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# Hospital Home Health®

*the monthly update for executives and health care professionals*



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## Emergency plans, teletriage decrease patient visits to emergency department

*Thorough, repetitive patient and staff education produces results*

**I**t's the middle of the night and the patient you admitted last week is having difficulty breathing. Because the nurse has only seen the patient once, and because of the time of day, and because both the patient and the caregiver are not sure what to do, they go to the emergency room.

This emergency room visit and a possible rehospitalization could have been prevented with a well-designed patient emergency plan as well as an effective teletriage system.

All home health agencies have some form of patient emergency plan and a teletriage process in place, but some agencies handle processes better than others, points out **Eve Esslinger**, BSN, MS, project manager for Home Health Quality Improvement Organization Support Center-Quality Insights of Pennsylvania in Harrisburg. "You can decrease visits to the emergency department and rehospitalizations by making sure that patients know when to call you," she says. In order to decrease those visits, agencies should take a careful look at their processes, policies, and education, she suggests.

Reducing hospitalizations was the reason that managers at Lutheran Home Care Services in Chambersburgh, PA, evaluated their own patient emergency plans and teletriage system, says **Kathy Johnson**, RN, director of the home care agency. "We reviewed our data against the CMS data of other agencies to set priorities for quality improvement programs," she explains. "We identified reduction of rehospitalizations and emergency department visits as a high priority." One year later, the agency has seen a drop in the number of patient visits to the emergency department and subsequent rehospitalizations, she adds.

As Johnson's agency staff members reviewed charts of patients who had made trips to the emergency department or were rehospitalized, they looked at what happened immediately before the trip to the hospital. Not only did the agency determine what initiated the patient's decision to seek help, but staff members also documented whether the patient called the agency and, if so, whether the nurse sent them to the emergency department. "We also looked at the date of admission for the

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patient," she adds.

"We did find a few trends in our study," says Johnson. "We found that many times patients just did not call us, especially if they were relatively new to home care," she says. "We also found that nurses who were newer to home health and were juggling a number of scheduled visits would not be able to visit the patient for several hours, so the patient would go to the emergency department."

Although plans to improve staff education and the teletriage process were made, the agency also improved the patient emergency plan process, says Johnson. "We realized that the first step in reducing hospitalizations is to get the patient to call us before heading to the hospital.

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"We always had information in our admission packet about when to call the home health agency, but we cover so much information with the patient at the first visit, it was hard for patient to remember," admits Johnson. "Now, we use a laminated, three-column card that describes symptoms, when to call the home health agency, and when to call 911 or go to the hospital," she says. At the first visit, nurses not only show the card to the patient and explain how to use it, but they also post it on the patient's refrigerator, she points out. Posting the card on the refrigerator not only makes the information easy to find but also emphasizes the importance of the information to the patient, she says.

"Of all the tools produced for the Home Health Quality Improvement National Campaign, I have had more people tell me they like the patient emergency plan tool the most," says Esslinger.

(See resource box on p. 4 for information on free patient emergency plan.) "The symbols catch people's attention and the format is easy to read and understand," she says. Although the emergency plan tool has been successfully used in many agencies, Esslinger does suggest that agencies modify it as needed to fit their own patients' needs. "It is available as a modifiable document so agencies may make additions, deletions, or changes," she adds.

## Educate all staff members

Once patients know when to call the home health agency, make sure that your staff are well trained and the process is well defined, suggests Esslinger. "When patients call, they should not be put on hold for a long period of time," she says. "They should be connected to a nurse if the patient is calling with a health-related issue."

Be sure that your teletriage process works well 24 hours a day, points out Esslinger. "Some agencies find that their on-call coverage outside of normal business hours works well, but teletriage during the business day is less smooth," she says. Although more employees are available during normal business hours, nurses that normally see the patient may be tied up with visits to other patients, or receptionists may not have clearly defined methods of getting the patient connected to a nurse. "All agency employees should be familiar with the process and know who can take the patient's call," she adds.

"Everyone needs to be on the same page,"

agrees Johnson. "Some of our patients only receive therapy visits so the therapist reviews the emergency plan and posts the card to make sure the patient knows whom to call," she points out. "Our home health aides are also trained to reinforce the emergency plan and to call a nurse if they notice symptoms that require attention."

