HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care

AHC Media LLC

IN THIS ISSUE

APRIL 2008
VOL. 13, NO. 4 • (pages 37-48)

Recall of transdermal fentanyl patch tests procedures at hospice agencies

Be able to ID, reach affected patients quickly with info

Although more than 30 million transdermal fentanyl patches are involved in a recent recall, well-planned processes enabled hospice agencies to contact and protect their patients affected by the recall.

In mid-February, 25 mcg/hr transdermal fentanyl patches manufactured under the brand name Duragesic (manufactured by PriCara; Raritan, NJ) and the generic patches manufactured by Sandoz (Princeton, NJ) were recalled voluntarily by the manufacturers due to a cut along the side of the patch that might result in the narcotic gel leaking.

"Only the 25 mcg patch was affected, not any of the other doses," says **Michael Cinque**, PharmD, chief pharmacy care officer for Hospice Phamacia in Philadelphia. "The chance of a patch leaking was one in 2 million, but it was important to contact all patients who received the patch."

"Our company received the recall notice on Feb. 12; and on Feb. 13, we contacted all of our hospice partners with the recall information along with educational information to share with staff members," Cinque says. Instructions on how to check for leaks included looking for oozing or wetness around the patch, he explains. Also, the cut in the patch is visible, so inspection of the patch was possible to determine if the patch was at risk for leaking, Cinque adds.

An additional recall of transdermal fentanyl patches manufactured by Actavis in Morristown, NJ, occurred shortly after the recall of the Duragesic patches due to a manufacturing error in which the packet was incorrectly folded in such as way that a leak might occur, says Cinque. "There were a limited number of lots of those patches affected, and none of our hospice agency partners received them," he says.

Janet Snapp, RN, MSN, vice president of clinical services at Hospice of the Bluegrass in Lexington, KY, says, "We chose to recommend disposal of all of the recalled patches that were in the patients' homes because we did not want to risk exposing nurses to a leaking narcotic as they inspected

the stock of patches in the home." Snapp's in-house pharmacy was able to act quickly to identify patients who received the patches involved in the recall, she says. "This recall serves as a wake-up call for hospice agencies to make sure that their processes for identifying patients on specific medications are effective," Snapp adds.

While Hospice of the Bluegrass has an in-house pharmacy, hospice agencies that contract with outside organizations for pharmacy services should expect the same service during a recall, Snapp says. "Because hospice agencies provide the drugs to patients, we are ultimately responsible for the safety of the medications," she explains.

Nurses encouraged disposal

Only seven out of Snapp's 1,000 clients were using patches involved in the recall, she says.

"A nurse visited each home to talk with the patient and the family about the potential risk and to recommend that the patches be destroyed," she says. "Even though the hospice provides the medication, it is the patient's medication, so we can't destroy it."

Her nurses strongly recommended disposal of the unused patches by flushing them down the toilet, as directed by the Food and Drug Administration (FDA), and explained that fentanyl patches from another manufacturer would be delivered the next day, she adds. "Disposal of medication is difficult for many of our patients," she admits. Because older patients who lived through the Depression want to hoard supplies, nurses emphasized the potential safety risk and reassured them that they would not run out of pain medication, she adds.

"We also informed all of our nurses about the recall, not just those nurses visiting patients with the recalled patch," says Snapp. "Some family members saw news stories about the recall and had questions, especially if their family member was using a fentanyl patch."

Because the nurses had been alerted, they were able to answer questions and reassure patients who had patches that were not affected by the recall, she says. "We wanted to avoid situations in which patients refused to use their medications because they did not understand the recall," Snapp explains. "Our nurses' knowledge about the recall and the medications involved increased our patients' confidence in our services."

Some agencies had very few patients using transdermal patches because hospice medical directors don't always rely upon them for pain control. **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospice and Health Network in Bethlehem, PA, says, "I'm not a fan of transdermal fentanyl patches, and we usually work to transition patients to another pain medication when they are admitted to our hospice service, so the recall was not an issue for us."

Transdermal patches are most effective for patients with chronic, stable pain, Baxter says. He prefers medications that are more flexible when managing pain and allow for quicker changes of dosage, he says. Two of the pain medications he prefers are oxycodone and methadone, but both of these medications recently were affected by legal and regulatory decisions that affect price and dose, he says. **(See p. 39 for more information.)** The issues raised by recent recalls and decisions affecting narcotic pain medication point out the need for hospice agencies to have systems in

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

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

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). **Hours:** 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editor: **Sheryl Jackson** (sheryljackson@bellsouth.net.)

Senior Vice President/Group Publisher: **Brenda Mooney** (404) 262-5403 (brenda.mooney@ahcmedia.com).

