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IN THIS ISSUE

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Three levels of therapy thresholds, new diagnosis codes in place for 2008

New HHPPS requires agencies to start preparation now

Three different therapy thresholds, a new payment model for non-routine medical supplies, and additional questions for OASIS are just a few of the changes in the Centers for Medicare & Medicaid Services' (CMS) Home Health Prospective Payment System (HHPPS) for 2008.

While some items related to OASIS and diagnosis codes were not expected to be finalized until mid-September or early October, **Mary St. Pierre**, MA, BSN, vice president for regulatory affairs at the National Association for Home Care and Hospice (NAHC) in Washington, DC, began preparing early. "Agencies will have to change software, change OASIS forms, and change billing forms," she says. "There are now 153 case-mix groups and 51 different clinical and financial items that need to be addressed by each agency."

Case-mix creep

There is a reduction in payment for all home health agencies to account for "case-mix creep," points out St. Pierre. The reduction in the national standardized 60-day episode payment rate will take place over a four-year period. The reduction will be taken at 2.75% per year for three years beginning in CY 2008 and at 2.71% for the fourth year in calendar year (CY) 2011. "The increase in payments based on case mix that home health agencies have seen over the years is due to improved coding and documentation rather than the actual condition of the patients, so CMS is adjusting reimbursement," she adds.

It is hard to predict how agencies will do financially under the new payment system because the case mix is so complex, says St. Pierre. Therapy thresholds are now set at six, 14, and 20 visits compared to the single 10-visit threshold in the previous system, and early episode vs. late episode must be documented, she points out. (For an item-by-item comparison of HHPPS changes, visit www.cms.hhs.gov/center/hha.asp.)

Agency managers should be working with their software vendors

now to make sure that changes in the PPS system are reflected in the software, suggests St. Pierre. "OASIS forms need to be updated and staff members need to be educated about the changes," she says. "Not only are there new codes but staff members will need to differentiate between early and late episode care for accurate reimbursement."

The 2008 PPS also requires agencies to report data for two additional quality measures — emergent care for wound infections, and deteriorating wound status and improvement in status of surgical wound — to the 10 measures currently reported, for a total of 12 measures to be reported on the Home Health Compare web site.

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The first step to prepare for the new PPS is to carefully review CMS documents, says St. Pierre. Then, meet with software vendors and evaluate your OASIS forms, printed or electronic, she says.

The key to successful preparation is to start now, suggests St. Pierre. "Everyone needs time to reprint forms if they are using paper, or reprogram electronic forms, as well as update software to handle the changes," she points out. In addition to making the changes, be sure to allow enough time to test the forms or software changes to make sure that your processes flow smoothly on Jan. 1, she adds.

Another important part of preparing for the new PPS is to thoroughly educate your staff, recommends St. Pierre. "Clinicians do have to answer a few different questions and use some different codes, and they must be careful to accurately document items, such as infected surgical wounds, abscesses, chronic ulcers, gangrene, dysphagia, tracheostomy, and cystostomy, because scores are now given for these conditions." ■

Are your employees ready for an emergency?

Personal emergency plans essential part of planning

Effectively preparing for an emergency requires plans that address those emergencies you are likely to experience. In New Hampshire, home health agencies have always been prepared for winter storms that cause treacherous road conditions and loss of power. What caught many New Hampshire agencies off guard in 2005 and 2006 was heavy flooding in many areas that created different situations than those previously experienced.

"Blizzards and other winter weather rarely

cause a problem for our agency because most staff members can make it to work," says **Claudette Boutin**, RN, CEO of The Homemakers Health Services in Rochester, NH. "Weather reports let us know that storms are coming so we have a chance to double up on patients before the storm and we are accustomed to driving in snow, so we can usually get to all of our patients following the storm," she adds.

The heavy floods occurred on a Sunday in 2006 so most staff members were visiting family and some were well away from the agency's home county. "I was visiting my mother four hours south of Rochester so I didn't even realize what was happening," says Boutin. Her agency's emergency preparedness plan worked well, even though it didn't specifically address floods, she points out. "We do have an adult day care service with several buses so the city asked us to help transport seniors to shelters," she says.