Johnson's agency also has improved the teletriage process during day. The night call process uses an answering service that has the capability to immediately forward the patient to the nurse's home or cell phones so there was no delay in reaching a nurse. During the daytime, however, nurses could not answer their cell phones if they were with patients, Johnson points out. "Now, our receptionist receives the call, then while the patient is on hold, finds the supervisor of the territory in which the patient lives and transfers the patient to the supervisor," she says. "The supervisor talks with the patient to determine if there is need for a visit, if there is something that can be done over the phone to alleviate the patient's concern, or if there is a need to call a physician or send the patient to the hospital.

"We also require nurses to get supervisor approval before directing patients to go to the emergency department," says Johnson. This step gives the supervisor an opportunity to make sure that there is a legitimate reason for the emergency department visit or to schedule another nurse to make a visit to the patient if the primary nurse is unable to do so due to her schedule.

"We did enhance our staff education," says Johnson. All employees learn about the emergency care plan and the teletriage process in orientation but nurses do not take a call for at least 90 days after they are employed, she points out. "Prior to taking call after hours, a nurse must attend a four-hour class that reviews the teletriage process and the tools and resources available to help nurses make decisions during triage." (**For decision-making resources, see p. 4.**)

### **Keep process simple, part of normal routine**

The key to successful implementation of any change in home health is to keep the change as simple as possible, suggests Johnson. "We have so many documentation requirements and processes for our nurses to handle that we need to make sure changes help them in their job rather than add to the complexity," she explains. Having the patient emergency plan card laminated and

easy to post on the refrigerator was simple and makes it easy for nurses to review with patients at each visit, she says. "Providing decision-support tools also simplifies the process and gives nurses information that is easy to access via laptop."

Make sure, also, that all employees understand the reason for the change, suggests Esslinger. Explain what your reasons are for making the change and report back to staff members results of the change, she says.

Johnson not only explains how rehospitalizations and visits to the emergency department affect the home health agency's bottom line but she also posts regular reports, divided by office location, about rehospitalization and emergency department visit rates on a bulletin board in each office. "We also talk about the patient emergency plans and teletriage in team meetings to review the process and identify ways to improve it," she adds.

Even with staff members explaining the emergency plan and reminding patients of the process at each visit, there are times that you may not be able to control the situation, points out Johnson. There are two situations that arise in Johnson's area that sometimes result in visits to the emergency department even if the home health agency has done everything it can.

"Because our local hospital has hospitalists on staff, primary care physicians in our area are less likely to leave room in the daily schedules for immediate visits from patients," says Johnson. Even if the home health nurse assesses the patient at the home and calls the physician to recommend that he or she see the patient, the physician is likely to send the patient to the emergency department to be seen by a hospitalist. If the patient does need to see a physician and the family physician won't see the patient immediately, there really is no choice but to send the patient to the emergency department, she adds.

The other situation that occurs is when out-of-town family members visit the patient, points out Johnson. When family members have not seen the patient in a long time, they may be surprised to see weight loss, less mobility than they remember, or other changes in their condition, she says.

"Even patients who speak regularly to family members don't explain every detail of their condition, so symptoms or conditions that are normal for the patient may seem alarming to a family member who hasn't seen the patient in a while," she explains. The family member's first

## SOURCES & RESOURCES

For more information about patient emergency plans and teletriage, contact:

- **Eve Esslinger**, BSN, MS, project manager, Home Health Quality Improvement Organization Support Center-Quality Insights of Pennsylvania, 2188 Crawford Road, Harrisburg, PA 17815. Phone: (877) 346-6180, ext. 7685. E-mail: eesslinger@wvmi.org.
- **Kathy Johnson**, RN, director, Lutheran Home Care Services, 2700 Luther Drive, Chambersburg, PA 17201. Phone: (717) 217-3529. E-mail: Kjohnson@lutheranhomecare.org.
- For a copy of the patient emergency plan, and other tools and plans developed by the Home Health Quality Improvement National Campaign, go to [www.homehealthquality.org](http://www.homehealthquality.org). Select "For home health agencies" on the left navigational bar, then choose "intervention packages" and scroll down to April 2007 to select "Patient emergency plan." This page contains links to documents related to patient emergency plans, including tools such as the patient emergency plan form.
- For access to decision-making tools that can be used in teletriage, go to [www.homehealthquality.org](http://www.homehealthquality.org). Select "For home health agencies" on the left navigational bar, then choose "additional resources." Scroll down to "Home Health Telephone Reference 2006/2007." This link will take you to the MedQIC site. On the right navigational bar scroll down to "Teletriage Decision Support Tools" to download.

reaction is to "find out what's going on and get the family member checked" even if the patient is seen by a home health nurse regularly, she adds.

