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First hospice PACE program opens doors, and more are the on way

Hospice director lists benefits to program

The hospice mission shares many of the goals and features of the mission of the Programs of All-inclusive Care for the Elderly (PACE), and so for hospices with enough resources, initiating a PACE program is a natural fit.

"PACE is about palliative care — trying to help people stay comfortable in the end of their days," says **Karren Weichert**, president and chief executive officer of Midland Hospice Care of Midland Care Corp. in Topeka, KS. Midland became a PACE provider on Feb. 1, 2007, making it the first hospice to open a PACE program.

"I think PACE fits in with what hospices are doing, and needing to become, to serve a greater population," Weichert says.

PACE also provides hospices with an avenue for growth to maintain a competitive edge, she says.

"I think most hospices today are looking at the competition and their own viability, and even though we're hearing about how hospice is growing, it's growing with some growing pains," Weichert says.

Hospices that need to stay competitive should look at the strategic plan and think as far ahead as 2020, she suggests.

"If you are looking at palliative care at all, then I think that looking at a PACE program would be a good fit," Weichert adds.

"PACE is a new model of care and a culture change," Weichert says. "It's a nursing home without the walls, and the reason this is such an easy transition for a hospice to make is because there are so many similarities between hospices and PACE — even in the regulations."

Hospice care and PACE are similar models, and PACE is a natural outgrowth of hospice care and could have a symbiotic relationship with hospices, says **Shawn Bloom**, chief executive officer of the National PACE Association in Alexandria, VA.

PACE programs are a model of care that provide all preventive, primary, acute, and long-term care services to people who are ages 55

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years and older and who are certified by their state to need nursing home care so they can live as independently as possible.

PACE programs receive Medicare and Medicaid capitation payments to assume full financial risk for enrollees' care. So far, there are 38 PACE programs in 20 states, with another 20 programs expected to be opened in 2007, Bloom says.

"We are looking at the doubling of PACE in the next few years," he adds.

The focus point of PACE services is an adult day center where PACE enrollees receive a multitude of health care and support services from dental care to physical therapy. And this is augmented with home care and common sense approaches to whatever services are needed to keep enrollees out of nursing homes and hospitals, Bloom explains.

Midland Hospice Care has had an adult day center since 1992. It was started to complement hospice services, Weichert says.

"It was a safe place for hospice patients to go during the day, and it gives caregivers a break," Weichert says.

In recent years, as the length of stay among hospice patients declined, interest in adult day centers increased among families of chronically-ill older adults, Weichert notes.

"We'd have people call us to see if family members who had strokes or Alzheimer's disease could come to the day program," she says. "Pretty soon, it became a community program for frail elderly adults in the community, completely separate from hospice, although we still had some hospice patients."

The National Hospice and Palliative Care Organization (NHPCO) contacted Midland Hospice to see if the hospice would be interested in becoming a PACE site, as the National PACE Association was looking for more health care providers and others to open PACE programs, Weichert recalls.

"So in 2002 we began to explore that opportunity and what it might involve," she says.

Weichert visited existing PACE sites, and the hospice decided PACE would be a natural fit with the existing adult day program and the hospice's existing expertise.

The next steps were to complete a lengthy application form, and hospice officials asked the Kansas state legislature for PACE funding, Weichert says.

The PACE program finally opened this year, with an adult day program that can enroll up to 75 people and a day center that can serve 51 people at any given time. **(See story on how Midland Care Connection's PACE operation works, p. 40.)**

The hospice had existing space in which to open a clinic within the day center, and there were facilities with therapy space and men's and women's shower rooms for assisted bathing, so necessary infrastructure was in place, Weichert says.

"We had an advantage where we didn't have all of the upfront costs some sites might have if they were starting from scratch," Weichert says.

PACE sites have to bear the burden of implementing the program, so some organizations will collaborate with health care systems in their community, or they'll seek grants to pay for start-up costs, she notes.

However, CMS recently announced \$7.5 million in competitive grants that are being awarded to 15 rural health care provider organizations for the purpose of developing PACE

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sites. The organizations that will receive a \$500,000 grant to support development of a rural PACE program include the Hospice of Siouxland in Sioux City, IA.

Midland's PACE staffing needs were supplemented with contracts, although the hospice did hire staff to coordinate the PACE data, as well as monitor performance improvement.

"We have contracts with therapists, and we use them when we need to, but it is our hope to have our own physical therapist on staff, and we're searching right now," Weichert says.