In addition to transportation, home health staff members were called upon to check on the patients who were classified "high priority" in an emergency. "When we admit a patient, we classify them as high priority for emergencies if they live alone, if the home has two elderly adults caring for each other, or if they are disabled," says Boutin. "Our staff members helped those patients who needed to evacuate pack their belongings that they needed for the shelter and ensured that they had their medications," she explains. Staff members who transported seniors to the shelters often stayed to volunteer their time, she adds.

The floods washed out roads, caused the evacuation of entire neighborhoods, and affected home health employees more than winter storms, points out Boutin. Employees who found themselves evacuated were unable to come to work until they found safe places for their families, she says. Sometimes, employees had to leave the area to stay with family or friends.

Prepare at home to report to work

Because it is important that employees take care of their own families before they can report to work, Boutin's challenge to her employees in 2007 was to create their own emergency plans. A staff survey asked each employee if they would be willing and able to work after different types of emergencies such as snowstorms or power outages. Employees could answer yes, after personal needs are handled, or no. "The majority of employees answer that after their own personal needs and family needs are handled, they would be willing to work during any type of emergency," says Boutin.

Because home health employees are an important part of a patient's ability to handle an emergency, it is important that employees be able to report to work so they are asked to prepare themselves and their families for an emergency. "This means having an emergency kit in their home that contains three gallons of water for every person, non-perishable food, a manual can-opener, flashlights, extra batteries, and other supplies that might be needed for different situations," says Boutin.

Another aspect of preparing for an emergency is the development of a personal emergency plan. Boutin gave all employees a checklist that guides them through development of their own emergency plan. "The checklist is a series of questions that asks employees questions about their children's school's emergency plan, child care or eldercare in the event of an emergency, and locations of emergency meeting places for family members," she says. Completing the checklist provides employees with a good sense of what needs to be done and what resources are to be used in the event of an emergency, she says.

"We also gave every employee an 'Emergency Readiness and National Security Wheel' that contains tips on how to prepare yourself for a variety of emergencies," says Boutin. **(See resources box.)** "The wheel describes specific preparations for emergencies such as terrorist threat, weather-related emergency, or power outage."

Preparation of their families and their homes for an emergency was the first step in Boutin's emergency preparedness seminars in 2007. The next step for Boutin's employees is preparing themselves for an emergency. "When they arrive at the next series of inservice classes, they will be asked if they prepared their own emergency plans," she explains.

Employees who have done so, receive a Good to Go bag that contains items such as a flashlight, a first-aid kit, a Mylar blanket, a bottle of water, a few energy bars, and a list of other items they need to add. Other items include one change of clothes, copies of important documents, and a copy of their emergency plan with phone numbers they will need, she says. "This bag is for the employee's car so that even if the emergency occurs while they are away from home, they have what they need."

The Good to Go program is part of the Home

Care Association of New Hampshire's (HCANH) program that emphasizes the concept that emergency preparedness begins at home, says **Susan Young**, executive director of HCANH in Concord, NH. "We have been offering programs to home health agencies over the past two years to assess their level of readiness and to help them improve their agency's preparations," she explains. "The Good to Go program was developed when it became obvious that no matter how good your plans are, they will only work if staff are available.

"The program is very low tech, but it is essential," admits Young. "For example, one of the items on the checklist is, 'How do your family members reach each other in an emergency?'" When local phone service isn't available or when areas are evacuated, it is important that there be a contact person located outside the employee's home area so that all family members can check in to let others know they are safe, she explains.

HCANH provides the personal readiness bags for the employees to all agencies along with a sample kit and a list of items that should be placed in the bag. "Some agencies are filling the bags for their employees while others only place a few items in the bag, but everyone includes the list so that employees can fill the bag with what they need," Boutin says.

"We have seen that home health agencies are very conscious of their role in an emergency and most agencies have good plans in place," says Boutin. "We never expected to have our own version of Katrina in the past two years but the experience has helped everyone better plan for emergency situations we might never have considered."

