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Hospice creates ideal tool kit for staff to use in caregiver education

Focus on clients' needs and building rapport

Hospice staff must provide spend a significant amount of time educating patients and caregivers, but the dilemma is how to do it efficiently and effectively.

The Community Hospice Inc. of Albany, NY, may have the solution in its newly-developed professional education tool kit.

"One activity that everybody in hospice does is patient education," notes **Carol Shenise**, MS, RN, corporate education specialist for the hospice.

"We wanted to support our staff with patient education and help them become more effective," Shenise says. "We began to think about what we could do that would support our staff and provide them with the tools that would make their patient teaching effective."

The result is a well-organized tool kit that is divided according to a list of principles and suggestions for enhancing patient/caregiver education. There are 26 "tools," which essentially create a framework for how to teach patients and their family caregivers. (*See sample of tools in education tool kit, p. 64.*)

"There is a tremendous amount of information that we need to communicate to patients and family caregivers, and what we needed were some tools to help staff members better understand how to communicate," says Patricia Martino, RN, CHPN, AAS, case manager/team leader. Martino and Shenise spoke about building a professional education tool kit at the National Hospice & Palliative Care Organization's (NHPCO's) 7th Clinical Team Conference & Scientific Symposium, held April 26-28, 2006, in San Diego, CA.

The tools are meant to be used by any hospice health care professional, and they can build upon them, Shenise says.

The idea is to change hospice professionals' thinking and approach to teaching, Shenise says.

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"The social worker or chaplain would use the same tools, but just gear them toward their own discipline and the purpose of their visit," Shenise says.

It's not a tangible tool, but a philosophical approach to dealing with a given educational opportunity, Martino says.

Here is how Shenise and Martino developed the tool kit and its main features:

1. First focus on nursing assessment.

With nursing experience, both Shenise and Martino knew that the first step was to look at the nursing process and nursing assessments at the initial visit.

"Assess, plan, evaluate—we needed to do assessments and learn the needs from both the staff and the patient and family," Shenise says.

"What I've observed from working with new staff members is we have a lot of information we need to communicate to new patients and caregivers, a lot of medical jargon," Martino

says. "We needed some tools to help our staff members learn how to communicate better with patients and families."

The pair worked to marry the caregiver education piece and the clinical piece together so information can be presented to patients and their caregivers in a way that they easily can understand, Martino adds.

For example, one of the tools included in the tool kit is the advice to "Ask open-ended questions requiring more than a 'yes,' 'no,' or 'nod' answer."

2. Consider the patient and family caregiver's learning needs.

The tool kit encourages nurses to assess the patient's and family caregiver's needs and to determine how they are dealing with the disease, including the emotional and physical aspects, Shenise says.

"I reviewed the literature and pulled together all of the best practices in the literature for patients, caregivers, and families," Shenise says. "We spent time reading, digesting the information and deciding how best to use it with our staff."

One of the common problems with hospice nurses and staff who educate families is that they will give out a wealth of information, without knowing how the patient and family are absorbing it, Shenise notes.

"We're so intent on what our needs are that we don't step back and say, 'Assess and really determine what the patient/family already knows and what they want to know,'" Shenise says.

So the tool kit is designed to base the family caregiver/patient education on the family's needs, she adds.

"One of the things we both feel very strongly about is that emotions and feelings are very important considerations when we're taking care of patients at the end of life," Shenise says. "These play a big role in their learning, so we're trying to keep the education as simple as possible."

Educating hospice patients and caregivers is a growth process that should be fine-tuned according to individual needs, Marino says.

"When I'm sitting in my car before going into someone's home, I debrief myself and think about the situation I'm going into and what I know about it already, and I think about what my approach needs to be and what my primary goals are for that day," Marino says.

Then when Marino enters the home and begins to use the tool kit, she has a good

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foundation for family education, but she can adjust it according to what she knows are some particular issues.

"It takes time and commitment and the ability to change focus," Marino adds.

3. Design tools to assist in establishing rapport.

The 26 tools are designed to encourage more depth in the assessment conducted by the health care provider, Marino says.

The tools also help the provider make the philosophical switch from teaching clients what they think the client should learn to teach what the client would like and is ready to learn.