Demonstration projects from the 1990s showed that a PACE approach can save states Medicare money. PACE provides a variety of services, including transportation, meals, social interaction, and health care to keep frail and older adults from entering nursing homes or from becoming frequent fliers at hospitals. When these patients need end-of-life services, PACE can contract with hospices to provide hospice care, as well, Bloom says.

"The rule of thumb, according to a government study, is that PACE saves Medicare 40%," Bloom says.

The mean Medicaid payment per PACE enrollee who is Medicaid eligible is about \$3,000 per month, and the mean Medicare payment per PACE enrollee who is Medicare eligible is about \$2,000 per month, Bloom says.

For enrollees who are dual-eligible, as are enrollees at PACE providers, the monthly capitation payment of roughly \$5,000 per patient covers all drugs, hospitalizations, specialty visits, therapy, transportation, meals, day care services, etc., Bloom says.

Some providers are pre-PACE providers who operate solely under Medicaid contracts for long-term care services only, and these sites are expected to become PACE providers in the near future.

Hospices can contract with PACE sites, but when Bloom speaks before national hospice, he outlines the benefits to hospices that decide to become PACE providers. Bloom is next expected to discuss PACE at the 22nd Management and Leadership Conference, sponsored by NHPCO, April 19-21, 2007, in Washington, DC.

"I think hospices that have approached us have generally approached us with an interest in PACE," Bloom says.

Hospices have a lot of competencies that are a good starting point for PACE, so there's a natural

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fit, he adds.

"We routinely provide end-of-life care to individuals in PACE," Bloom says. "And if you look at the place of death among PACE patients, you will see that our place of death statistics are on par with hospice, in terms of giving people the opportunity to die at home, as opposed to in an institution."

The Centers for Medicare & Medicaid Services memorandum clarifies that PACE organizations can contract with hospices for providing end-of-life care and palliative care to PACE enrollees, Bloom says.

So far, maybe 5 to 10 PACE sites contract with hospices, and the others provide in-house palliative care services, since many of the medical directors are board-certified in palliative care, he adds.

"Most of our folks have comorbidities, and the average enrollee is in the program for 2.5 to three years," Bloom says. "They form very strong relationships with the PACE staff."

In the case of Midland Care Connection's PACE, there will be a natural relationship between the hospice and PACE.

"We have an interagency agreement to provide hospice services to our PACE participants," Weichert says. "PACE patients can't be transferred to the hospice benefit, but we contract with ourselves to provide a hospice team, when necessary, and so that becomes a part of the review we do in PACE, and the hospice team becomes part of the interdisciplinary team." ■

Kansas hospice describes how its PACE program works

Participants receive day-long help

The first hospice to implement services under Medicare/Medicaid's Programs of All-inclusive Care for the Elderly (PACE) has made the philosophical skip to expanding its care to the frail and elderly who are not hospice-eligible.

"PACE is about helping people maintain the highest cognitive and physical levels possible, and it's about wellness, coordinating, and managing care, and it's more palliative in nature than aggressive," says **Karren Weichert**, president and chief executive officer of Midland Hospice Care of Midland Care Corp. in Topeka, KS.

"It's aggressive to the point that you want to help people maintain their independence," Weichert says. "There are some aggressive components in terms of how much physical therapy and occupational therapy a person needs, but our goal is to keep people healthy as long as possible so they can focus on their quality of life."

When the Midland Care Corporation's PACE program officially opened Feb. 1, 2007, it consisted of an adult day center in which 51 frail, elderly people could receive services on any given day. It also has a clinic, showers, and a therapy room.

The PACE team is interdisciplinary and consists of a nurse, social worker, home care coordinator, clinic nurse representative, a transportation coordinator, adult day center site director, an occupational therapist, a physical therapist, a dietitian/nutritionist, and a physician. A speech therapist is called in when deemed necessary, Weichert says.

"Essentially, PACE provides everything a participant needs in terms of health support services, from the primary care to cardiologists, to eye-glasses, to a podiatrist, to a wheelchair and lifeline in case the person falls," Weichert explains. "We even provide meals if the person needs them, we help to keep the person's diabetes under control, and we provide all pharmaceutical needs."

PACE enrollees typically meet eligibility requirements for both Medicaid and Medicare, as well as for these 4 criteria:

- they are age 55 or older;
- they live in the service area of the PACE site;
- they meet the threshold score set by their

state to be eligible for long-term care services; and

- they have the ability to live safely in the community with supports in place.