One tip that Boutin offers home health agency managers who are evaluating their emergency preparedness plans is to look carefully at the priority given to emergency planning. "Agencies are struggling to provide good quality services in a time of declining reimbursement so multiple tasks are assigned to managers or supervisors," she says. "This often means that emergency planning becomes part of a to-do list for a person who is already very busy.

"It's important that emergency planning not fall to the bottom of the to-do list because it is an issue that should be continually reviewed, updated, and communicated to employees," she adds.

Emphasizing the personal emergency readiness plan is also important, says Boutin. "It is every home health employee's professional responsibility to be personally prepared for an emergency. It's easy to prepare yourself for an emergency and it doesn't cost anything." ■

SOURCES/RESOURCES

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• The "Emergency Readiness and National Security Wheel" can be purchased from EHS Publishing in Durham, NH. For more information go to http://www.ehspublishing.com/cart/product.php?productid=16134. Phone: (800) 558-3464 or (603) 868-1496. Fax: (603) 868-1547. Web site: www.ehspublishing.com.

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Understanding Laws, Rules, Regulations

Determining fair market value of consulting services

By **Elizabeth E. Hogue**, Esq.
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As many providers already know, the so-called "Stark law" prohibits physicians from making referrals to providers who render "designated health services" (DHS), if referring physicians have an ownership or investment interest in, or compensation arrangement with, the provider. Designated health services generally include home health, home medical equip-

ment, infusion services, and outpatient hospital services, among others. Likewise, providers of DHS generally cannot bill for services provided to patients referred by physicians who have ownership or investment interests in or compensation arrangements with them which violate the Stark law.

Exceptions to these general rules were published in the form of final regulations on Jan. 4, 2001, the so-called "Phase I" Stark rules. On March 26, 2004, "Phase II" Stark regulations were published as interim final rules in the *Federal Register*. These Phase II regulations further clarified exceptions to the statute described above.

The Phase II regulations provided specific guidance regarding the use of physicians to provide consulting services to physicians who also make referrals as follows:

(1) Many providers utilize the services of referring physicians as consulting physicians to their organizations. These consulting physicians perform a wide variety of appropriate services to providers. There is an exception for personal service arrangements that may include payments to referring physicians for consulting services.

In order to meet the requirements of this exception, providers must:

- Enter into a written agreement with physicians signed by providers and physicians that specifies the services covered by the arrangement.
- The arrangement must cover all of the services to be furnished by referring physicians to providers.
- Aggregate services provided do not exceed those that are reasonable and necessary for the legitimate business purposes of providers.
- The term of each arrangement is for at least one year. To meet this requirement, if an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the remainder of the first year of the original term of the agreement.
- Compensation paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
- The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(2) Also, as described above, providers must pay for services from consulting physicians at fair market value. Many providers have asked how they should determine fair market value.

Currently, the Stark II rules make it clear that fees paid to referring physicians for their services will be considered to be at fair market value only if hourly payments are calculated using either of the following two methodologies:

- The hourly rate is less than or equal to the average hourly rate for emergency room physician services in the relevant physician market, provided there are at least three hospitals providing emergency room services in the market.
- If there are fewer than three hospitals that provide emergency room services in the geographic area where the provider operates or if providers choose to do so, they may pay physicians at an hourly rate that is determined by averaging the 50th percentile national compensation level for physicians with the same physician specialty or, if the specialty is not identified in the survey, for general practice in at least four of the following surveys divided by 2,000 hours. The surveys are:
- Sullivan, Cotter and Associates, Inc. — Physician Compensation and Productivity Survey
- Hay Group — Physicians Compensation Survey
- Hospital and Healthcare Compensation Services — Physician Salary Survey Report;
- Medical Group Management Association — Physician Compensation and Productivity Survey
- ECS Watson Wyatt — Hospital and Health Care Management Compensation Report
- William M. Mercer — Integrated Health Networks Compensation Survey

As of Dec. 4, 2007, the above formulas will no longer apply. Nonetheless, providers must be able to demonstrate using some reasonable basis that compensation paid to consulting physicians who also make referrals is at fair market value.