The typical hospice approach is for the nurse to meet the clients and then launch into their prepared speech about hospice care, Marino says.

Shenise has witnessed this teaching approach, and what typically happens next is that the patient and family caregiver will begin to stare with eyes glazed over, and they cannot absorb the information, Shenise says.

Instead, hospice professionals should assess the situation, give it some thought, adjust the education to the client's needs, and allow for feedback, Marino explains.

"Staff should start a conversation with the patient, find out what they want to know, and then establish a rapport with them in a safe and comfortable environment," Marino says.

One of the tools talks about creating a safe environment and establishing rapport with clients.

"When I meet the family and introduce myself and ask where they'd like to sit and talk about things, I make a general statement so I can ask about their needs and what they know about hospice care," Marino says.

Some conversation-openers that can be asked to help build rapport are as follows:

- * Tell me about how you first heard about hospice.
- * How have things been going?
- * What have you heard about hospice from your family or friends?
- * What have you heard from the doctor?
- * What are you worried about?

"So nurses use the first few tools to establish a safe environment and find out some information," Marino says.

4. Use teaching sheets and bullet points.

The hospice has teaching sheets that are part of the tool kit, and these have been used on a

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trial basis. The teaching sheets are simple with the key information on the front page and medication information on the back page, Shenise says.

Some are longer. The teaching sheet for chronic obstructive pulmonary disease (COPD), which is called the respiratory or dyspnea teaching sheet, for example, is four pages long.

Teaching sheets make use of bullet points to emphasize specific instructions, Marino says.

Hospice nurses show patients and their families the teaching sheets, and they go over the main points, emphasizing certain points. For instance, the respiratory teaching sheet explains how patients can breathe easier, and it includes tips on how to get medical control of a situation.

The nurse will write down the name of a drug, along with the amount that the patient will need, and the nurse provides very simple and individualized instructions, Shenise says.

Simplicity and accessibility are key, Marino notes.

"What I see in the field is that when patients are new they receive a lot of information, and we give a lot of information verbally," Marino says. "Then the nurse leaves, and at 2 a.m. when Mr. Jones can't breathe, Mrs. Jones wakes up and is nervous because she can't remember all the things the nurse said."

Even if the nurse wrote out some instructions, the caregiver might have trouble finding the handwritten note, so the teaching sheets provide an easy solution with simple, clear instructions, Marino adds.

6. Educate staff to use the tool kit.

The Community Hospice has been teaching staff how to use the tool kit, with the goal of

Here are sample tools from hospice education tool kit

Hospice staff follows these guidelines

The Community Hospice Inc. of Albany, NY, has created an education tool kit for nurses and other hospice staff to use when meeting and educating patients and their families.

With permission from the tool kit's creators, **Patricia Martino**, RN, CHPN, and Carol Shenise, MS, RN, here are a few examples of the "tools" included in the tool kit:

- *Tool #2: Find out what the patient/family knows; don't spend time repeating it.
- *Tool #5: Know your patient/family; their age specific and cultural practices.
- *Tool #10: Talk slowly, ask questions, and allow time for answers.
- *Tool #12: Discuss simple concepts first before moving to complex concepts.
- *Tool #15: Follow the WIIFM (What's in it for me) principle for explaining reasons and emphasizing benefits.
- *Tool #17: Use interactive formats and appropriate visual aids.
- *Tool #21: Leave written materials for patient/family reference.
- *Tool #25: Decide your goal for each patient/family interaction.

educating everyone through team meetings, informal and formal sessions, orientations, and inservices, Shenise says.

"For the most part, it's been informal," Shenise explains. "For instance, when Pat teaches an orientation, she incorporates the tool kit into the content of her discussion."

The 26 tool kit items are handed out to staff for discussion purposes.

"At team meetings we talk about individual family characteristics and how we can structure our approach to meet their needs," Marino says.

Ongoing training will involve new tools, sharing important literature, and other items that will be added to the tool kit, Shenise says.

"We'll bring new items forward and communicate with staff about them," she adds. "It's continual and the education doesn't end." ■

Significant symptom relief when cancer patients engage in art therapy

Anxiety, fatigue showed greatest improvement

New research shows that cancer patients who engage in one hour of art therapy show immediate improvement in eight of nine symptoms, with the greatest improvement noted in anxiety and tiredness.¹

Art therapy provides a benign way for people to deal with their feelings, says **Nancy Nainis**, MA, ATR, LCPC, an expressive arts therapist with Northwestern Memorial Hospital in Chicago, IL.