To address this situation, nurses remind patients of their emergency plan and contact numbers for the home health agency if they know family members are visiting. Johnson suggests that by saying, "It's wonderful that your daughter's coming to visit this weekend. Remember that if she has any questions about your health or your care, she can call the agency any time.

Be sure to show her the refrigerator card with our phone numbers," you get an opportunity to answer questions and help the patient avoid an unnecessary trip to the emergency department. ■

## Boost all outcomes by improving diabetes care

*Check use of meters, medication, and diet*

Over 20 million people in the United States are diagnosed with diabetes — about 7% of the country's population, according to the National Diabetes Information Clearinghouse, a service of the National Institutes of Health. More than 20% of people age 60 or older have diabetes.<sup>1</sup>

The prevalence of diabetes, especially in older people, means that most, if not all, home health agencies have patients who are diabetic. The challenge is recognizing the impact diabetes has on overall care, even when the primary diagnosis is not diabetes, according to experts interviewed by *Hospital Home Health*.

"Our patients may have diabetes but most of the time the primary diagnosis for home health admission is not diabetes," admits **Janet Morrison**, RD, CDE, registered dietitian and diabetes educator for HealthEast Home Care in St. Paul, MN. "They can have any one of or a combination of diagnoses but we need to make sure we know about the diabetes," she says. Of all other conditions the patient may have in addition to the reason for home care, diabetes has the greatest impact on the outcome of most primary diagnoses, she points out.

"If a patient is not managing their diabetes, wounds won't heal as well and treatment for other conditions won't be as effective," says Morrison. "We use a multidisciplinary approach to diabetes care so that all of our staff members are educated about diabetes and know how to educate the patient." Staff education courses cover an explanation of what diabetes is, the importance of managing blood sugar levels, and how to use different meters. "We also have a clinical pathway that all employees, including social workers and aides as well as nurses, can use to determine what steps need to be taken if a patient is not managing their diabetes well," she says.

"We make sure that we identify the diabetes during the initial assessment," says Morrison. Patient education regarding diabetes is an ongoing effort, she says. "At the initial assessment, staff members make sure the patient understands the importance of measuring blood sugar levels at regular intervals and that they know what their acceptable levels are and how to properly use their

meter," she says. "There are so many different meters available and some are easier to use than others, so we often suggest other options if the patient has trouble with their meter."

Setting codes on the meters presents problems for many patients, points out **Joy Pape**, RN, CDE, a diabetes nurse educator and president of EnJOY Life Health Consulting in New York City. "Elderly patients often forget this step, which affects the accuracy of their readings," she explains. "There are new meters on the market that don't require codes so it is much easier for most patients." Other meters use larger displays to make the numbers easier to read or require less of a blood sample than older meters, she adds. (**See source box, below.**)

Watching the patient check themselves helps nurses identify reasons that testing is not done regularly and gives them a chance to suggest new products to the patient or to ask for a consultation with a diabetes educator to further evaluate the patient's technique, suggests Morrison.

Sometimes the lancet is the reason that patients don't check blood sugar levels regularly, points out Morrison. "Patients will save lancets to reuse to save money; as lancets get dull, they hurt more and patients will stop testing themselves," she says.

Because financial resources are an issue for many elderly patients, Morrison and the social workers at her agency often find themselves counseling patients on Medicare reimbursement for diabetes supplies as well as medication. "There are many patients that don't understand that supplies are covered," she says. "I have spoken with many pharmacists to set up accounts for my patients' diabetes supplies so that they can be reimbursed."

Not only do patients not realize that supplies and meters may be covered by Medicare, but many don't realize that a number of local pharmacies will deliver to the home, points out Pape. Patients may be ordering from another source because they deliver to the home but the advantage of using a local pharmacy is the fact that it can be the same pharmacy that handles all of the patient's medications, she adds. This simplifies the patient's record keeping and ensures that the pharmacist has a complete picture of the patient's medication use.

### **Check patient's knowledge**

After making sure that the patient knows how to check blood sugar levels, nurses will check the patient's knowledge about their medications, says Morrison. "We ask what types of medication

they take, how much they take and when, and what the potential side effects of the medication are," she says. "We also make sure they know the signs of hypoglycemia and what to do if they develop it."

"We know that there is a lot of information to remember, so we have a cheat sheet for both the nurse and the patient," admits Morrison. Having a quick reference tool to review ensures that the same information is covered with every patient, she adds.

Another important part of assessing a diabetic patient's home is making sure that they are eating regularly and correctly, says Morrison. "We ask if they can eat without difficulty and then we check to see that there is food in the house," she says.