Providers could, for example, conduct what amounts to a "salary survey" of providers that operate in the same geographic area regarding the amount per hour that other providers pay consulting physicians. Such a survey is likely to produce a range of hourly rates. Providers should document the results of these surveys and pay physicians at rates that do not exceed the highest end of the range.

The above described change with regard to the use of formulas to calculate compensation at fair

market value is an appropriate and very welcome change. The formulas proved difficult, if not impossible, for home care providers to use. Providers can now avoid the frustration of trying to comply and breathe a sigh of relief. ■

Palliative care program stresses teamwork

Uses hospitalists trained in palliative care

What makes an award-winning palliative care program? In the case of the program at the University of California at San Francisco, it's the combination of a collaborative approach to individualized patient care; extensive use of hospitalists; and a program that educates practicing physicians and medical, nursing, and pharmacy students and residents.

Those are some of the factors cited by the American Hospital Association when it recently named the UCSF program as one of the three winners of its annual Circle of Life Award for innovative efforts to provide end-of-life care.

"One of the problems in modern hospitals is that all these professionals — doctors, nurses, social workers, pharmacists, physical and occupational therapists, and chaplains — typically work independently," notes **Eva Chittenden**, MD, assistant professor of medicine at UCSF and acting director of the palliative care service at the UCSF Medical Center. "One of the things we do is break down these barriers. We all discuss the patients and learn from one another, and end up giving patients better care that's comprehensive and individualized."

Collaboration a necessity

Interdisciplinary, collaborative work is essential to such a program, notes Chittenden, asserting that "you can't be a palliative care service without being a collaborative."

Nevertheless, it is the way the collaborative unfolded at UCSF that helped earn it national recognition. On a daily basis, the team meets at 9 a.m. on the wards. It includes a physician, a social worker, often a pharmacist, a chaplain, and often a nurse as well as trainees — fellows, residents, medical students. "We meet in a room and discuss all the patients on the service," says Chittenden. "Then, depending on the needs of the patients that day, we break into smaller groups and work with them — or we may see the patient as a team." Often, however, the size of that team is limited for fear of overwhelming the patient and family.

The team often will touch base in the afternoon as well as to reconvene and discuss what has happened during the course of the day, says Chittenden.

Every other week there is a formal interdisciplinary meeting for two hours. It includes all the physicians on the service; the head of the chaplaincy program and the chaplains; and nurses who are leaders but may not round with the team on a daily basis. Complementary alternative medicine providers are also present, says Chittenden. "We will discuss the patients in a larger framework, and talk about service needs and administrative issues," she explains.

Individualizing care

Providing "individualized" care, says Chittenden, "means we are focusing the care on the goals and values of that particular person." In other words, the team does not use a "one-size-fits-all" approach.

"We sit down with the patient, and whoever is important to them, and start by asking that person, 'What's important to you?' 'What are you looking for in the future?' 'What worries you?' 'What do you want to accomplish with the time you have left?'" Chittenden relates. "We discuss their hopes, goals, dreams, worries, anxieties, and fears, and then try to make the medical care we provide fit those feelings, to help achieve those goals." Those goals, she adds, can be medical, social, psychological, or spiritual.

"Let's say, for example, that someone's goal is to get home and spend time with their family — and we're talking about meaningful time," Chittenden offers. "That patient has to have excellent symptom management. If they have severe pain or shortness of breath or significant nausea, they are not going to enjoy their time with their family." Too often, she notes, providers will focus on the disease, and not on issues such as these.

If a spouse or child is in complete denial about the situation, a chaplain or social worker may be brought in for conversations to help everyone understand the patient's status and feelings. "It if is a cancer patient, they can help decide if the patient will have another round of chemother-

apy," says Chittenden.

"The patient may consider the burdens greater than the benefits; they may not want to go to the clinic every few weeks to get an infusion that will make them feel sick if the potential benefit is less than 10%."