If the potential enrollee is already on Medicaid, the enrollment could be concluded in as little as 10 days, Weichert says.

"If someone is filling out the Medicaid application, too, it could take 45 to 50 days," she says. "From the time we get our information into the state for their assessment in determining the frailty score, the state will take about 48 hours to turn it around, so the process can be quick if the other components are in place."

A typical PACE enrollee may be 85-years-old with congestive heart failure. He will have had a stroke and is wheelchair bound. PACE staff will encourage him to attend the day center as much as possible after first bringing him to the center on a trial basis, Weichert says.

Once enrolled, the man is assessed by a nurse, a physician, a dietician, occupational/physical therapists, and an activities coordinator.

"They talk to the patient about what his goals are, and we develop a plan of care around the goals," Weichert says.

Goals might be as simple as these:

- "I want to be able to transfer myself to go to the bathroom."

- "I want to get out of this wheelchair."

"These people want to live as fully as possible, so we develop a plan of care around that idea," Weichert says.

The recommended course of action might be to have the person come to the day center 3 days a week. PACE will send someone to the person's home to get him ready and to pick him up. Once at the center, the person will be given physical therapy by a physical therapist or physical therapy assistant, Weichert says.

The person will receive a consultation with the dietitian, as well as see the nurse practitioner once a week. The physician will see the person once a month unless the health needs are complicated, she adds.

"We will involve the person with a product called 'It's never too late,'" Weichert says. "It's an interactive computer system that's great to utilize to improve cognitive and physical ability."

The PACE enrollee also will have lunch while at the day center, and he'll receive a teeth cleaning from a dental hygienist. If the person has an appointment with a cardiologist or another specialist, PACE staff will transport him to the

appointment, stay with him during the doctor's visit, and then escort him back to the day center, Weichert says.

"Then we'll take him home in the evening, and we'll send out a home health aide to get him ready for bed, prepare his evening meal, and let the dog out before he settles in for the night," she adds. ■

Expert advice on 'growing' your average daily census

Train to obtain more bang for your buck

Hospice professionals may loathe using the words 'sales,' 'marketing,' and 'customers' to describe what they do to improve their average daily census, but these words will need to be considered if a hospice is to remain competitive in today's industry, an expert says.

"Today's world of hospice is very competitive, and you have very fine hospices that have served the community for many years who are now suddenly faced with a lot of new competition," says **Michael Ferris**, managing principal of Home Care and Hospice Marketing Solutions of Chapel Hill, NC. Ferris works with hospice programs to develop their sales, marketing, and customer service programs.

"So we've been working with those organizations to help them look at what they are doing currently to get the word out and to make sure referral sources and the medical community understand what it is they do and how it is they are different from others serving their market," Ferris says.

"We look at the average daily census (ADC) as the most common way to monitor the success of efforts to improve sales, marketing, and customer service," Ferris says.

"If we see a growth in ADC, then we're doing something right," Ferris adds. "The two objectives in bolstering sales and marketing programs are to increase the number of patients admitted to hospice services, getting patients into hospice service earlier, and increasing the length of stay."

Ferris has seen hospice programs that have doubled or tripled their ADC over a period of a year or two once they've focused on specific sales and marketing strategies, which he outlines here:

1. Improve training of sales team.

"Of course when you're talking to nurses and social workers and others, the word 'sales' may make their skin crawl," Ferris acknowledges. "So sometimes the key is in how we frame it when working with staff."

For example, the outside sales team might be referred to as the community outreach or community/physician liaison team, he says.

And the on-site sales team could be the intake and admissions staff, he adds.

Whatever the sales team is called, the key is to not react to new competition in the knee-jerk way of adding more staff without first assessing the organization's ability to train staff in a way that will provide the desired outcomes of increased referrals, Ferris says.

Hospices that handle the situation that way will have a hard-working team that has not been trained to be effective at selling hospices services in the community, he explains.

Training should include the intake and admissions staff, and here are some things to consider with their training:

- Intake/admissions employees should not view themselves as order takers or gatekeepers who ask a lot of questions to evaluate whether a proposed patient qualifies for hospice care, Ferris says.

"We've found that anytime we can make the other party's life easier, then we'll be the preferred place to call for a referral because we're easier to work with and because they can give us basic information and we'll take it from there," Ferris explains.