When talking with patients about eating properly with diabetics, be aware that there is no "diabetic diet," points out Pape. "The best diet is a healthy diet that has decreased amounts of sugars," she says. If you talk about a specific diet that must be followed, patients may feel overwhelmed, she adds. "Just focus on eating healthy," she suggests.

Keeping the entire process simple is the key to compliance for most home health patients, says Morrison. "We teach nurses to check the meter's memory to double check information in case patient's don't remember everything. We also ask patients to keep a logbook, we pre-fill syringes, and we call upon an occupational therapist if the patient has difficulty with any of the tasks," she says.

If you make sure that patients understand why you are emphasizing diabetes care even if your primary reason for home care is wound care, you can increase compliance, says Morrison. She explains, "We explain that if they learn to better manage their diabetes, they can maintain their independence even longer."

### **SOURCES**

For information about diabetes care, contact:

- **Janet Morrison**, RD, CDE, diabetes educator, HealthEast Home Care, 1700 University Avenue W, St. Paul, MN 55104. Phone: (651) 232-2800.
- **Joy Pape**, RN, CDE, president, EnJOY Life Health Consulting, 345 E. 93rd Street, New York, NY 10128. Phone: (212) 933-1756. E-mail: [joypape@mac.com](mailto:joypape@mac.com).

## **Reference:**

1. National Diabetes Information Clearinghouse. National Diabetes Statistics 2005. [www.diabetes.niddk.nih.gov/dm/pubs/statistics/#7](http://www.diabetes.niddk.nih.gov/dm/pubs/statistics/#7). ■

# **Plan provides patients with referrals, home care**

*Demonstration project aims to reduce hospitalization*

**A** Medicare demonstration project at Montefiore Medical Center in New York City provides care coordination to help high-cost, fee-for-service beneficiaries comply with their medical treatment plan and access the community services they need to manage their chronic conditions.

"We are leveraging the experience we have in a managed care environment and applying it to a fee-for-service, high-cost population. We are using some of the principles of case management that are used in managed care and applying them in a non-managed care environment while working directly with patients, providers, and caregivers," says **Ann Meara**, RN, MBA, associate vice president, network care management.

## **Part of CMS demonstration project**

Montefiore Medical Center, the largest health care provider in the Bronx, is one of six health care providers chosen by Centers for Medicaid & Medicare Services (CMS) for a three-year demonstration project showing how care coordination, assistance with social support, and monitoring of patient's medical conditions can help prevent complications from illness and reduce emergency room visits and hospitalizations.

CMS has identified chronically ill Medicare beneficiaries who live in 16 designated zip codes in the Bronx and meet the criteria for the Care Guidance care coordination program. Participants in the program are all fee-for-service Medicare beneficiaries. If they join a Medicare Advantage or other plan, they are automatically withdrawn from the program.

"All of the participants have had some contact with the Montefiore system. It may be as minimal as having blood drawn here but CMS did include a loyalty criteria in the selection process," Meara says.

Each Medicare beneficiary who agrees to participate is assigned a care coordination team, depending on where they live and what their primary language is. The teams, led by a nurse case manager, include outreach specialists, patient educators, and social workers.

The care management team works with patients to understand the challenges they face in complying with the medical treatment plan. They identify social issues and other challenges that may hinder patients from fully complying with their treatment plan and work with them to overcome the challenges.

"This is not a disease management program. It is a program that deals with those issues that interfere with a patient's ability to adhere to a treatment program. We are providing caregivers with the resources they need to take care of the patients and help them stay healthy," she says.

For instance, the teams have found more appropriate housing for some participants whose living arrangements had been contributing to their frequent hospitalizations. They may arrange transportation for medical visits or connect participants with community services, such as Meals on Wheels.

Life planning is one of the biggest issues that the team addresses with the participants, Meara says.

"We talk a lot to the patient and family members about health care proxies and advance directives and the importance of having these documents in place," she says.

Many of the participants don't understand their medication regimens and the case managers work to educate them. They educate the participants about their conditions and about lifestyle changes they can make, such as exercising or good nutrition, to help keep them under control.

They refer people who are at risk for falls to the hospital's falls risk prevention program.

"The case managers make a lot of referrals for conditions that have not gotten attention. For instance, we have identified a network of dentists in the community who will treat Medicare beneficiaries and who have arrangements that base payments on a sliding scale that is tied to income," she says.

When the program was initiated, the medical center hired a temporary outreach team of community members with previous customer service experience and trained them on the program and how to communicate with the beneficiaries. Some of them are peers to the people they are calling.