Using trained hospitalists

The hospitalist group at UCSF is one of the first of its kind in the country, say Chittenden. "We have a large group — at this point, maybe 25 to 30," she says. "We have a core group of six on the service who are certified in palliative care." One of the benefits is that, as hospitalists, they are in the hospital all day long. "This is wonderful, because we need to spend time with the patients and their families," says Chittenden. "We are used to working with an interdisciplinary team."

In addition, she says, it adds to the job satisfaction of the hospitalists. "I like the fact personally that I get to do both types of work [general hospital care and the palliative care]. They are very different," Chittenden shares.

The hospitalists can perform this dual role, she explains, because of their training. "In our [basic hospitalist] training, we often do learn about some of the core skills in palliative care, but we have gone on to get more training, which is critical," Chittenden notes.

Chittenden adds that research by her group shows that having hospitalists in a hospital improves the chances of your palliative program being successful — even if they are not on your service. "They may be an additional source of referrals," she explains.

Education part of hospital's mission

Training the next generation of providers "is a core part of our mission," says Chittenden. "We have education programs in our medical school, nursing school, and pharmacy school — in preclinical and clinical areas." In addition, she says, there are programs for medical residents, and for practicing physicians. "We also have a fellowship program — for residents who finished internal medicine and who want to have one or two years in palliative care training."

The clinical elective for fourth-year students has been available since the palliative care program began in 1999, and now 30% of the students elect to take it, Chittenden says. "It's a little early to tell if [graduates of the two-week hospital program] will work with us," she adds.

Of the internal medicine residents, five have gone on to do palliative care fellowships. "This is really new," Chittenden observes.

UCSF also has established the Palliative Care Leadership Center to educate and mentor hospitals around the country interested in starting their own programs. "A group from an interested hospital makes application and comes to our program, which is a very intensive two-day course," Chittenden says. "There is a lot of individual attention and mentoring as they go through a set of modules we created, followed by a year of telephone mentoring."

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What hospice docs need to know for a home visit

It's a major change for some

Making a home care visit is one of the biggest challenges for physicians and other health care practitioners trained in the medical model because they're not in control of the interview.

While hospices train their nurses and nursing assistants to work in a home care setting, they may be overlooking the needs of hospice physicians and nurse practitioners, experts suggest.

"When you see patients at an office you decide when they come in, decide when to see them, and you walk away when you're finished," says **Deidra R. Woods**, MD, FACP, CMD, hospice medical director of LifePath Hospice & Palliative Care Inc. in Ruskin, FL.

"You're really controlling that interaction," Woods adds.

It's an entirely different scenario during a home visit.

"When you enter someone's living space, they are the king of the castle, and you're no longer in your own environment," Woods says.

Physicians and nurse practitioners sometimes find themselves surprised and uncomfortable in a home care situation.

For instance, Woods once was visiting a man who was sitting on his screened-in porch, where it was very hot. As the man talked with Woods, the man's daughter held a hand-held video camera and was videotaping the interaction.

"It was quite a surprise," Woods says. "I said, 'Oh, how unusual,' and the daughter was very clear that she didn't care who her daddy was talking to; she was taping her daddy in his dying days."

Woods had been uncomfortable, thinking the camera was connected to the care she was providing, but to the patient's daughter, it was all about recording his last moments, even when he was talking with his hospice doctor.

As LifePath Hospice's business has grown, the hospice has hired additional nurse practitioners and physicians who previously had not done home visits, says **Terri Massaro**, MS, ARNP, AOCN, APRN, BC-PCM, a nurse practitioner with LifePath Hospice & Palliative Care in Tampa, FL.

"So we were talking in our medical staff meetings about what makes a good hospice visit and what were some of the trials and tribulations," Massaro says.

As a result of these conversations, Woods and Massaro have spoken at national hospice conferences about how practitioners can achieve successful home visits.

"It's difficult because you are on the patient's turf, and you are a guest in their home and that kind of shifts the power," Massaro says. "It's still a clinical visit, but you're a guest in their home, and it's easy to lose boundaries when you're looking at pictures of their grandchildren and petting their animals."