All that's really needed from a referral source is the patient's name and contact information, Ferris says.

Typically, discharge planners, when making a referral to hospice, will give the hospice the first page from the chart, which has most of the necessary information, including the physician's information, emergency contact information, power of attorney, diagnosis, contributing diagnoses, hospital admission dates, etc, Ferris says.

Surveys of discharge planners show that they most desire responsiveness from a hospice, he says.

"They need to call and know somebody will be there quickly to take care of the patient," Ferris says. "So it comes down to service and making their life easier."

- **Obtain marketing buy-in from all employees.**

"It really does all come back to mission, and our mission is to make sure that everybody in the

community who would be appropriate for hospice care is advised by their medical professional, or knows from our community outreach efforts that hospice is an option," Ferris says. "And they should have the information and accessibility to hospice to make that selection."

This means the clinical staff also need to provide the type of quality in care that results in patients' families spreading the word about hospice care, he notes.

However, if clinical employees are told to help "sell" hospice services, then there won't be a buy-in because they will take the wrong message away from this and worry about whether their jobs are secure, Ferris says.

The key is to obtain their buy-in through a focus on improving quality care.

"Ultimately, our goal is that everybody participates in the marketing efforts in some form or fashion," Ferris says. "If a hospice with maybe 200 employees encourages and recognizes the people who do something to get the word out in the community, and if everybody on the staff was responsible for one additional referral a year, then the management could look at this and say, 'Wow! That's a big number.'"

So hospices should encourage staff to mention their work at their churches, organizations, and to their relatives, Ferris says.

2. Encourage medical community to expand hospice use.

It's as important to work with the medical community to increase hospice referrals as it is to improve a particular hospice's competitive edge in existing referrals, Ferris says.

"It's not about just getting the referral that's going to a hospice and not having competitors get it," he explains. "That's important, but you can gain as much, if not more, through potential new referrals and from helping the community better understand how to use hospices."

Although discharge planners and social workers might think they know a great deal about hospice, they still could benefit from education about the many different services hospices provide, Ferris says.

One simple way to increase referrals is to train the staff working with referral sources to develop a habit of asking the following questions:

- Do you have anybody else that we should be talking to about hospice?
- Do you know of any other patients we should help be prepared for a hospice diagnosis?

- Are there any patients or families you'd like us to work with, so when the time is right they'll make a good choice?

Hospice staff have to ask these questions because discharge planners are calling with their minds on one particular patient, Ferris says.

"If you jog their memory and ask them if anybody else is coming in, they might say, 'Yeah, I've got this person,' and we've made their job easier, and we have these other referrals," Ferris adds. "These really simple things can produce big results."

Hospice organizations and staff should focus on what the referral source's needs are and present the hospice as a solution to these needs, Ferris says.

This works much better than trying to "sell" referral sources on the hospice, he notes.

"We can increase referrals if we can be good at asking probing questions and getting the medical community to tell us, in their individual situations, what's important to them, what their needs are, what their frustrations are, and what patients are causing them the greatest problems," Ferris explains. "Then we can show them how using our hospice, or one of the hospice services, could help them resolve their problems and make their life easier."

3. Develop strategies for reaching new referral sources.

Each community outreach associate should be encouraged to pick up a few new referral sources, Ferris says.

"What they need to do is pick five qualified prospects, and make sure they are qualified, and have patients who would benefit from hospice care," Ferris says. "Look at each one of these individually at the account level. Who are players in the account and who actually calls in the referrals to hospice?"

While the physician, physician's assistant, or nurse practitioner might decide the patient would benefit from hospice services, there likely is someone else in the practice who calls in the referral, he notes.

"So I coach people that we should start there because that person knows what is or isn't happening," Ferris says. "Find out what's important to that person, what criteria they use, and how they determine where to make that referral."

Then that liaison person can be used to reach other people in the practice to determine what other needs can be met through a hospice referral, Ferris suggests.

Need More Information?

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"Get in front of them and make a sales pitch and you're on your way," he says.

By doing a little investigating before meeting the physician or nurse practitioner who determines which patients to refer to hospice, the outreach associate can have a very productive meeting with the actual referral source.

"So when you do get face time, you can say, 'When talking to Marge she told me this,' and you target in on the specific patient or subset of patients in their practice," Ferris says. "With physicians and others in decision-making positions, we need to help them connect the dots because they don't wake up thinking, 'I wonder if I have any patients who might benefit from hospice?'"