After the initial group was enrolled, the medical center hired three members of the outreach team to continue enrolling participants.

When a participant enrolls in the program, a case manager calls him or her on the telephone and conducts an extensive assessment that covers nine domains, including: cognitive capacity, level of function, risk of falls, medical condition, end-of-life planning, and previous medical history, she says.

The information is collected in an electronic system, which stratifies the participants based on their psychosocial and medical needs and how much intervention they are willing to accept. One group of beneficiaries is self-directed. They were willing to participate but didn't want to complete an extensive assessment.

The care coordination team uses the electronic system to generate a problem list and develops an individual care plan for each member. The nurse team leader reviews the plan with the team, and depending on the participant's needs, assigns the person to a member of the team. For instance, if a participant needs help scheduling an appointment, that task is assigned to a non-clinician.

The teams are supported by a full-time pharmacist, a full-time nutritionist, a geriatric psychiatrist, and an internist. For instance, if there is a polypharmacy issue, the pharmacist calls the patient or caregiver and reviews the medications.

Follow-up calls are made according to the stratification level of the participant.

The Care Guidance program began a telemonitoring initiative for patients with heart failure in late 2007. Participants who meet certain criteria for congestive heart failure receive a scale with a monitoring device that connects to their telephone. They weigh themselves each day and answer a set of questions that they transmit into an electronic system that notifies the care coordinator if the patient appears to be having problems.

The case management interventions are primarily telephonic. The nurses may go to the home if the participant is uncomfortable doing the assessment over the phone, if he or she is hard of hearing, or if the primary caregiver prefers to be present.

## **Home assistance**

Home-bound patients who are not receiving regular medical care from a primary care physician are referred to the medical center's Medical

House Calls program, a team of physicians and nurse practitioners who provide care to patients in their home.

The team gets a hospital census every day to identify anyone in the program who has been admitted to Montefiore. If someone is hospitalized, the team's physician visits them in the hospital, assesses the condition, and makes a determination about appropriate follow up.

"This program is under our network care management program. The nurses who are conducting the telephonic case management work with the nurses at the hospital who are involved in utilization management and care management," Meara says.

The Care Guidance team coordinates care with the utilization nurses and case managers in the hospital and with the treatment teams throughout the health care system. Everyone in the health system has access to the same clinical information system and can share information.

"One of the things we've tried to do is to integrate what we do when people are outside the hospital with what we do when they are in the hospital," she says. ■

## **Patient education from a partnership perspective**

*Tools for teaching must become interactive*

ProHealth Care in Waukesha, WI, is in the process of implementing its "Partnership with Patients Work Plan." Susan M. Kanack, BSN, RN, patient education coordinator, is determining how to make the patient education tools more interactive to fit with the new partnership culture that is being developed.

In a partnership, nurses and other clinicians will engage patients in their care from all aspects, whether it be a task or procedure or in decisions made concerning patient education.

Currently, the tools are script like, states Kanack. They dictate things to be covered such as what a patient needs to do and who he or she needs to contact if there are questions.

"That information is great, but a lot of times it is still the same as lecturing the patient. So changing the formatting of our patient education will help in that the patient might have to write on it and engage with the material, make it their own,"

explains Kanack.

Although no new tools have yet to be selected, Kanack plans to move away from the checklist of topics that must be taught to the patient. She concedes that sometimes certain topics are required by administration or a regulatory agency but other than mandated information, educators will determine what to cover by interviewing the patient prior to engaging that patient in formal education.

Kanack envisions more of a dialogue between patient and practitioner to customize the education topics to the patient's needs — more of a give-and-take interaction than a general needs assessment interview.

For example, a woman who has just given birth would have different concerns if she already had children at home than if she were a first-time mom. During dialogue a new mom might express a need to know how to bathe a baby while the woman with other children might want to know about juggling sibling care with the needs of a new baby. By engaging the patient, the education is more meaningful, explains Kanack.

### **Changes will evolve**

The educational tools will not be changed to promote a patient partnership until the initiatives being implemented to create that type of culture are in place.

Kanack says the approach is similar to the one her health care institution has taken in regards to health literacy. First, the issue was presented and once staff understood the problem they began to ask for solutions. The same should hold true for patient partnerships. As care is changed little by little, staff will begin to ask how patient education applies.

Kanack does not want to introduce a new education process via an inservice, but have it evolve as the partnership initiatives become common practice. She says a more interactive approach to teaching will start to make sense as a partnership culture develops, and by the time the department is ready to really change how patient education is delivered, it will seem obvious to the staff and they will start to ask for more interactive teaching tools.

