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about insurance and
risk management for
hospices and home
health care agencies.

Communicating and Documenting Patient Assessments and Laboratory Findings

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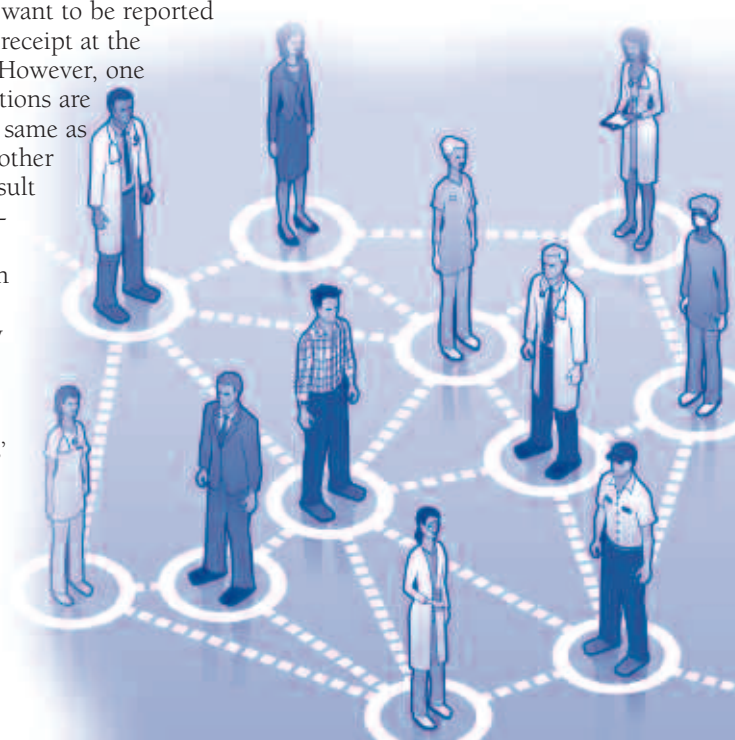
Home care and hospice staff routinely conduct patient assessments and perform treatments and venipunctures for the purpose of laboratory testing. Staff is expected to perform these assessments and document and report changes and findings to other team members, physicians and family, as necessary and appropriate. While documentation is expected at the time of care delivery, determining a timeframe for follow-up reporting is not always clear. As a result, there can be instances when either too much or not enough is documented and communicated in a timely manner. Providers continually strive to improve documentation and communication to other healthcare providers involved in the patient's care and to the patient's family/significant other. Both documentation and communication have similar essential elements. Consistency is important to both of these processes and it can be problematic to establish clear expectations, especially in the area of communication.

Laboratory Test Results

While performing a venipuncture for laboratory tests ordered by a physician is a routine part of a skilled nursing home care visit, it is not always as routine to determine the proper form and time-frame for reporting laboratory values, especially those that are outside the normal value range. Laboratory tests can be ordered as stat (i.e., statim-as soon as possible) or routine. Most tests have an expected turnaround time (TAT) that is prescribed in the laboratory's handbook, which details its testing process and protocols. When a stat test is ordered, physicians want to know the results as soon as possible. They also want results ASAP when any laboratory test result is determined to be critical.

There are some physicians who inform healthcare providers about their expectations with regard to laboratory and other test results, as well as results/values they want to be reported immediately upon receipt at the provider's offices. However, one physician's expectations are not necessarily the same as the expectation of other physicians. As a result of physician preferences, it might be difficult to establish one protocol for reporting laboratory results, including critical laboratory results, which will meet all physicians' expectations.

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Resources for handling critical laboratory results are available, including online references, such as the International Society of Laboratory Hematology (ISLH), the Dartmouth-Hitchcock Medical Center, the Medical Center at the University of California, San Francisco Medical Center and Trauma Center, and Massachusetts General Hospital. Each of these medical centers' handbooks provide critical value results for specific laboratory tests performed within its facility, and each handbook outlines the process to follow for reporting results, including timeframes, format and to whom test results are to be reported. Each of these medical centers' laboratory resources are available at the websites included in the references at the end of this article.

Massachusetts General Hospital (MGH) defines critical results as those that if left untreated, could place the patient at serious risk or be life threatening (www.mgh.org). Provider staff need to be aware that the critical lab result can come from both routine and stat laboratory tests and that this definition applies to all lab tests that are performed. The MGH lab assigns turnaround times for the communication of critical lab tests. For example, the responsible licensed caregiver is to receive the lab result within 40 minutes of the result being available. This time is broken down into two sections: 30 minutes within the lab from the time of identification of the test result to when it is reported to the floor or practice. In the case of community-based settings, the floor would be defined as the home health or hospice office. The remaining 10 minutes is the expected turnaround time from when the floor or practice obtains the results until they are communicated to the responsible licensed caregiver. With specific other test results, non-critical values, the lab or floor staff are expected to make courtesy callbacks or send courtesy emails notifying the responsible licensed caregiver (www.mgh.org).