Again, the key is to make it easy for them by looking at their needs and showing them how you can meet those needs, Ferris explains.

"That's where you get new relationships," he adds. "And you build them from a strong foundation standpoint when you get them to give you a patient so that you can impress them with what you do."

As an industry, hospices do a poor job of getting credit for their success, Ferris notes.

"We know what a difference we've made in someone's life, but from the referral source side, we need to let them know what we've done," he adds. ■

New palliative/hospice care framework published

National Quality Forum is publisher

The National Quality Forum (NQF) has released a new publication entitled, *A National Framework for Palliative and Hospice Care Quality*

Measurement and Reporting, which is based partly on the "Clinical Practice Guidelines for Quality Palliative Care," which were issued in May 2004, by the National Consensus Project.

The National Consensus Project is a consortium of hospice and palliative care organizations, and it includes the National Hospice and Palliative Care Organization (NHPCO).

The new framework is considered a first step in creating a comprehensive quality measurement and reporting system for hospice and palliative care services. It outlines consensus practice guidelines from more than 300 organizations, and it includes 38 preferred practices.

For more information on the publication, visit the web site: <http://www.qualityforum.org>. Also, the National Consensus Project guidelines can be downloaded for free at the web site: <http://www.nationalconsensusproject.org>, or the print version can be purchased at the NHPCO Marketplace by calling (800) 646-6460. ■

Keep pediatric skills high with competencies

Improve referrals by showcasing staff

It's the classic question: Which comes first, the chicken or the egg? Or, in the case of five home health agencies in New England: Which comes first, the pediatric referrals or a nursing staff who are well-trained to handle pediatric patients?

"We were getting some referrals for pediatric patients but not enough to keep our staff's pediatric skills up to a high level," says **Beth Shelton**, RN, clinical team leader at Home Healthcare, Hospice and Community Services in Keene, NH. Shelton's agency, along with other home health agencies, worked together to develop a program that enhances home health nurses' pediatric skills and promotes their skill level to referral sources.

"Hospitals don't know what home health can do for pediatric patients, and many home health agencies don't have staff members dedicated to pediatric patients," explains **Tina Smith**, RNC, maternal child manager for Concord Regional VNA in New Hampshire. "We thought it was important to develop care standards and staff competencies for pediatric care to improve our ability to care for children."

A grant from the VNA Health System of Northern New England enabled the agencies to work together to develop a pediatric care program. "We met monthly to identify the clinical areas that were most important and find information on competencies or standards that already exist," says Smith.

Diabetes and asthma were chosen as the first pediatric care standards for development, for several reasons. "These are very common diagnoses for children, and there was a lot of information available to help us get started," says Smith.

Although the standards or clinical pathways are important, the most important step the group took was to develop pediatric competencies for home health nurses. "Each agency in our group was different in terms of how many pediatric patients were seen and how many staff members had pediatric experience," points out Smith. "My agency has a staff of maternal child health nurses, but most agencies rely upon nurses with no specific pediatric training," she says. For that reason, the group not only developed staff competencies but also planned educational sessions to teach nurses.

A skills day is held twice a year and is open to staff members of all five agencies. "It is a full day that is a combination of speakers and hands-on learning," says Smith. Speakers focus on topics such as assessment of premature infants or pain management for children. Hands-on learning stations give nurses a chance to start an intravenous line, insert nasogastric tubes, set up ventilators, and operate nebulizers, she explains. All of these stations are related to pediatric competencies, she adds.

Physical assessments of newborns and young children are very different than assessments of adults, points out Smith. "Not only are they smaller, but they can't tell you what is going on," she adds. Nurses need highly tuned assessment skills and must be able to recognize reactions, such as a facial expression, that indicate pain, she explains.

There is also a completely different psychosocial need in the home of a pediatric patient, points out Smith. "You might be seeing a five-year-old for wound care, but you have to be calm for both the mother and the patient's sake," she explains. "You also have to be ready to play a few minutes with the younger sibling to distract him and make everything seem normal."

Reassure nurses

The differences in adult and pediatric care cre-

ate some reluctance among nurses, admits Smith. "We make a point of showing nurses that there are a lot of similarities, such as the IV pump, which is the same pump you use for adults," she explains.