The process of education would not be extremely different from what currently happens in that staff conducts needs assessments before teaching. However, rather than an interview, the assessment would be more of a discussion, says Kanack. In a

traditional needs assessment the nurse takes the information provided by the patient and formulates a plan. In a partnership, there is a dialogue that continues beyond the needs assessment and the patient and health care practitioner set goals together.

It will be a culture change because health care providers have a desire to impart their knowledge on patients, providing information they think patients must know, says Kanack.

The development and selection of tools to promote partnership in patient education will be accomplished with the aid of the practice council, says Kanack. They will help define what is needed from a bedside standpoint. ■

## **Could payment changes be on horizon for hospices?**

*Hospice Medicare cap poses current problems*

**S**tarting next month, hospices will have to report to Medicare all nursing, hospice aide, and social worker visits made for patients. Then a few months later, the new conditions of participation (COPs) will be finalized, which will require greater attention to documentation of services and quality.

If anything can be learned from the past, it's possible that some sort of Medicare payment changes will not be too far behind, experts predict.

"I think there's validity to the observation that Medicare might be thinking of doing something similar to the hospice environment that they've done already in home health," says **Jeneane Brian, BSN, MBA**, clinical executive of Misys Healthcare Systems of Raleigh, NC. Misys Healthcare markets Misys Homecare software, which provides financial and office management assistance to home care agencies and hospices.

"Look at what Medicare did with skilled nursing care," Brian says. "Even further back in the 1980s, Medicare put hospitals on the DRG reimbursement system, which has case rate payments."

### **Home care rates change — Is hospice next?**

Most recently, the Centers for Medicare & Medicaid Services (CMS) required home care agencies to use a new assessment tool, named

OASIS, and then switched payment to a case rate, Brian adds. "It's not too much of a stretch to say Medicare is looking to do the same thing in hospice," she says. "Just look backward."

On the positive side, if CMS changes the way hospices are paid, it could make transitions to and from hospice less complicated, she adds.

"If everyone's payment is similar, then everyone's motives will be aligned, and then the decision will be clear without competing agendas," Brian says.

The Government Accountability Office (GAO) recommended in 2004 that there be a modification made to hospice payments, says **Annette Lee**, MS, RN, COS-C, clinical product development specialist for the Corridor Group of Overland Park, KS, which provides consulting services to the hospice and home care industry.

Although hospice reimbursement has not changed yet, the way hospices report data has changed. First, in 2007, CMS required hospices to start reporting where patients reside, and soon they'll have to report the visits made, she explains.

"We've never had to report this data because we're paid on a per diem basis," Lee says. "We're given a daily payment whether we saw the patient or not."

So while the reimbursement hasn't changed yet, the writing is on the wall, Lee says. "CMS is gearing up for quality in all areas right now, and that's their tag line: 'Getting the best care for the bills they're paying,'" Lee says. "But in other arenas, they're not tying that quality and measures of quality to payment."

While hospice directors and experts can only guess what the future will hold, it is clear that all hospices will need to maintain a steady and ongoing stream of referrals that give them the ability to manage their cost structure, says **Michael Ferris**, managing principal of Home Care and Hospice Marketing Solutions in Chapel Hill, NC. "One thing we can count on over the next five to 10 years is we have to be much better at running a hospice program or health care program, for that matter," Ferris says. "We have to be much better at generating those referrals with fewer resources, which means our sales people have to be better trained, more effective, and more efficient."

Staff who market hospices services will need to generate more business than they do now, and they need to look at some of the basic Business 101 strategies in doing so, Ferris recommends.

## **Data quality is top priority**

The hospice community faces several important changes, says **Jon Keyserling**, JD, vice president of public policy and counsel for the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

"I think there's a trend in health care over the past 10 years or so to both document quality and to substantiate outcomes for your protocols," he says. "And the hospice community is not going to be immune to that."

NHPCO has sponsored several data gathering tools and benchmarking tools to help hospices with quality data collection, he notes. The tools are available online to NHPCO members only. NHPCO membership starts at \$200 per year and goes up, depending on a hospice's total annual patient census.

"We're very active in suggesting to CMS that they include a quality improvement plan in the new COPs that will be released next year," Keyserling says. "This is an industry that is well known for its reputation of delivering quality improvement care, and the patient satisfaction scores are unequalled in any area of health care."