Woods and Massaro offer these ideas of the challenges to successful practitioner home visits:

• **Environmental challenges:** Home visits may involve uncomfortable temperatures and unsanitary conditions to which practitioners must adjust.

"I've had shoes melt, the soles come off my shoes because it was so hot," Woods says. "Naples [FL] is pretty hot about 360 out of 365 days of the year, and we had one patient who lived in a shack with the windows nailed shut."

The interior of the building was incredibly hot, and the soles of Woods' shoes literally came unglued.

"You have to carry a big jug of water and stop at Burger King so you can breathe for half an hour," Woods says.

Besides lacking air-conditioning, some patients' homes have no heat in the winter or running water year-round, Massaro notes.

"You have to be prepared for that because not everyone lives in a nice, clean, cozy home," Massaro says. "You don't want to be dressed in flip flops and shorts, but have to go out there dressed in a professional manner because otherwise it will feel more like a social visit to the patient."

Practitioners can talk with patients about their environmental challenges and how to handle them, Massaro suggests.

"If there's a problem and they can't pay for their electricity, we get counselors involved to see if there's any way to negotiate with the electric company to make this person comfortable," she says. "Or we may have the person move out of the house; home visits aren't for everyone."

Another challenge might be providing handicap-accessible features to homes, Massaro says.

Before the medical staff visit a home, other hospice professionals will identify environmental concerns, such as whether it will be possible to bathe the patient, she adds.

"If you come from a hospital or clinical setting, you are used to having a clean, sterile environment when seeing patients," Massaro says. "You're not going to have that when you go into a home, and you need to be prepared."

• **Setting boundaries:** It's challenging for medical professionals to remain detached when they see unsettling things in the patient's environment, such as a lack of electricity or running water, Massaro notes.

"We have to go in as medical professionals and then get the right people involved and not fix the problems ourselves," Massaro says.

"Families want to be gracious, and oftentimes, they want to give you a cup of coffee or something to eat, which makes it more social," Massaro says. "But even crossing that boundary can be a problem."

Massaro cautions staff against accepting the coffee because it sets the expectation that the patient's family will do something for the hospice professional at each visit, and this distracts the professional from doing his or her job.

Fortunately, hospices typically have a policy that outlines what to do when offered gifts by patients and their families, Woods says.

"People who are attracted to this work have an unfortunate propensity to becoming enmeshed in the family system," Woods explains. "So we recognize that as an industry, and it's an issue we're

aware of and address proactively."

Hospice policies can range from forbidding staff from accepting any gifts to having them redirect gifts to the hospice foundation, she says.

"If a family wants to recognize a caregiver who has done a particularly good job, then they can do so with a letter of thanks to the person's supervisor," Woods says. "But it's not appropriate to accept material goods from dying people — it's fraught with too many ethical issues."

• **Coping with pets:** "People love their pets, and we've seen everything at home visits from snakes to ferrets to big dogs," Massaro says. "There's always a safety concern."

Some health care and hospice agencies will mandate that the animals be put away in a separate room during the visit, and other agencies permit but do not require staff to make that request, she says.

"I've had birds crawling up my shirt and dogs slobbering on me and cat hair covering the back of my pants when I leave, and even a pet squirrel crawl up my leg," Massaro says. "I love animals, but not every practitioner loves animals."

Plus, there have been hospice staff members who've been bitten, and that's always a concern, she adds.

Woods says she also loves pets, but draws the line at birds.

"I have difficulty with the bird that is flying around the house and lands on my head," Woods says.

And it's surprising how many patients will let their birds defecate all over the house, creating a sanitation nightmare, she notes.

"It's their bird, but I absolutely will ask them to put the pet somewhere safe," Woods says.

In one hospice situation, a nurse practitioner whose fear of dogs was phobic asked that the family put the family dog away during her visit, Woods recalls.