Often, the laboratory will define critical laboratory tests and procedures. These tests and procedures are to be performed and reported quickly since the results can determine the appropriate course of care. Examples of tests, so defined by MGH, are Acute Care PTT, CBC Core, Blood Gas Potassium, Pediatric CBC and Diff Counts,

Transfusion Reaction Work-Up, Blood Transfusion Services Donor Cross-Match, Stat Gram Stain Microbiology and Frozen Section Surgical Pathology tests. Expected timeframes for conducting these tests range from 10 - 90 minutes.

Communicating and Documenting Results

Providers seek to develop the most efficient and effective process for communicating laboratory results and for accurately documenting each communication. One source for possible best practice formats is the laboratory itself. Locally, providers can use several facilities for laboratory tests. So it is a good idea to contact each laboratory utilized and obtain its critical laboratory value results and its process for notification of critical and routine results. Providers can use these as a basis for establishing their own protocols and procedures. Many medical centers have an electronic notification system, which might be effective for non-critical results, but is usually expanded upon for critical results. It is usually recommended that critical results be reported with phone notification to the ordering physician's designated phone or beeper number. The caller should identify whom they have reached and verify the results by having the receiver repeat the results back to them. In addition, a printed or faxed report can be sent to locations specified by the individual ordering the tests, but it is necessary that the phone call is also made. The phone call's documentation needs to include who called, their credentials, time of call, the patient's full name, to whom the information was provided, and the laboratory result reported. For example:

Time: 15:15

Date: November 10, 2011

Patient's Name: John Patient

Lab Test & Result Reported: PTT (Partial thromboplastin time)

Result: >100 seconds [<http://mghlabtest.partners.org/CriticalValues.htm>]

Communicated to & Read Back by: Sally Office, Office Manager (Name and Title)

Signature: Barbara S Gingerich, RN

A voice mail message is not sufficient and should only be used as a last resort. The documentation of the voice mail message left should include all avenues employed for reporting, prior to leaving the message, along with the date, time and details of the message left, including whom to contact to verify that the message was received and understood.

Condition and Assessment Changes

Assessing the patient's condition is an essential aspect of care. Assessments look at markers related to the patient's primary diagnosis/condition, such as physical (i.e., wound measurements, weight) changes. Ongoing assessments also look at other patient factors, such as mental (i.e., confusion, mood) changes and system assessments (i.e., circulatory, pulmonary, etc.). The assessment findings of any one visit are a snapshot at that point in time. Some assessments present a clear picture of approaching problems, such as when a wound is beginning to separate, i.e., dehisce, and provide the assessor enough information to take immediate action. More often assessments, such as wound measurements, provide a pattern or lack of pattern indicative of the ongoing healing process. While in many cases there are no action steps to take, there are several

Clear, timely,
and appropriate
communication
should be a
care team effort.

guidelines that might be used as resources for decision making.

Best Practices – Evidence-Based Care

The clinical pathway model was introduced into home care and hospice in the mid 1990s. Clinical pathways incorporated the best practice, disease state management and clinical practice patterns that were present at that time. The key focus was prevention, treatment and control of disease and its impact on the individual's quality of life (Gingerich, 1995, 2000). These care delivery models have continued to be refined as Medicare reimbursement and care expectations continue to change with Prospective Payment System (PPS), Outcomes Assessment and Information Set (OASIS), Hospice Conditions of Participation (CoPs) episodic care reimbursement and the ongoing scrutiny of Medicare costs. As computerized care systems were developed with point of care documentation, many of the earlier care models were incorporated into the system's clinical content, with ongoing refinements made in response to changing practice standards as part of the computer company's updates. A care delivery model does not dictate care, but rather provides examples and patterns for care. When determining what, when and to whom to report assessment findings, working closely with individual physicians is key to successful communication. As noted, many physicians have clear expectations regarding specific changes in assessments and the format for communicating these changes. However, it is not feasible or practical to pre-identify every changing aspect and develop clear-cut action steps. In addition to practice standards, there are resources available that can assist in the process.

Other Resources

Colorado's Kaiser Permanente has developed a framework for communication, referred to as the SBAR (Situation-Background-Assessment-Recommendation), which is its tool for communicating between health-care team members and care settings. This model is focused on the key essentials of communication. The two components of the SBAR model are the SBAR Guidelines and SBAR Worksheet, i.e., Guidelines for Communicating with Physicians Using the SBAR Process and SBAR Report about a critical situation. Providers can use this tool as part of their staff in-service training to assist staff to better understand what needs to be communicated and approaches

to use in organizing and sharing information with physicians and other healthcare professionals (<http://www.ih.org>).