For that reason, Congress and other policy-makers have recognized that the Medicare hospice benefit is a wonderful success story within Medicare, he adds. "It's important to make sure that whatever changes policy-makers undertake does not threaten the high-quality and comprehensive interdisciplinary approach to end-of-life care that millions of patients and families have availed themselves of over the past 25 years," Keyserling says.

## **Hospice Medicare cap changes discussed**

One possible change that would be positive for hospices involves raising or eliminating the Medicare hospice cap, which is an aggregate per beneficiary limit on Medicare payments to hospices.

The Medicare Payment Advisory Commission (MedPAC) recently met to discuss issues surrounding Medicare spending and the limitations the cap places on the rapidly growing hospice industry.

In recent years, the cap has posed hardships for hospices that have seen dramatic changes in their patient population, including more non-cancer patients than cancer patients for the first time since the Medicare hospice benefit was

introduced. As a result, it's become more difficult to predict the length of stay of a particular hospice patient, and some hospices are being forced to pay about 1 million dollars because they've unwittingly exceeded their Medicare cap.

The Medicare cap is \$21,410 per hospice patient, so a hospice that has 250 patients in one year will have a total cap of about \$5.4 million, according to CMS.

"I don't believe MedPAC or CMS are at the point of taking action around the cap, but they're in an information gathering and analytical mode," Keyserling says. "At some point, I anticipate MedPAC will make some recommendations based on further analysis of data and changes in the hospice patient population that we've seen over the years."

For example, hospice was once a service provided to cancer patients. Now, fewer than half of hospice patients are dying from cancer. Since other chronic conditions and diseases, such as Alzheimer's disease, have a less predictable life expectancy, it means hospices have a more difficult time predicting costs, experts say.

Another problem is that the cap is not adjusted for high-wage areas even though Medicare payments are adjusted. This means that hospices in high-wage areas will be able to provide fewer visits than hospices in low wage areas before they reach the cap.

Hospices sometimes are told two years after a hospice patient has died that they must pay back some of the Medicare payments they received, even though the patient was eligible and the payments were legitimate, Keyserling reports. The repayments are in response to the flaws and complexities associated with the aggregate financial cap, he adds.

Medicare spending for hospice care was \$5.6 billion in fiscal year 2003, and CMS estimates the spending will exceed \$10 billion in fiscal year 2008. Meantime, the hospice benefit has been unchanged for 25 years, Keyserling notes.

### ***Medicare cap is complicated***

Since part of that Medicare hospice payment

increase is due to more spending per beneficiary, it means that hospice providers increasingly are exceeding their allotted hospice cap. In fact, there was a 41% increase in hospice programs exceeding their cap in 2005 over 2004, Brian says.

Among the hospices that exceeded their cap, they were an average of \$800,000 over the cap, per hospice, according to a major Medicare intermediary, she adds. "There are a lot more people in hospice who are staying longer, and it's very hard to manage under that cap," Brian says.

The cap is very complicated to compute even without the unknowns regarding patients, Keyserling says. For example, a hospice might admit a patient who has been served by another hospice. The hospice is required to apportion some part of that patient's Medicare cap to the other hospice, he explains.

"One of the suggested adjustments that may make real sense is to let hospice programs treat that patient as a whole patient rather than to share that patient's cap among other programs," Keyserling says.

One of our goals is to remove financial disincentive from the financial programs' sphere of issues and let it be a clinical decision, Keyserling says.

"Nobody wants to game the system, but it's really an issue of making sure that eligible patients are able to be served without financial penalties being assessed well after the fact," he says.

Hospices should be able to serve eligible patients with quality services without being penalized because a group of patients had a longer than expected length of stay (LOS), he says. "There are different diseases, and different groups of patients have different trajectories, and it's those kinds of changes that the cap may not be keeping pace with," Keyserling says.

"Ultimately, providers caring for eligible patients are being penalized for the services they are providing simply because the patient cap hasn't kept pace with the changing patient population." ■

### ***COMING IN FUTURE MONTHS***

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# Grief counselor offers ideas for dealing with male grief

*Here are some common misconceptions*

**T**rue or false: If a male caregiver/family member doesn't show any emotion, then he is coping well with his grief over his loved one's dying.

The answer is "false." This is a common misconception among some hospice workers and the public when it comes to dealing with male caregivers, family members, and patients.

"There are a lot of ways to grieve that don't have anything to do with crying or showing emotion," says **Keith A. McDaniel**, MFT, CT, a grief counselor with the FirstHealth Hospice and Palliative Care of Pinehurst, NC. People handle grief according to how they learned to express their feelings and emotions growing up, McDaniel says.