Associate Publisher: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).

Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

Editorial Questions
For questions or comments, call **Joy Daughtery Dickinson** at (229) 551-9195.

Need More Information?

For more information about fentanyl recall patch recalls, contact:

- **Ric Baxter**, MD, Hospice Medical Director and Director of Palliative Care Services, St. Luke's Hospital and Health Network, 2455 Black River Road, Bethlehem, PA 18015. Telephone: (610) 997-7120. E-mail: baxterr@slhn.org.
- **Michael Cinque**, PharmD, Chief Pharmaceutical Care Officer, Hospice Pharmacia, 1601 Cherry St., Suite 1700, Philadelphia, PA 19102. Telephone: (877) 882-7822 or (215) 282-1615. E-mail: mcinque@excellerx.com.
- **Janet Snapp**, RN, MSN, Vice President of Clinical Services, Hospice of the Bluegrass, 2312 Alexandria Drive, Lexington, KY 40504. Telephone: (859) 276-5344. Fax: (859) 223-0490. E-mail: jsnapp@hospicebg.org.

To sign up for notification of recalls, go to www.fda.gov/opacom/Enforce.html and click on "Sign up to receive FDA Enforcement Reports."

place not only to identify patients on specific medications, but also to identify alternative medications for those patients, he adds.

Planning ahead means making sure that all pharmacies, including local pharmacies, that your agency uses have a process to notify you of recalls, identify patients using recalled medications, and provide direction on how your staff can identify and dispose of medications, says Cinque. **(See resource box, above, for information on how to sign up for FDA recall notices.)** "We included instructions on what to do if a patient, family member, or nurse got fentanyl gel on their skin," he says.

While soap and water usually is the recommended way to clean skin, water only is recommended for removing the narcotic gel, he says. "Soap changes the permeable barrier of the skin, making it easier for the drug to be absorbed, so water alone is better to remove the gel without increasing the risk of absorption," he explains.

When planning your response for a recall, don't forget to address how you will handle the recalled medications if, as in the recall of the fentanyl patches, the patient can continue using the medication once it is inspected for safety, says Cinque. "Disposal of medication can be costly, so you have to decide at what point risk outweighs cost," he says. For example, some agencies examined the patches by opening the packages to check for cuts that could cause leaks; other agencies simply recommended disposal of all patches without inspection, he says.

"This is a decision that needs to be made by each agency in each recall, taking into account the number of patients and the amount of medication involved, and the potential risk to patients and staff as they inspect the medications," Cinque says. ■

Court ruling affects cost of narcotic

Availability of some methadone changed

The February 2008 recall of transdermal fentanyl patches was an important issue for hospice agencies, but it only was one part of a bigger issue facing hospice agencies and palliative care providers.

"The transdermal fentanyl patches are one choice of a long-acting narcotic pain medication, but decisions affecting two other long-acting narcotic pain medications, oxycodone and methadone, will have a significant impact for hospice providers," says **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospice and Health Network in Bethlehem, PA.

Purdue Pharma in Stamford, CT, the manufacturer of Oxycontin, has won a patent infringement suit that will keep the generic form of the medication off the market, says Baxter. "The cost of the extended-release Oxycontin is over and above the per diem reimbursement for medication," he says. While hospice physicians won't start a patient on Oxycontin while in hospice care, many patients are started on the medication while in the hospital, he explains. "The cost of the medication is buried in all of the other hospital expenses, so it doesn't have the same impact as it does when the patient moves to hospice," he says. The patient and the hospice provider are faced with a decision as to whether to continue the Oxycontin or to switch to another pain medication, he adds.

Another long-acting narcotic pain medication that is used for hospice patients is methadone. "The Food and Drug Administration decided that, for safety reasons, 40 mg-strength methadone pills would be available only to drug treatment providers," says Baxter. Although methadone is

available in 10 mg strength, patients who need 40 mg may not be able to swallow an additional three pills in addition to all other pills they may be taking, he says. "The additional pills increase the complexity of medication management for the patient and caregiver and increases the likelihood of noncompliance," he says.

Another issue to address is how often medications should be delivered to the home, points out Baxter. By increasing the number of methadone pills fourfold, patients may receive hundreds of pills at a time, he says. "This increases the opportunity for diversion of the narcotic to someone other than the patient because it is more difficult to monitor the number of pills in the bottle," he explains. Delivery of smaller amounts of medication at more frequent intervals is one answer to the dilemma, he suggests.