Although few agencies have the number of referrals that justify a pediatric-only staff, it is important to carefully choose who will be seeing pediatric patients in addition to adult patients, suggests Shelton. "When nurses join our agency, we ask for their special interest, such as IV, wound care, or pediatrics," she says.

After evaluating the nurse's background and considering his or her areas of interest, they are assigned an area in which to specialize. While the nurses still see adult patients, or patients who don't fall within these specific areas, they are also assigned patients with needs in their area of interest, she explains. "Nurses attend training to improve their knowledge and expertise in their area of special interest, and they know that they will see enough patients with these needs to maintain their skills," she adds.

Nurses who see pediatric patients have benefited from the additional education, the clinical pathways, and the competency standards developed by the group of five agencies, says Shelton. "In our agency, we conducted a skills survey in 2002 and 2006 to see if competency levels increased," she says. "We found that we improved our skill level in preemie assessments, insertion of NG tubes, and placement of IVs," she explains.

Data showing skill levels, and sharing the clinical guidelines developed for the care of pediatric patients, demonstrates your agency's competency to referral sources. But Smith and Shelton's group of agencies goes one step further to improve their relationship with referral sources. "We hold case conferences at different hospitals to discuss different cases referred to one of the agencies," she says. Physicians, nurses, and discharge planners from the hospital attend, as well as managers and nurses from the home health agencies.

"We always hear the parents' side of the story, in which they tell us that the hospital staff never taught them how to do certain things, so the case conference gives us a chance to develop a stronger communication link," Smith says.

One suggestion to a hospital was that the staff use a checklist of specific activities taught to the parent at the hospital, she explains. "Our home health nurse could refer to the checklist and remind the parents that they were shown how to

change the dressing," she adds.

In some cases, the home health nurse is not prepared to start an IV or change a dressing because the referral information did not mention that need. "We discuss this type of situation in our case conference and develop an action plan that identifies the type of information we need, as well as contact information for who to call if we have questions," she says.

The contact information is important because sometimes the parents learn on one brand of equipment in the hospital and come home to another brand that looks different, says Smith. "The home health nurse can call the hospital nurse to find out what was used for teaching and then adjust her instruction to help the parents understand how to use the new equipment," she adds.

"Case conferences not only improve communications but they also promote our capabilities so that the hospital staff is comfortable discharging a pediatric patient to our agency," says Shelton. "Having the home health nurses at the case conference is beneficial because the hospital staff get to meet the people providing the care, not just the managers," she adds.

Pediatric referrals at all five agencies have increased since the development of a pediatric care program, and the group of agencies is in the process of developing other pediatric standards, says Smith. "Failure to thrive, jaundice, and prematurity standards are currently in draft form," she explains.

Working with other agencies has been invaluable, says Shelton. Sharing information, ideas, and different perspectives has resulted in tools that help everyone, she says. She adds, "We've been able to work together with our referral sources to create a smooth transition from hospital to home for children." ■

Train nurses to improve outcomes for depression

Observation and conversation are key

Depression is often the rule rather than the exception for most home health patients, though home health nurses are often not taught how to recognize symptoms of depression and assess the need for intervention, according to

researchers at Cornell University's Weill Medical College in Ithaca, NY.

"Older home health patients often have coexisting medical conditions, as well as emotional issues which they are facing, such as loss of social connections and role changes within their families," points out **Martha L. Bruce**, PhD, MPH, professor of sociology in psychiatry at Weill Medical College. Although depression may be common in home health patients, it is important not to overlook the condition during nursing assessments and development of patient care plans, she adds.

The challenge for home health nurses is the lack of training related to depression or other psychological conditions, but it is possible to educate home health nurses so that they can recognize symptoms of depression, says **Thomas Sheeran**, PhD, ME, assistant professor of psychology in psychiatry at Weill Medical College.

The Cornell Homecare Research Partnership is working with home health agencies to teach nurses how to assess depression and to help agencies develop the infrastructure necessary to help depressed patients, says Sheeran. The key is to correctly identify depression and to bring in the right resources to help the patient, he says.

One of the first steps to correct assessment of depression is to realize that older people won't talk about depression, says Sheeran. "You have to learn to speak their language," he says. Don't ask if the patient feels depressed; instead, ask if they smile or laugh as much as usual, he suggests.

Look also for visible symptoms, such as a disheveled appearance in a normally neat patient, a patient who is wearing nightclothes when the nurse makes an afternoon visit, or no lipstick on a female patient who always wears makeup, recommends Bruce.