"The family member asked for a different medical provider because she was insulted that the nurse practitioner asked her to put the 150-pound dog in a back bedroom," Woods says. "I don't expect medical providers to go into a situation where they're not comfortable, so we asked a different medical provider to go into that home."

• **Time management and scheduling:** Scheduling and time management are challenging for medical practitioners who are used to seeing many patients in one setting, with office visits running back to back.

"Time management is something you can get better at with experience," Woods says.

"We initially find that when people start to do this work it can be overwhelming, and it may be difficult for them to set [time] limits because they are in the patient's environment," Woods explains. "It's a skill you get better at over time."

And there always will be the occasion when the doctor or nurse practitioner has to wait at the house until someone else arrives because of an emergency that occurred, she notes.

Another challenge is negotiating the geographical distances involved in hospice home visits, Massaro says.

"With gas costs being so high, you want to keep your visits within a reasonable geography for the day," Massaro says. "You don't want one visit on one end of town and another one on the other end of town."

Plus, hospice medical practitioners will need to make certain their automobiles are in good condition and are well maintained and that they pay close attention to their surroundings as they drive in new areas, Massaro says.

"Safety is always of utmost importance," she adds.

"Someone always needs to know what your schedule is," Massaro says. "And hospice employees learn about safety in orientation."

Also, because the hospice has wireless Internet access, employees can visit MapQuest in their cars if they need to find a new home or if get lost, Massaro says. ■

Grief counseling should be supported despite bad rap

Researcher says negative studies were bad science

It only took one research paper in 2000 to cast a negative view over grief counseling, but that single widely repeated and reported study has had a long-term and unjustified impact on the practice, an expert says.

Hospice professionals may have read in *Newsweek* and other major media outlets about how a study showed that one-third of grief counseling clients and 50 percent of "normal" grievers were worse off than a control group as a result of grief counseling treatment. This statistic has been reported in national magazines and newspapers, cited in professional journals, and used by the

psychological, hospice, and counseling industries to promote a negative view of grief counseling.[1]

The trouble is that the statistics are based on data in a dissertation that was not peer-reviewed or published and that experts say is bad science, says **Dale G. Larson**, PhD, a professor, in department of counseling psychology at Santa Clara University in Santa Clara, CA. Larson also is the interim dean of the school of education, counseling psychology, and pastoral ministries at Santa Clara University.

Larson was intrigued when he first saw the grief counseling statistic, so he ordered the original citation, a 28-page dissertation, which first had been cited in a 2000 *Death Studies* paper.[2]

The *Death Studies* paper has been widely cited as evidence of the negative effects of bereavement counseling, even though the original citation — the dissertation — had never been published or peer reviewed.

"It was cited by everyone else as evidence for harmful effects of grief counseling, but no one returned to the original research, which was under the radar and never critically evaluated," Larson says.

"So I studied that dissertation and immediately began to question the validity of the research because there were many problems with it," Larson says. "The statistics had never been vetted and were not approved by the methodological research community."

The study had analyzed data from a number of studies to determine what has become to be called "treatment-induced deterioration effects."

Larson consulted with statistical and methodology experts across the country to see if the research was valid.

"If the research was invalid, it was an extraordinary discovery because the study had shaped the entire way we were viewing bereavement in literature," Larson says. "In the seven years since the article, it had set the stage for the emergence of a pessimistic outlook on bereavement counseling."

The statistical experts confirmed that the dissertation's findings were invalid, Larson says.

So why did the media and research community pounce so easily on a flawed study to cast doubt on the positive impact of bereavement counseling?

Larson suspects it was a perfect storm of several things: "What happened is a number of people who are advancing counterintuitive positions overall, saying we don't need to talk about our loss experiences, found these dramatic counterintuitive findings to be very supportive of their positions, and so they championed them."

Since no one before Larson examined the original data, the findings were immune to critical review, he adds.

And since the media likes controversy and finds counterintuitive findings more interesting, the negative view of grief counseling has a longer-lasting public presence than it might have otherwise, he says.

"If you want to get into the *New York Times*, it's much easier to say you shouldn't talk about loss experiences, because to say you should talk about loss is not very interesting," Larson says.