Another resource that assists in defining nursing practice is the individual State Boards of Nursing, where the duties and responsibilities for Licensed Vocational/ Practical (LV/PN), Registered Professional Nurses (RN) and Advanced Practice Nurses (APN) are detailed. Most home health and hospice providers use their state standards of practice as a resource in developing their position descriptions and as an ongoing resource to be consulted when needed.

The American Medical Director's Association (AMDA) also provides clinical practice guidelines that encompass reporting and communicating patient information when there are acute changes in condition. The AMDA focus is on acute condition changes, defined as a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional domains (<http://www.cpgnews.org>). The frequently asked questions (FAQs) on the website are a useful resource for home health and hospice providers in developing their own guidelines.

In addition, there are other accepted practice guidelines for assessing and reporting changes in condition available for specific diagnoses, for example Congestive Heart Failure (CHF) and weight gain. Nurses assessing CHF patients are aware that they need to look for sudden weight gain, such as 2-3 lbs. per day or more than 5 lbs. in 5 days and to report findings to the patient's physician (<http://nursing.advanceweb.com>).

However in some situations, such as wound measurements, the pattern of assessment findings should be reviewed for consistency in assessment, as well as signs of wound improvements, such as wound dimension, appearance and size. It is important that the case manager compare individual assessments over time to ascertain that the wound is healing. If findings do not support wound healing, then reporting and seeking revised wound orders is an appropriate action to take that would be in keeping with acceptable standards of practice.

Reporting: Internal and External Communication

Timely communication is fundamental to both internal and external reporting, accompanied by accurate and complete documentation of both the findings and

the communication. Internal reporting follows the chain of command noted on the organizational chart, but organizations usually delineate a clinical findings reporting system. The important element is that any changes in condition or other relevant findings are communicated promptly to the appropriate individual within the organization. For example, healthcare aides could be instructed to report findings to their immediate supervisor, and these findings are then communicated by the supervisor to the patient's case manager. In other organizations, the healthcare aide is instructed to report findings directly to the patient's case manager. Of primary importance is that regardless of the communication protocol, it is followed consistently.

A similar approach might be used for physical therapy assistants (PTAs) and certified occupational therapy assistants (COTAs). According to the provider's protocol, they could report findings to the Physical Therapist (PT) or Occupational Therapist (OT) coordinating the patient's care. In this organization, the PT or OT reports the findings and communications to the patient's case manager. In other organizations, the first communication goes to the patient's case manager, with the expectation that the COTA or PTA also communicate the findings to the coordinating OT or PT. In this situation, the case manager takes the lead in directly communicating findings to the patient's primary physician (or appropriate physician) and also is expected to communicate the findings to the Clinical Services Director.

Documentation

Staff are expected to clearly document findings, along with to whom and how the findings were communicated in their daily charting. It is also expected that any case conferences or team meetings in which the patient is discussed are noted on the patient's record. As the case manager is the responsible staff position that usually reports to physicians and obtains ongoing or revisions in orders, it is this position that is designated to chart the communication with the physician and to document any and all verbal or written orders received. However, any staff member/ position who directly communicates patient findings to physicians or other care providers is responsible to accurately and comprehensively document the communication.

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Summary

Staff and organization seek to include care management and preventive care concepts in best practices. These are incorporated into the patient's care plan or interdisciplinary clinical pathway, which in turn provides guidance relative to anticipated clinical outcomes and improvement. The clinical pathway or care plan only serves as a blueprint for care. The responsibility for appropriate care levels, reporting and communicating rests with the care team interacting with and assessing the patient in the care setting. It is the organization's policies and protocols addressing documentation, communication process and patient assessment, which form the foundation for clear, timely and appropriate communications with other members of the care team, both internal and external to the organization. ♥

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Patient Falls

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Injuries caused by falls or accidents at home are one of the most frequently reported adverse events for patients

receiving home care services.

Thirty percent of people age 65 and older living in a community setting fall each year. One in five of these falls will require medical attention. Falls are also the leading cause of injury-related death (National Center for Patient Safety).

A 2008 claims analysis of our patient care related claims revealed that patient falls represented just slightly over 25% of the top 100 claims, in terms of frequency. Incident data from insured hospices and home care agencies reveals a possible reason for the claims activity—patient falls also tend to be the most frequently reported patient incident.

Significant research has been done to identify the risk factors associated with the likelihood of an individual falling. These factors are present whether that individual is receiving care in an inpatient setting, a nursing home or assisted living facility, or in their own home. These risk factors are generally categorized into extrinsic (factors outside of the patient's body) and intrinsic (patient's internal, psychological factors).