While medication recalls may grab the headlines, hospice managers and medical directors should stay alert to other medication issues that affect patients, says Baxter. "I think that it is important that hospice providers work with local hospitals and referring physicians to make sure that they understand the financial implications of prescribing certain medications," he says. "By addressing pain management choices prior to admission to hospice, hospice staff can focus on life-closure issues and quality of remaining life as opposed to discussions of medication costs and financial decisions." ■

Inpatient hospice, nursing home situation is win-win

From financial drain to successful unit

(Editor's note: This is the second part of a two-part series on partnerships between hospice agencies and long-term care providers. Last month, we looked at the key issues to address in relationships that involve hospice employees visiting residents in long-term care facilities. This month, we look at a hospice agency that has developed an inpatient hospice unit within a long-term care facility.)

When the management at Rainbow Hospice in Park Ridge, IL, determined that the agency had reached a size and daily census that would support an inpatient hospice unit, they looked to current long-term care partners as potential landlords.

"Many inpatient hospice units are located in hospitals, but we wanted a different environment," explains **Pat Ahern**, chief executive officer of the hospice. "We didn't want our patients and their family members negotiating a hospital campus, and we didn't want them restricted by hospital visiting hours." By going to a facility other than a hospital, the hospice was able to create a warmer, more homelike environment, she says.

"We work with 85 long-term care facilities in our area, so we contacted them to see which ones might have the space we needed and be willing to lease it to us," explains Ahern. Requirements on Ahern's wish list included 7,000 square feet, the ability to convert the space into private suites for patients and their families, separate entrance for the unit, and close proximity to the home office to make it easy to manage the construction and startup of the unit, she says.

"We had one long-term care partner that was ideal," says Ahern. Not only did the nursing home have unused space, but they were experiencing a decline in occupied beds and were looking for a way to cover costs, she explains. The nursing home only is a five-minute drive from the hospice central office, and the facility's goals and patient care philosophy is a good match for the hospice, Ahern says.

Converting one wing

Because the nursing home was built with a number of wings, the hospice was able to rent one wing that previously housed 24 nursing home patients. It was able to convert it to 15 patient care suites along with a home-like reception and waiting area, and a hospice-specific entrance, says Ahern. "We paid for the renovation, and our rent includes dietary and housekeeping services, utilities, and parking," she says. Having a hospice entrance that is separate from the nursing home is important for the convenience of hospice families and for the privacy of nursing home residents, she adds.

Although services such as dietary and housekeeping are purchased from the nursing home, the inpatient hospice unit is staffed by hospice employees and all patient care is provided by hospice employees, Ahern says. "We have 17 employees for the hospice unit," she says. The staff consist of nurses, nursing aides, a physical therapist, and a music therapist, she says. "Three nurses came from our hospice agency, and others

Need More Information?

For more information about development of an inpatient hospice, contact:

☎ **Pat Ahern**, Chief Executive Officer, Rainbow Hospice, 444 N. Northwest Highway, Suite 145, Park Ridge, IL 60068. Telephone: (847) 685-9900. Fax: (847) 685-6390. E-mail: pahern@rainbowhospice.org.

came from other hospice agencies," she says. "Inpatient hospice nursing is not for every hospice nurse because it is more intense." Working at the inpatient unit is voluntary, but staff members will float between the agency and the inpatient unit as needed based on census, she adds.

Start new service slowly

In the first three months of operation, the inpatient hospice has reached eight patients, says Ahern.

"We are intentionally building slowly," she says. "Every patient needs us to do this right, and we don't get a chance for 'do-overs.' We have to do it right the first time."

Patients admitted to the inpatient unit have experienced an exacerbation in symptoms that cannot be managed at home, says Ahern. Examples of reasons for admission to an inpatient hospice include increasing pain, agitation, or the inability of a frail spouse to provide care, she explains. "About one-half of our admissions come from patients we are seeing through our agency, and the other half are directly from the hospital," she says.

Hospital patients' families like the availability of an inpatient hospice because they often are afraid that the family member won't get the same level of care in a home setting as they can receive in a hospital, says Ahern. "Our unit is a win-win for the hospital and the family," she says. Not only does the hospital have an appropriate place to which patients can be discharged, but families are reassured by the inpatient setting, Ahern explains.

Hospice managers who are considering development of an inpatient hospice unit should keep a few things in mind to ensure a successful partnership, suggests Ahern. "Make sure that the mission and values of the other organization match your mission and values," she says. Ask to see their mission statement, discuss the results of their most recent state survey, and even look up their profile on the Nursing Home Compare web site, she suggests. *(Editor's note: Go to www.medicare.gov, and select "Compare nursing homes in your area.")*

Also, be very open about your plans and why you are proceeding the way you are, says Ahern. Long-term care facilities don't get reimbursed in exactly the same way hospices are reimbursed, so use your initial talks to educate potential partners, she suggests. "Share your business plan and talk about how your plans can complement or affect their business," Ahern says. "Be sure to cover all issues related to staffing, services, equipment, and the building in your conversations as well as your contract."