"I'm in my early 50s, and people in my generation didn't have fathers who knew how to share feelings and emotions because their fathers didn't," McDaniel says. "If our fathers didn't know how to share feelings and emotions, then it's difficult for the sons to know how to do that, and it's a re-learning experience."

McDaniel saw his own father cry only twice.

"If you think about it with kids, when they get into athletics, the coach will say, 'Shake it off, you're okay,' and so we're conditioned to have that stiff stance and stuff our emotions," he adds.

This type of emotional conditioning has a lasting influence and doesn't dissolve at the end of life.

"So then as an older male when we have a traumatic event occur, we don't have the tools to express those emotions," McDaniel says. "It's okay to be angry, but it's not okay to be sad."

The key is for hospice professionals to offer male patients and family members an action-oriented way to express their grief, he says. For example, a hospice could invite men to participate in a volunteer session of fixing or making something because men sometimes can work through their grief by working with their hands, McDaniel says.

"Men typically are doers, and they'll get involved in things that allow them to work with their hands," he explains. "One man created an urn for his wife's ashes in his workshop." Making or creating something is a way of expressing grief without outward emotions, McDaniel says.

Exercise, such as golf and walking, also can be

## CNE questions

1. During normal business hours to whom does the receptionist at Lutheran Home Care Services direct patients' emergency calls during the day, according to **Kathy Johnson**, RN, director of the agency?
  - A. The patient's primary nurse
  - B. Any nurse who is available at the time
  - C. nurse specifically trained for after-hours duty
  - D. The supervisor of the area in which the patient is located
  
2. What step is most frequently forgotten by elderly patients when they check their blood sugar levels, according to **Joy Pape** RN, CDE?
  - A. Maintaining a log book.
  - B. Setting the code on the meter
  - C. Pre-filling the syringe with medication
  - D. Eating regular meals
  
3. According to **Ann Meara**, RN, MBA, one of the biggest issues the team addresses with participants is life planning.
  - A. True
  - B. False
  
4. In a culture that supports a partnership between health care practitioner and patient, educational tools should be more interactive rather than script-like?
  - A. True
  - B. False

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

good strategies for dealing with grief, and hospice counselors can encourage men to return to their favorite exercise past time, he says. Hospices also could provide male-only support groups, although it can be difficult to get men to show up, he notes.

"We've had as many as five men come to a support group meeting, and these have been older men," McDaniel says. "It's very powerful when you have five or six men expressing their grief and crying with other men."

While it took a great deal of encouragement to fill the support group, once the men began to attend the meetings, they opened up and began to share their feelings, he adds.

Another strategy for working with grieving men is for nurses and social workers to sit back and not push them to open up, McDaniel suggests. By just being with them, practicing being a presence in their lives, the hospice workers might earn their trust.

"Just be there and talk about what they like to do, like what their hobbies are and those kinds of things, as opposed to trying to get directly to how they feel about their illness," McDaniel says.

Men also might be open to journaling.

"I think journaling is wonderful," McDaniel says. "The other thing is I deal a lot with dreams. I always ask the bereaved person if he has had any dreams about the loved one or dreams in general."

Men usually are not hesitant to talk about their dreams, McDaniel says.

Hospices might offer men massages and other types of therapeutic interventions, he says.

"I learned after my dad died to get massages, because I knew the grief would get stuck in my body and massages help to keep the grief flowing," McDaniel says. After a loved one has died while in hospice care, the husband or caregiver might need to get away for a while.

"One man after he lost his wife said, 'I don't know why, but I think I need to go to the coast,'" McDaniel recalls. "So he took a week to spend it alone traveling and just reflecting and keeping a journal." When the man returned, he said the time away had made all the difference.

"One man, while his wife was dying, would go to Wal-Mart or somewhere like that, once a week and he'd buy a fishing lure — one at a time," McDaniel says. "He collected these lures during the time of his wife's illness, and then when she died, he knew he needed to go out and fish for a week."

"The main thing to keep in mind is that everyone grieves differently," McDaniel says. "Just because your father is not showing emotions does not mean he's not grieving." Hospices can encourage men to attend support groups or inquire about grief services by distributing fliers and mailings, as well as by contacting men directly, he suggests.

"You can say, 'We're having a men's group, and we'd like you to come,'" McDaniel says.

"I think often times that men are looking for ways to express or deal with their grief, but they don't know what's out there, and they don't know that there are counselors who deal with grief," McDaniel says. "When you start to get enough men to come in, they'll start telling their buddies that it's okay." ■

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