In fact, Larson was interviewed this past summer by a reporter from *Newsweek*, who persisted in writing a story that was largely negative about grief counseling, despite his spending time explaining to her that this finding was based on bad science.

"I told her that every outside reviewer and methodologist has said the same thing, that the data is meaningless, and it's not just a judgment call," Larson says.

So a stigma about grief counseling persists, and it is hard to shake, he says.

"It's a psychological challenge to turn the field's view around," Larson says.

But hospices and bereavement counselors should take heart in the findings that have disproved the pessimism about grief counseling, he says.

"For bereavement workers who have felt self-doubting of the efficacy of their interventions, this should be very good news," Larson says. "This is about a scientific issue."

Larson has published a paper that disputes the pessimistic view in the August issue of *Professional Psychology: Research and Practice*, and he hopes hospices and other health care entities will use this study to shore up support for grief

COMING IN FUTURE MONTHS

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counseling.

"I've heard many times that the [earlier] negative findings have been used to critique funding for bereavement programs with people saying, 'Why should we support bereavement services if they're harmful?'" Larson says. "And now the hospice world has some real good arguments in favor of bereavement services."

References

1. Larson DG, Hoyt WT. What has become of grief counseling? An evaluation of the empirical foundations of the new pessimism. *Prof Psych: Res & Pract*. 2007; 38:347-355.

2. Neimeyer RA. Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Stud*. 2000; 24:541-558. ■

NEWS BRIEF

Study proves danger of abbreviations

Abbreviations in health care may be efficient, but their use comes at the expense of patient safety, according to a new study published in the September 2007 issue of *Joint Commission Journal on Quality and Patient Safety*. The findings of this study provide further support for The Joint Commission's "do not use" list of abbreviations that is part of its National Patient Safety Goals. The study also suggests the need to consider additions to the "do not use" list.

Although abbreviations are known causes of medication errors, the study, "The Impact of Abbreviations on Patient Safety," is the first to examine the exact characterization and impact of these errors. The study collected and analyzed data through a retrospective review of errors resulting from abbreviations as reported to the United States Pharmacopeia's Medmarx, a national database for medication errors, from 2004 through 2006.

The study found that nearly 5% of all errors reported to Medmarx during this time period

CNE *questions*

1. How will therapy for home health patients be affected by the new rule for the Home Health Prospective Payment System, according to **Mary St. Pierre**, MA, BSN, vice president for regulatory affairs, National Association for Home Care and Hospice?
   A. No changes for therapy
   B. Two therapy thresholds in place now as compared to one
   C. Three therapy thresholds now in place
   D. Number of therapy visits don't affect reimbursement

2. What is the purpose of the Home Care Association of New Hampshire's Good to Go program, according to **Susan Young**, executive director?
   A. To publicize home health agencies' services to the community
   B. To evaluate home health agencies' preparation for emergencies
   C. To give home health patients emergency supplies
   D. To help home health employees prepare themselves for emergencies

3. According to **Eva Chittenden**, MD, having hospitalists as part of your hospital improves the likelihood that your palliative care program will be successful.
   A. True
   B. False

4. **Dale G. Larson**, PhD, criticized earlier statistics on grief counseling because the data they are based on were not:
   A. correct.
   B. peer-reviewed.
   C. real.
   D. coherent.

Answer Key: 1. C; 2. D; 3. A; 4. B.

were attributable to abbreviations. This analysis of nearly 30,000 medication error reports involving abbreviations suggests that health care organizations should consider additions to the "do not use" list. Candidates for an expanded list include drug name abbreviations (for example, PCN, DCN, TCN), stem abbreviations (amps, nitro, succs), µg (mcg), cc (mL), and dose scheduling (BID, TID, QID), according to the authors.

Reference

1. Brunetti, L, Santell JP, Hicks RW. "The impact of abbreviations on patient safety." *Joint Commission on Quality and Patient Safety*. September 2007. Vol. 33: 576-583. ■

CNE 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. ■

CNE 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 **March 2008** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■