For example, a patient who may find it too overwhelming to express his anger over his cancer diagnosis might be able to express his anger through his art.

"I had someone who created angry Easter eggs once, and a lot of feeling came out while he was making those eggs," Nainis recalls.

Nainis and co-investigators studied the impact of a one-hour art therapy sessions provided on an individual basis by Nainis on 50 patients at an inpatient oncology unit in a large urban academic medical center.

Most of the patients, within an age range of 19 to 82, had leukemia or lymphoma and had been diagnosed within the prior two to three years.¹

Participants in the study included African Americans (26.5 percent), Hispanic/Latino (4.1 percent), and Asian (2 percent). About one-third were single, and 56 percent were married, while 10 percent were divorced.¹

Using the Edmonton Symptom Assessment Scale (ESAS) and the Spielberger State-Trait Anxiety Index (STAI-S), investigators measured the patient's severity of nine symptoms, on a scale from zero to 10, both before and after the art therapy intervention. The symptoms included pain, tiredness, nausea, depression, anxiety, drowsiness, lack of appetite, their well being, and shortness of breath.¹

With the exception of the symptom of nausea, there was a significant improvement noted in all of the symptoms after the art therapy intervention.¹

"I was absolutely blown away by the results," Nainis says. "This was a pre/post test, so I don't know if the improvement was sustained a day or two, but immediately afterwards there was this positive reaction."

The symptoms of anxiety and tiredness were highly significant, making this the first study finding that art therapy energizes people, Nainis says.

"It was cute because the research assistant said, 'What do you do with the patients? I go in and do the pre-test and they're very tired and just lying there and can barely talk. Then I go back, and they're sitting up and their eyes are sparkling,'" Nainis recalls.

Creative activities can be very empowering, but more research is needed to find out more about the whys and hows, she says.

"Everyone knows distractions help patients, but does art therapy do more than that?" Nainis says. "We need to do more research to really know."

At the very least, art therapy distracts patients and helps them focus their minds on something besides their symptoms and illness, Nainis says.

"When people were asked how art therapy affected their quality of life, some people said it made them feel more worthwhile, and most people said it was fun and relaxing," Nainis says.

Nainis has ideas about why art therapy provided some symptom relief to the cancer patients, but she would like to see research continue with the purpose of determining how art therapy helps.

"We just wanted to see if there was credible evidence that art therapy impacted symptoms, and we didn't match what the patient chose to do with what their symptoms were," Nainis says.

Future research could look at the impact on symptoms of individual types of art therapy, she suggests.

For example, she has found that when patients wrap something, such as wrapping yarn around a stick, it helps with pain. And some patients find it helpful to engage in a repetitive activity, working with soft materials, such as cloth and yarn, Nainis says.

With the art project of taking broken pieces of glass and making mosaics, there is an emotional metaphor inherent in the art work, Nainis notes.

"It's like taking bits and pieces of your life and making something of it," she says. "You're giving meaning to your life, and this helps us cope spiritually, mentally, and physically."

For the study intervention, Nainis showed patients a cart that held a variety of materials, and they were asked to select what they wanted from the cart.

The art therapy supplies included cards and envelopes, jewelry and beads, clay, journals, sketch pads, collage materials, paper pulp masks, fancy papers, paints, feathers, finger paint, felt, stained glass, foam shapes, tempera, glitter glue, watercolor, glue sticks, rainsticks, magazines, stained glass sun catchers, pipe cleaners, stamps, sequins, wooden boxes, tissue paper, wooden frames, yarn, pencils, charcoal, pastel chalk, markers, pens, and oil crayons.¹

Then Nainis followed a standardized script of introducing herself and explaining that the art project wasn't about talent, but about allowing oneself to try something new, Nainis says.

"I'd explain what the materials were and the possibilities," Nainis says. "Then, they selected a project, and I helped them with it."

Nainis had patients whose arm swelling was so severe that they couldn't manipulate the art objects on their own, so Nainis became their hands.

"So they'd pick a project and tell me what they wanted, and I would do it for them," she says.