Even with thorough planning, there are glitches, admits Ahern. "We identified every possible need for families, patients, and staff members and thought we had addressed everything," she says. One of the issues addressed was parking, and both Ahern and the long-term care manager believed that there were plenty of parking places for families of both facilities' patients. Four spaces were designated for hospice visitors to make sure there were places close to the entrance for them, she says. Other visitors could use nursing home spaces as well, she adds.

"We quickly realized that we underestimated our need for parking when 40 family members arrived to visit our second patient," Ahern says with a laugh. "We worked with the nursing home to negotiate overflow parking space with a church that is located one block from the facility. We direct families to the overflow parking when the lot is full, and we've had no more problems." ■

Hospice research is possible and helpful

Two Duke University Medical Center researchers tackle the question "Is it ethical to conduct clinical trials with patients in a hospice environment?" in the Feb. 4, 2008, "Professional Issues" section of the *American Medical News* web site.

Thomas W. LeBlanc, MD, resident in the Department of Internal Medicine at Duke University Medical Center in Durham, NC, and **Amy P. Abernethy**, MD, director of Duke Cancer Care Research Program, address two opposing

points of view. "The hospice environment is so different from other clinical settings as to be antithetical to research," is one view and "Palliative care seems woefully behind other medical specialties in its use of research-derived evidence and is thus in dire need of high-quality clinical research," is the second view.

Concerns raised by those who oppose clinical studies on hospice patients are outlined and addressed by the authors:

• Hospice patients are too vulnerable to give consent or be research subjects.

The authors point out that the portrayal of all hospice patients as frail and near death is not accurate. Many hospice patients are functional and autonomous, especially in early enrollment. The authors respond that several studies have shown that hospice patients "are interested and willing to participate in research," that "doing so is an autonomous act, a declaration of life and independence . . ."

• The use of placebos is inappropriate in hospice patients.

Placebo-controlled trials are only ethically justifiable when it is not clear which therapy is more efficacious, according to the authors. They explain that a "placebo-controlled trial of a pain medication vs. placebo would be ethically indefensible in any patient, in hospice or not. Such an experiment contradicts the physician's pledge not to let a patient's pain go intentionally untreated when an effective option — the standard of care — exists," say the authors.

• Research intrudes into the "circle of care" around the hospice patient.

The authors admit that "this concern is quite legitimate, but not insurmountable" and say that care must be taken to maintain the consent process, but that research "may enhance the experience." The added interaction of occasional visits by a clinical research assistant may "foster a sense of meaning for the patient and a feeling of accomplishment in helping to improve the quality of future care for others."

The authors conclude, "The many objections to hospice-based trials are not insurmountable." They point out that well-designed clinical trials can protect research participants, even when they are hospice patients. They add, "Furthermore, the need for data-driven care makes this endeavor ethically desirable, if not obligatory." *(Editor's note: The article can be found online by going to www.ama-assn.org/amednews. Under "Listings" on the left navigational bar, select "By date." Scroll down to "Feb. 4" and in the "Professional Issues" section, select "Research in hospice possible, even helpful.")* ■

Aging baby boomers may cause work comp boomlet

Safe patient lifting can reduce injuries

As the Baby Boom ages into an elderly boom, and demand for long-term and home health care soars, health care employees face changing realities at work. You can expect rising workers' compensation claims. Aging employees may need accommodations to stay in patient care. And keeping older workers will be a challenge.

Those are the trends detected through workers' compensation claims and injury data and analysis of workplace changes. While injury rates are dropping in workplaces overall, they have remained stable in hospitals and nursing homes. The frequency of workers' compensation claims in nursing homes are double the national average for private industry, and the frequency of claims in home health is 17% higher than average, according to a report by the National Council on Compensation Insurance (NCCI) in Boca Raton, FL.[1]

Meanwhile, home health care will have the strongest employment growth through 2014, according to the Bureau of Labor Statistics. Registered nurses, home health aides, and nursing aides are all the in the top 10 occupations with the largest job growth.[2]

"The biggest asset you have is your employees," says **Lynda Enos**, RN, MS, COHN-S, CPE, an ergonomics consultant with HumanFit consulting firm in Oregon City, OR. "They're expensive to replace, even those low-paid ones in nursing homes." The biggest challenge is turnover, Enos says. "A lot of that is due to the physical demands of the job," she says.