A lack of interest in activities in which they usually participate is also another indicator of depression, says Bruce. If patients are no longer interested in their favorite activities, such as knitting, reading, or watching television, it is important to talk with them to determine the level of depression.

Observe patient before making a referral

Not every depressed patient needs a referral to a mental health clinician, points out Bruce. "If the depression doesn't present a safety issue and the nurse sees some improvement over the course of a few visits, then it makes sense to wait before

a referral is made," she says. "A nurse should look for persistence of depression, or for increased depression, before making a referral," she adds.

While a patient's depression might be triggered by a specific event, such as the loss of a family member or friend, or the diagnosis of illness, it is important to remember that older patients may develop depression over time due to the change in their own role, says Bruce. "We often find that older patients develop a sense of worthlessness in their daily lives as they rely upon other people to care for them," she explains.

This ongoing sense of worthlessness does increase the risk of suicide for older patients who can't overcome depression, points out Bruce. "It's important that the nurse be comfortable asking a patient if he or she has thought about hurting themselves, or listening for cues from the patient's conversation," she says. "You won't put the idea of suicide in a patient's mind by asking about it," she says.

If the patient admits to suicidal thoughts, or if the nurse believes that there is a risk, it is important to talk to the family, says Bruce. "Ask the patient if it is OK to talk with his or her family members," she says. Many times, family members won't know that the patient is depressed and at risk for suicide, she adds.

Every agency should have a list of appropriate resources for depressed patients, even if it means "beating the bushes" to find the best help, says Sheeran. "Mental health counselors, outpatient clinics, and primary care physicians who treat depression should be on the agency's resource list," he says.

Another important part of a nurse's training should address how to talk to the physician or mental health professional, points out Bruce. "Depression care is very evidence-based, and it is important to talk to the clinician in the same language," she says. "Nurses should be taught how to present a case so that it is clear to the clinician," she adds.

Antidepressants can be very effective for many patients, but Sheeran points out that many home health nurses are wary about management of the medication. "Antidepressants are very easy to manage and monitor, and there are fewer drug interactions with antidepressants than with other medications older patients are often taking," he says.

One of the tools that participants in the research partnership use is a clinical guideline

that gives the nurse a roadmap to use for ongoing, routine monitoring of patients for depression. "Nurses are initially reluctant to care for a patient with depression because they are not sure how to monitor the patient," says Bruce. "A guideline that helps nurses know when to call a mental health professional is valuable to them," she adds.

Agencies that approach identification and treatment of depression as a disease management process with thorough training of staff and development of protocols and resources that help nurses manage their patients will see an overall improvement in outcomes, points out Sheeran. Depression has been linked to falls, incontinence, and medication noncompliance, he says. He points out that by treating depression appropriately, the patient's quality of life and outcomes are improved. ■

End-stage renal disease patients need hospice care

Health providers need more education

Renal disease patients live only one-third as long as persons who do not have kidney disease, and they typically have many co-morbidities, including diabetes, heart failure, high blood pressure, and circulatory problems. About 20% of dialysis patients withdraw from dialysis treatment, which typically results in their death within 4 weeks.

So the big question is: Why doesn't this very sick population receive high-quality palliative and hospice care as often as needed?

The Robert Wood Johnson Foundation, of Princeton, NJ, funded a renal disease workgroup to look at palliative care issues as recognition of the reality that too few renal disease patients were receiving palliative services, says **Alvin H. Moss, MD**, a professor of medicine at the West Virginia University School of Medicine in Morgantown.

The workgroup consisted of people who cared about dialysis patients and wanted to improve their care, particularly at the end of life, Moss notes.

"Most of us were seasoned clinicians, doing this work for 15 to 20 years and longer, and we

were burdened by the amount of suffering we saw in patients we care for," Moss says. "We wanted to figure out how we could provide better care to them."

Workgroup members quickly identified hospice care as being underutilized for dialysis patients, Moss says.

"You think of cancer patients as a sick-patient population," Moss says. "Dialysis patients, on average, live only half as long as cancer patients, with 70% of cancer patients, and only 35% of dialysis patients, living five years."

Also, when dialysis patients stop treatment, 96% of them will die within the month, so hospice care is appropriate for these patients, he says.

"Every renal patient who stops dialysis should be offered hospice care, and most would use it," Moss says. "Yet, only 40% of dialysis patients who stop treatment receive hospice care."