"People tend to focus on images that are relevant to their issues," Nainis says. "One gentleman focused on a picture of a woman with a long neck, and that made him think of his wife."

The man talked about how much he cared for his wife and how his illness made him worried about what would happen with her when he died, Nainis recalls.

"We were able to talk about this issue because we looked at this picture that he chose to focus on," she says.

After patients selected their art goal, Nainis would ask more probing questions only when patients indicated they were interested, she says.

"A number of people would say, 'I just want to do this for fun, and then they'd ask me, 'If you were going to analyze this, what would you do?'" Nainis says. "I'd say, 'When you

chose those colors were you thinking of anything in particular?' and then I'd take the image and put it on the wall so this would change their point of view and provide a different perspective."

Art therapy is a natural fit with hospice care, Nainis notes.

"What's wonderful about hospice is when you go into the home you have access to their photos and their things," Nainis says. "One hospice patient was teaching her art therapist crocheting stitches, passing on her legacy, knowing it would go beyond her."

Other hospice patients have enjoyed putting together scrapbooks and other arts and crafts items to leave a legacy for their families.

"They use these to express some fears," Nainis says.

For example, Nainis worked with a cancer patient who had incurable cancer and knew she was dying.

"We had a project where she and her four nephews made a mural, and they each made representations of themselves and of their aunt, and then we created an environment to place all these things," Nainis says. "It helped everybody see what their relationships were and how they felt about each other, and it was a marvelous vehicle to share their love and feelings."

The boys were between eight and 13 years, and at that age they typically find it hard to verbalize feelings, she notes.

But through their mural artwork they were able to express themselves as plants or animals and create a flower that represented their aunt, Nainis says.

"Their aunt made animals to show how she saw her relationship with them and who they were in her eyes," she adds. "They made this castle, and she was kind of in the center, and it was beautiful and a wonderful way to share their love."

The woman brought the mural home and died shortly after the experience, Nainis says.

"I can see art therapy as being really helpful in situations like hospice, where families are brought together and given a way to focus their feelings without being overwhelmed," Nainis says. "Then you have this art, this evidence, this piece you can keep together and look at years later." ■

Reference:

1. Nainis N, et al. Relieving Symptoms in Cancer: Innovative Use of Art Therapy. *J Pain Symptom Manage*. 2006;31:162-169.

Rural hospices develop new strategies for surviving in a competitive world

The key is collaboration, flexibility

One of the biggest problems for rural hospices is that payments and regulations are calibrated toward urban hospices, and they largely overlook the challenges rural and small hospices face, a rural hospice expert says.

"It's hard in today's environment for a very small hospice to make it," says **Beth Virnig**, PhD, an associate professor at the University of Minnesota in Minneapolis. Virnig spoke about rural hospice survival strategies at Hospice Minnesota's 2006 End-of-Life Conference, held April 18-19, 2006, in St. Cloud, MN.

"We have some that choose not to be Medicare-certified because they're not capable of pulling it off," Virnig says. "Things are very fragile and vulnerable right now, and we do hear from a lot of rural hospices that they're caught between their need and an immense compassion to help others."

Some rural hospices believe that if they don't provide the services, nobody will, so they find themselves stretched further and further, she adds.

The Medicare regulations and financial reimbursement system makes it even more difficult for these hospices.

For example, all hospices are required to employ a social worker, but social workers tend to live in urban areas, and some small hospices do not have a large enough caseload to afford a full-time social worker, Virnig says.

If hospices were allowed some flexibility in how they cover the services social workers typically provide, then they might find a nurse who is trained in counseling or a counselor who could take on the social worker role, Virnig says.

"But the regulations say you have to have a social worker," she says. "So if you're a really small hospice with a daily census of eight, you don't need a full-time social worker, but if you were lucky enough to find a social worker, you'd have to pay 100 percent of the person's salary because it would be difficult to convince

someone to move to the area to pay only part-time."

This is just one example where the regulations do not match the rural hospice's reality, Virnig explains.

"Hospices have to pay disproportionately for a social worker in rural areas because they need to pay for more than what they need," Virnig says.

Rural and small hospices face other problems, as well.

For example, it's harder for these hospices to provide evening and weekend nursing care, Virnig says.