Wellness, injury prevention, and safe patient handling will be the keys to maintaining the aging work force even as demand for workers grows, Enos says. "I do see that employers look at the aging work force as a liability, but I think that's the wrong way to look at it," she says. "If you're proactive as an employer and you design safety programs, then you're looking at being able to accommodate all workers and keep your older workers at the workplace."

Nationally, the average age of nurses was 47 in

2004. About 41% of nurses were 50 or older, and only 8% were younger than 30, according to a study by the Health Resources and Services Administration.[3] The cost of replacing a single nurse is $92,442, according to a Robert Wood Johnson Foundation study.[4]

The retirement age is rising, and employees want to keep working, says **Sherry Taxer**, RN, COHN/CM, CCM, CPDM, senior clinical risk management consultant with Medical Protective, a consulting firm based in Beaverton, OR. But employers will need to be flexible, she says. "We want the good, seasoned, hard-working person who's dedicated to the job," says Taxer, who previously worked as an employee health nurse in home health care. "If the employer's not open to accommodating, they're going to lose that work force, and they need them."

Greater total WC losses

Workers in hospitals and nursing homes are injured at about twice the rate of all workers in general industry. The primary reason: Greater risk of musculoskeletal injuries due to patient handling.

NCCI estimated total loss costs by multiplying the incidence rates by the average incurred severity from its claims database. Total loss costs for home health care and nursing and personal care were higher than for general industry in 2004. About a quarter (23%) of all workers' compensation claims in long-term care were related to lifting.

The growth of a high-injury industry is an "emerging issue for workers' compensation," says **Tanya Restrepo**, MBA, an economist with NCCI and a co-author of the report. "We want people to be aware that [health care] is a growing industry due to the aging of baby boomers," she says. "It's a good idea to be aware of the characteristics of injuries in that industry." For example, a worker older than 40 with a musculoskeletal injury will be off work 12 days longer, on average, than a younger worker, according to data from UnumProvident, a Chattanooga, TN-based disability insurer.

Home health care in particular presents challenges for safe patient handling. While some home health nurses may have access to portable lifts, others try to assist patients without any mechanical devices. The rise in obesity increasingly puts home health workers at risk, Taxer notes. "The back strain in home health is unbelievable," she says. "You're in the home, and you're expected to lift with whatever [assistance] you have available. You could be by yourself [and be] expected to lift the patient."

Hospitals should do more to bring those injured nurses back to work in a job that isn't physically demanding, says **Kenneth Mitchell**, PhD, vice president of Health and Productivity for Unum. "It always amazes me that some of the hospitals have the least progressive transitional work programs," he says. "A hospital can save money by having an incremental return-to-work program. [You should] show you're committed to bringing people back to work."

Employers should take a "holistic" approach to preventing injuries, says Enos. In addition to ergonomic programs to reduce risks of musculoskeletal injuries, employers should provide wellness and stress management programs to encourage a healthier work force. "If you keep your body fit and healthy, and you're flexible as you get older and you deal with your stress, you're a happier worker," she says. "[Being fit] may also provide some immunity against the microtraumas and musculoskeletal disorders. You may also heal more quickly. It's all interlinked."

References

1. Restrepo T, Shuford H, De A. An emerging issue for workers' compensation — aging baby boomers and a growing long-term care industry. *NCCI Research Brief* Fall 2007. Accessed at www.ncci.com/ncci/media/pdf/research-baby-boomer-fall07.pdf.

2. Hecker DE. Occupational employment projections to 2014. *Monthly Labor Review* 2005; 70-101. Accessed at www.bls.gov/opub/mlr/2005/11/art5full.pdf.

3. Health Resources and Services Administration. The Registered Nurse Population: Findings from the 2004 National Sample Survey of Registered Nurses. February 2007. Accessed at ftp.hrsa.gov/bhpr/workforce/0306rnss.pdf.

4. Hatcher B, Bleich MR, Connolly C, et al. *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace.* Princeton, NJ: The Robert Wood Johnson Foundation; June 2006. Accessed at www.rwjf.org/files/publications/other/wisdomatwork.pdf. ■

Adverse events high in elders for these 3 drugs

Blood thinners may be linked to traumatic injuries

One-third of the estimated 177,504 emergency department visits by elderly patients for adverse drug events were caused by warfarin,

insulin, and digoxin in 2004 and 2005, says a new study.[1]

Interventions targeting warfarin, insulin, and digoxin use could prevent more ED visits for adverse events, says **Dan Budnitz**, MD, MPH, CDR, USPHS, the study's lead author and a researcher with the Centers for Disease Control and Prevention's Division of Healthcare Quality Promotion. Many of the methods used by emergency nurses to avoid problems with these medications also are helpful for hospice nurses. For example, to avoid adverse drug events, inform patients of the following, says Budnitz:

- how to take their warfarin, insulin, or digoxin, and particularly explain any changes that were made;
- whether newly prescribed medications or new diagnoses may interact with the medications;
- when and how to monitor medications with blood testing;
- what are warning signs of problems;
- who to call if problems occur.