One of the renal disease workgroup's recommendations to the field of nephrology health care professionals was that they more consistently refer dying dialysis patients to hospice care, or that they adopt a palliative care approach to their management, Moss says.

The workgroup also recommended that the Centers for Medicare and Medicaid Services (CMS) collect data on hospice utilization on their death information form, Moss says.

"In October 2004, CMS changed the death notification form based on the recommendations," Moss says. "So CMS now collects data about hospice use on every dialysis patient who dies, and its data that will be readily available."

The main obstacle to getting end-stage renal disease patients into hospice care is that Medicare won't pay for two different programs for the same diagnosis, Moss says.

"They won't pay for hospice and also pay for dialysis for kidney disease, so most providers think dialysis patients can't have hospice services," Moss explains. "But one of the things we did was to identify precisely what the CMS regulations were, and we found that renal disease patients who are dying from cancer and heart

failure can continue to receive dialysis, as well as receive the Medicare hospice benefit."

Hospice professionals traditionally have thought of dialysis as a life-saving treatment, when it's not life-saving, but can add a little time and quality to a patient's life, says **Malene Davis**, MBA, MSN, RN, CHPN, president and CEO of Capital Hospice of Falls Church, VA. Davis also is the chairperson-elect of the National Hospice and Palliative Care Organization of Alexandria, VA.

"So one of the understandings of hospice is that we're not permitted to pick up a patient who is on dialysis," Davis says. "So what we would do is wait for people to stop dialysis, and then we would have them in care for only two or three weeks before they died."

The reality is that most dialysis patients also have diabetes or cardiac problems or another chronic illness that makes their case more in line with a hospice philosophy, Davis adds.

"In West Virginia, we had a patient who had cancer but started to develop renal failure while on the hospice program," Davis says. "Then the patient went on dialysis to improve her quality of life and enable her to stay at home and eat better."

One day, Davis visited the woman and found her watching "The Price is Right," and then her grandson called her.

"I asked her if she liked to go to the dialysis center, and she said, 'No, there will be a day when I won't want to go back there,'" Davis recalls. "But it was buying her time to spend with her grandson and his children — so it's all about quality."

A minority of dialysis patients have only renal disease, Moss says. This is why education is so crucial to improving dialysis patients' access to hospice care, Moss says.

The Kidney End-of-Life Coalition, along with hospice and other partners, work to educate the medical community about how they should not discriminate against dialysis patients, Moss says.

In studies that will soon be published, a survey shows that health providers who are aware of the renal disease workgroup's recommenda-

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tions and work are well prepared to provide palliative and end-of-life care to their patients, Moss says.

“One thing we worked on was developing core curriculum for nephrology products, and that was done and published, and it’s now out there for educating people who are training to be nephrologists,” Moss says. “About 39% of nephrologists now say they are well prepared to do end-of-life care, so it’s still a minority, but the number is increasing.”

From the hospice perspective, data show that the average hospice patient has eight or nine symptoms that are out of control, and end-stage renal disease patients have the same number, Davis says.

So it is unethical for the health care field to send these patients home from the dialysis center with no support, she says.

“We have to step up to the plate, go to dialysis centers, and do a presentation for their staff,” Davis suggests.

One of the first things hospice professionals can teach dialysis center staff is about advanced care planning and advanced directives, she says.

Members of the renal disease workgroup discovered in their research that dialysis units did not have a consistent policy about whether they would honor patients’ wishes regarding CPR, in the event of a cardiac arrest, Moss says.

“So we conducted focus groups with dialysis patients and their families,” Moss says. “We

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talked with them to find out what their concerns, needs, and level of understanding were.” The group developed a draft policy based on these discussions, he adds.

“Dialysis centers don’t have time for social work, so it’s up to hospices to provide a community service by visiting dialysis centers,” Davis says.

When Davis speaks with dialysis center staff, she typically asks them if they can predict which patients will choose to go off of dialysis, and they say they can.

“They call these patients the ‘dwindlers,’ because they are people who still are coming in for dialysis, but their blood pressure is not staying up, and it’s just wearing them out,” Davis explains. “These are the patients who need to be helped with their decision and, if hospice were involved, they could be educated and more comfortable about making a decision to stop dialysis.”

Hospices that develop good relationships with dialysis centers could assist the centers in providing patients with palliative care services, as well as increase their referrals, Davis says. ■