"The cost of care is higher in rural areas because you need to have someone on call 24/7/365, but if you only have eight patients, you don't need that many nurses," Virnig explains. "A hospice that has two nurses on staff will need them to be on call nearly all of the time, and this leads to burnout."

This is where the Medicare payment structure does not make sense for rural hospices, since they are paid the same per diem rate as larger hospices that may not have as many staffing difficulties, she says.

"What can hospices do to make it easier to live in this context?" Virnig says. "We can all say we want more money from Medicare, but you better have a back-up plan, so the one thing we want is to encourage hospices to think creatively."

Virnig offers these suggestions for how rural and small hospices can find solutions to regulatory, payment, and other problems:

* Change the "territorial" mindset:

"Rural hospices tend to be very territorial," Virnig says. "They have their own identity, like a small town."

Hospices work well in small towns because they have community buy-in and hospice workers know everyone, she notes.

"You might be taking care of the mother of your friend or the woman who sold you candy at the corner store when you were growing up," Virnig says. "And that's a caring environment with inter-relationships, and that's the positive aspect of it all."

On the downside, rural hospices can become territorial, fearing they will lose their identity if they make any changes, Virnig says.

The solution is for rural hospices to change the territorial mindset and figure out ways to

cooperate with neighboring hospices, without losing their own identities, she says.

For instance, rural hospices across a state could band together to form a cooperative for buying medication, since hospices typically have a 98 percent overlap in their medication formularies, Virnig suggests.

"My guess is they would negotiate hugely lower drug prices than they have right now," Virnig says. "But that would involve having a huge amount of trust."

* Form a float pool:

Maybe individual rural hospices cannot afford to hire enough staff to cover vacations, but a number of hospices together could provide fill-in staff for vacations or other types of staff time off, Virnig says.

"Imagine if 20 or 30 hospices were to band together and develop a float pool for social workers," Virnig says. "If there was a pool of social workers that everyone could tap into, then when their own social worker needs a vacation, they can go to the float pool to find someone to fill in."

Likewise, a number of rural and small hospices could share a special nursing on-call center that would triage evening and weekend calls and then send a nurse to the community from which the call arrived, Virnig says.

"Rather than have every hospice hire their own private service for on-call nursing, they could each take one week of on-call duty," Virnig says. "So two weeks out of the year, your hospice would cover this, but the rest of the time, somebody else would cover it."

This would work similarly to how large hospices with satellite offices handle on-call duties, Virnig says.

"They will share on-call on weekends and share calls if a nurse goes on vacation because they have a pool of nurses within the larger organization," Virnig says. "We're seeing this happen within consolidations of single organizations into satellite offices for a larger organization."

But it would be possible for small rural hospices to do the same thing and still maintain their own identity, she adds.

"It would allow hospices to remain more financially stable, which may help them avoid having to go the route of becoming incorporated," Virnig says.

* Use technology to increase efficiency:

If hospices do band together, it's very easy

with today's technology to have an individual hospice's telephone number transferred to a shared service center or to another hospice for a period of time, Virnig says.

The hospice staff could give patients and families instructions that contain simple codes, such as, "If you need help on weekends, then ask for Mary or Carol," Virnig says.

These would be the code names for that particular hospice, so when the call comes in, the person handling the off-hours calls will know that the patient is served by Hospice AAA and not Hospice CCC, she explains.

Even simpler, the caller ID services available will let the call receptionist know the call was routed through Hospice AAA, so the person could answer the phone, "Hello, this is Hospice AAA, how can I help you?" Virnig adds.

"So patients wouldn't necessarily know that the call transfer is going on," Virnig says.

"Imagine what this type of call-forwarding service would do for staff morale?" Virnig says. "Staff burnout is hard; you are taking care of your third grade teacher or friends or aunt, and that means your hospice work is a much more personal thing, which is both positive and negative."

Another technological possibility is tele-nursing, which has been used successfully in recent years by home care agencies, Virnig says. ■

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 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. ■

Liability of MCOs for contracted services

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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 nonpreoperative 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 pre-printed 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." ■

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

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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, et al. Complementary and Alternative Medicine Use as Health Self-Management: Rural Older Adults with Diabetes. *J Gerontol B Psychol Sci Soc Sci* 2006; 61(2):S62-S70.

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