ED nurses at Alegent Health Immanuel Medical Center in Omaha, NE, are seeing significant numbers of elderly patients with adverse reactions caused by warfarin, insulin, and digoxin, says **Linda L. Jensen**, RN, MSN, CEN, ED educator and emergency medical services coordinator. They have seen patients with either high or low prothrombin time/international normalized ratios (INRs) as a result of lack of understanding the dosing regimen, lack of assistance with medication administration by caregivers, and knowledge gaps regarding nutritional considerations, says Jensen.

ED patients may present with altered level of consciousness caused by dangerously low blood sugars related to new insulin regimens, says Jensen. "The elderly diabetic patient is often dependent upon others to assist with medication administration and monitoring physical symptoms," says Jensen. "This is a challenge for many elderly patients, especially if they lack interested, knowledgeable, and engaged family members or caregivers."

Do a head-to-toe comprehensive nursing assessment to uncover problems such as bruising hidden by clothing, says Jensen. Obtain a complete, current medication list by asking the patient for this information, examining medication bottles, contacting the pharmacy where the patient fills prescriptions, and obtaining the most recent hospital medical records, advises Jensen. "There are numerous sources that we need in order to put all those pieces together," she says.

Ask about blood thinners

If elderly patients report a fall injury, ask them if they are on any kind of blood thinner, even a daily aspirin, and determine the dosage they are taking, says **Sarah L. Anderson**, PhD, RN, CEN, SANE-A, clinical manager for the ED at University of Virginia Health System in Charlottesville.

"It may take a lot of investigative work to figure out what they are actually taking," she says.

For example, a patient may have a headache and report a fall injury that occurred several days ago, notes Anderson. "If the patient is on any blood thinner, symptoms of an injury might not show up for one or two weeks," she says.

Reference

1. Budnitz DS, Shehab N, Kegler SR, et al. Medication use leading to emergency department visits for adverse drug events in older adults. *Ann Intern Med* 2007; 147:755-765. ■

Select deemed status survey to save time

Joint Commission option eliminates need for survey

No hospice manager looks forward to any type of survey, but agencies that elect to undergo a deemed status survey by The Joint Commission can take care of two surveys in one visit.

The deemed status survey option not only serves as The Joint Commission accreditation survey, but also replaces the state Medicare survey. "The deemed status survey determines compliance with federal conditions of participation [CoP] requirements and conditions of coverage and evaluates compliance with The Joint Commission's standards," says **Debra Zak**, PhD, RN, executive director of the Home Care Accreditation Program.

Although the survey is not a state licensure survey, The Joint Commission is recognized in 24 states for renewal of licenses, says Zak. "Our survey is not recognized by states for the initial license," she adds.

Because the Centers for Medicare & Medicaid Services (CMS) has fewer requirements for a hospice survey than The Joint Commission, agencies

must meet Joint Commission requirements for eligibility, says Zak. The Joint Commission requires that a hospice has served 10 patients with two active patients at the time of the survey. CMS has no patient volume requirement.

A significant change to The Joint Commission's general eligibility requirements is the elimination of the need to have four months' data on compliance, says Zak. "Now, every organization is expected to be compliant at the time of the survey," she explains.

Agencies that already are accredited by The Joint Commission can request a deemed status survey be conducted at the same time as their accreditation survey when it is scheduled or, if an agency is a year or more away from the regular survey, an agency can request a Medicare CoP survey prior to the accreditation survey, says Zak." Agencies cannot request a Medicare-only survey for an initial survey," she adds.

Even if an agency is Joint Commission-accredited and Medicare-certified, it cannot be automatically given deemed status, says Zak. "Deemed status is an option and must be selected by the agency," she adds.

Following the survey, an organization has a 10-day period to explain reasons that a document could not be produced or respond to other items on the report. If an organization has a standard out of compliance, there is a 45-day period to submit evidence that the organization is in compliance, says Zak. "Standard-level deficiencies must be corrected before Joint Commission can recommend accreditation to CMS," she points out.

