interaction with home remedies.

Reference

1. Arcury TA, Bell RA, Snively BM, et al. Complementary and alternative medicine use as health self-management: Rural older adults with diabetes. *J Geront B Psychol Sci Soc Sci* 2006; 61(2):S62-S70. ■

CE *questions*

5. How does Cindy Krafft, MSPT, COS-C, recommend that home health managers improve therapists' perception of home care as an option?
A. Remove all responsibility for paperwork from their jobs.
B. Offer huge signing bonuses.
C. Keep therapists and nurses in their own departments.
D. Set up internships with local schools and talk to classes.

6. What does Randy MacDonald, RN, CWN, recommend that a home health agency keep in mind when evaluating negative pressure wound therapy systems?
A. Number of dressing changes per week
B. Type of dressing required
C. Outcomes
D. All of the above

7. What does the acronym COPE stand for?
A. creativity, optimism, planning, and expert
B. caregiving, optimism, preparing, and effort
C. caring, optimism, planning, and expert
D. creativity, openness, planning, and expert

8. Current law gives the Centers for Medicare & Medicaid Services the power to investigate complaints filed by Medicare patients, but not to take any action when the complaints are found to be true.
A. True
B. False

Answer Key: 5. D; 6. D; 7. A; 8. B.

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:
1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CE instructions

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