In addition to cutting one extra survey out of your busy schedule, Zak points out that CMS is overburdened and cannot always perform surveys in a timely manner. Agencies also have the ability to talk one-on-one with trained professionals to discuss best practices that can help with challenges that are faced by the organization, she adds. *[Editor's note: To apply for a deemed status survey, contact Jasmina Juric, business development specialist, at (630) 792-5251 to request an application. An online application can be accessed at www.jointcommission.org/Hctoolkit.]* ■

Community case managers help navigate health care

Outcome: more effective care plans

Faced with a complex, difficult-to-negotiate health care system, multiple providers, and myriad treatment options, many health care consumers are looking for somewhere to turn, and that means opportunities for case managers, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM.

"Consumers pay for tutors for their children. They pay for legal advice and financial advice," says Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company. "Why wouldn't they be willing to pay for an independent professional case manager to be their advocate as they visit the doctor, to help them understand their treatment options and their medication and to help sort out the confusion?" she asks. Mullahy frequently hears case managers say they are discouraged by increasing paperwork that takes them away from direct patient contact. But while they are not satisfied with their jobs, they don't want to leave the field.

Community-based case management gives independent case managers the satisfaction of developing long-term relationships with their patients and allows them to balance their home life and their professional life, she says.

Getting back to the patients

The process of case management works so well, but you can't do effective case management when you have a caseload of 100 patients, says Mullahy. Case management is so individualized and involves so many components, she says. "The best way is to put case managers in the community," Mullahy says. "When you can see a person in his own environment and develop a personal relationship with him, you can be a better advocate."

Her words are echoed by **Susan Moore**, RN, PN, a Chicago-based case manager who specializes in oncology and contracts with cancer patients and their families to support them through diagnosis, treatment, and survivorship. "Meeting with people helps develop a closer relationship," Moore says. "The people I see personally think of me as a nurse case manager, advocate, and a friend. Those I work with by telephone see me as a nurse case manager and a resource, but the personal contact is lacking."

When Mullahy speaks at health care seminars and forums, she asks the nurses if they have patients who are readmitted to the hospital or

visit the emergency department repeatedly because of something that happens after discharge.

Regardless of the setting in which the nurses work, the answer is always "yes."

Discharge plan problems rampant

Patients are getting out of the hospital quicker and sicker, but hospital discharge planners don't have the time to make sure that the discharge plan that looks great on paper really works, Mullahy says.

"Sometimes the patients are being treated by multiple physicians and they don't know which practice to call when they have symptoms," she says. "They call and get voice mail and the problem isn't corrected, so they go to the hospital and are treated by yet another doctor."

Chronically ill or catastrophically ill patients may receive telephone calls from a case manager, a disease manager, a health coach, and a discharge planner, but they don't talk to each other and none of them know what's going on in the home or what issues or obstacles to adherence the patient may face.

"The health care system is broken," Mullahy says. "The process of case management is a wonderful process, and it's not broken. What is broken is where and how case managers are being used."

Mullahy recalls the words of a patient in the hospital coronary care unit where she started her nursing career. "I was telling him how he needed to make lifestyle changes, to pace himself better, and to consider another job," she says. "He said, 'You have no idea what my life is like,' and he was right. You can't possibly know what an individual's life is like and help him or her make lifestyle changes until you have a relationship with them."

Case managers can't determine whether their discharge plan will work unless they know what is going on in the home. Is it in a trailer park or the inner city? Is it crowded and dirty? All of those factors can affect the discharge plan and the patient's ability to adhere to the treatment plan, she says. "I remain convinced that the best way to do case management is on site," she says.

The on-site model

The model already is working with geriatric case managers who help manage the care of elderly patients whose children are living in other parts of the country, Mullahy says. Many geriatric case managers are social workers, but there are many elderly people with complex conditions who could benefit from the help of a nurse case manager, she adds.

You can't work with elderly Medicare patients over the telephone, Mullahy says. "You have to see them up close and personal to determine what is wrong," she says. Some have dementia. Some have personal problems. Many have hearing problems. "You can't work with them telephonically, and you can't expect them all to use a web site to obtain the answers to the questions they may have or get the reassurance they need," Mullahy says.

Some insurance companies are beginning to provide face-to-face interventions for their high-risk clients. For example, WellPoint locates community resource centers in areas where there is a large population of members in its publicly financed insurance programs to better serve its members by building a relationship, says **Nancy Atkins**, MSN, RNC, NP, vice president of state-sponsored business for WellPoint.

"We realized that we couldn't adequately serve members' complex medical and social needs with just a toll-free number," Atkins says. "With people whose needs are so complex and far-reaching, it takes a personal relationship to make a difference."

But the elderly and other publicly funded clients are not the only people who could benefit from an independent, community-based case manager, Mullahy adds. People who are catastrophically ill, people who are newly diagnosed with cancer, those with life-changing illnesses such as congestive heart failure or end-stage renal disease, parents of children with multiple handicaps or chronic illnesses all could benefit from someone who could help them understand their condition, evaluate treatment options, and help them comply with the treatment plan, she says.

"The goal would be to empower patients and families to become their own case managers," she says. "Some people may need only a few weeks of help until they understand what's going on. Others may need case management for several months."

In addition to patients and family members, sources of referrals for community-based case managers may be treating physicians, Mullahy points out. "As the trend toward giving physicians pay-for-performance incentives continues,

some physicians are hiring case managers to help them improve the outcomes for complex patients," she says. "There is more recognition that complex patients need a different kind of intervention."

Sources of referrals could include physicians who have difficult-to-manage patients, financial advisors who work with trust funds on behalf of individuals who suffered birth injuries or life-altering injuries from accidents, employers that offer health savings accounts, or self-insured employer groups not large enough for a managed care case management program.

"There's a push toward consumer-driven health plans and consumers assuming control of their health care but the system we have is not one that works for the average person," Mullahy says. "Of equal concern, the system is difficult even for those of us who have worked in the midst of it for all our professional lives. Patients and their families need someone to advocate for them and to help them through the health care maze, and the community-based care managers can be that caring professional." *(Editor's note: For more information, contact Mullahy at Mullahy & Associates, Huntingdon, NY. E-mail: cmullahy@mullahyassociates.com. Web: www.mullahyassociates.com.)* ■

Palliative care standards are open for comment

The Joint Commission has released proposed standards for palliative care for comment from those who provide palliative care services.

The draft standards are posted on The Joint Commission's web site and have been sent out for comment to health care organizations and national palliative care experts. The deadline for feedback is April 8, 2008.

The draft standards cover program management, provision of care, management of patient information, and performance improvement. Palliative care services seeking Joint Commission certification also will be expected to use evidence-based national guidelines or expert consensus to guide their services.

The proposed palliative care standards are part of The Joint Commission's Health Care Services Certification Program. Scheduled to launch in August 2008, this new evaluation program is designed for health care services provided to patients in various health care settings. *(Editor's note: To see the proposed standards, go to www.jointcommission.org/Standards/FieldReviews and select "Proposed Palliative Care Certification Standards and Elements of Performance.")* ■

Partnership to provide resources for caregivers

The Hospice Foundation of America (HFA) has partnered with AssistGuide Information Services (AGIS), an online community and information resource for family caregivers, to offer advice and information on end-of-life issues for caregivers. The AGIS web site is www.agis.com.

"This partnership enables HFA to reach a large audience of caregivers who are looking for answers about a variety of end-of-life issues, including caring for someone who is dying, hospice care, and grief," said **David Abrams**, HFA president, in a prepared statement. "This partnership is exciting for us because AGIS is one of the few online communities to have successfully reached across generations to provide information that all of us will someday need."

The AGIS elder care portal showcases HFA's expertise in caregiving issues involving terminal illness, grief, emotional pain, and other complex issues associated with the last months or weeks of a loved one's life.

COMING IN FUTURE MONTHS

- Music therapy in hospice care
- Meeting the needs of bilingual patients
- Use the right words when talking with families
- Tips for web sites that generate referrals

The new AGIS interactive HFA "Ask the Experts" section enables families to find specific answers to personal challenges easily online.

AGIS site includes long-term care resources, Alzheimer's disease and dementia information, legal and financial preparation tips, checklists, and suggestions for new caregivers. Other groups partnering with AGIS include Alzheimer's Foundation of America and the Family Caregiver Alliance. ■

CMS releases final HIPAA security paper

The Centers for Medicare & Medicaid Services (CMS) has released the final paper in the Health Insurance Portability and Accountability Act (HIPAA) Security Educational Paper series. Titled *Security Standards Implementation for the Small Provider*, the paper is intended to assist small health care providers with HIPAA security rule compliance.

In addition to an overview of the security rule standards as they apply to small organizations, the paper includes a table that describes each standard, an example of proper implementation, and questions that each organization should ask to evaluate compliance.

The other papers in the series include:

- *Security 101 for Covered Entities*;
- *Security Standards Administrative Safeguards*;
- *Security Standards Physical Safeguards*;
- *Security Standards Technical Safeguards*;
- *Security Standards Organizational, Policies and Procedures, and Documentation Requirements*;
- *Basics of Risk Analysis and Risk Management*;

To see a copy of the *Security Standards Implementation for the Small Provider,* go to www.cms.hhs.gov/EducationMaterials/Downloads/SmallProvider4final.pdf. ■

Online bonus book for *HMA* subscribers

Readers of *Hospice Management Advisor* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2008 online bonus report, visit **www.ahcmedia.com**. ■