Extrinsic Factors:

- ✓ Hazardous activities (generally related to the patient's need to maintain their independence)
- ✓ Clutter
- ✓ Time of day
- ✓ Lighting
- ✓ Spills/wet floors
- ✓ Loose electrical cords
- ✓ Unsecured rugs

Intrinsic Factors:

- ✓ Age
- ✓ Muscle weakness
- ✓ Gait and balance disorders
- ✓ Visual disturbances
- ✓ Cognitive impairment/mental status alterations
- ✓ Dizziness/vertigo
- ✓ Postural hypotension
- ✓ Incontinence
- ✓ Poly-pharmacy
- ✓ Chronic disease

Certainly a large proportion of patients treated in a home setting are going to have at least one intrinsic factor that might make them at risk to fall. The goal of fall prevention activities should be twofold. First, there should be an effort made from the time of patient admission to identify and mitigate any extrinsic factors in the patient home environment. This should include a documented safety assessment of the home or care environment.

Secondly, since many intrinsic factors will also impact the potential for a patient fall, it is important to identify patient-specific factors and develop an individualized plan of care that addresses fall prevention activities. It will most likely include the identification of equipment and/or technology that might compensate for any intrinsic factors. The care plan might include the need for an electric bed, walker, shower chair, etc.

INCIDENT EXAMPLES

Falls in the bathroom:

1) Patient care was being provided to an 80-year old male patient in the home setting. The caregiver left the client alone in the bathroom to use the commode, and he fell from the commode fracturing his femur.

Falls in the bathroom setting, or when the patient is attempting to get to the bathroom, are a very common incident that results in litigation. Many of these “attended” falls actually occur because patients request privacy and the caregiver is trying to respect that need. Unfortunately, it is often a poor decision that ends up with an injured patient. No matter how many times the caregiver may say “wait for me and I will help you back to bed,” the instinct of a patient wanting to maintain their independence is to try to get up on their own. One of the most important fall prevention activities is education of the patient and their family about the need to consider their safety above all else and to accept assistance as needed. Consideration should be given to the need for raised toilet seats or a bedside commode.

2) Non-medical in-home living assistance was being provided to an 88-year old female patient. The attendant was assisting the patient in the shower when she fell and fractured her hip.

Another frequent fall location is in the bath or shower. It is important that the caregiver carefully assess the environment before beginning the bathing process. Safety and assistive devices such as shower mats, grab bars and shower chairs can be helpful. Consideration should also be given to whether a bed bath would be the safest alternative.

Falls while ambulating, transferring or transporting:

3) Companion care staff provided in-home assistance with activities of daily living to an 84-year old female. The caregiver allowed the patient to stand unassisted. She fell to the floor, fracturing a hip and vertebra.

When providing care in the home setting, it is important that the caregiver always assess the patient’s level of independence, including their ability to stand and assist with transfers, or to ambulate on their own. Fall prevention should be an ongoing process since the patient’s ability may change over time. Sometimes there will be improvement, but often there will be a decline in their abilities. Staff education should focus on how to correctly transfer patients, and when necessary, assist a patient to the floor to prevent a serious injury if a fall cannot be avoided.

4) Home care was being provided to a 79-year old male patient who was recovering from a subdural hematoma caused by a prior fall. While being transferred from bed to chair, the patient fell a second time and injured his back, requiring surgery, prolonged hospitalization and rehabilitation.

A higher level of supervision and attention is required when there is knowledge of a history of prior falls. A history of a fall, or falls, “puts you on notice.” It is important to know as much as possible about any factors that contributed to the prior fall and provide a safe environment that limits the potential for a second serious fall.

5) Employee was pushing a 67-year old personal care client across the road in his wheelchair when the wheelchair struck a hole, causing the client to fall face first on the road. He sustained a significant left eye injury, which resulted in surgery, a three-month hospitalization and loss of sight in the eye.

Patient safety will always be dependent on good caregiver judgment also. Patients being transported in a wheelchair need to be secured with a lap belt of some type, particularly when being taken on longer rides in an outdoor setting. The individual pushing the wheelchair needs to be aware of the environment and avoid hazardous conditions on the path, sidewalk, or roadway.

In Summary

A good fall assessment program is the most important loss control measure to avoid patient falls that result in injury. The risk of a fall to the patient is present when care is provided on a continuous or an intermittent basis. The risk of a fall with serious injury may be higher in the home setting due to the lack of environmental controls and lack of twenty-four hour supervision. The type of fall most likely to result in litigation is a fall where staff is present and should have provided a safer environment for the patient. All patients should be assessed at the time of their admission as to their “risk to fall.” This assessment should be repeated on a regular basis, since the patient’s risk level may change due to their health status or to medication. When a patient is identified as a risk to fall, fall prevention measures should be included in their plan of care. This might include making equipment such as electric patient beds, shower chairs, walkers, canes, or bed/chair alarms available in the care setting. All staff should be able to easily identify those patients who have been assessed as a fall risk, so that they can educate the patient and family on fall prevention strategies and take extra precautions when working with the patient in the home setting. When a fall does occur, an incident report form should be completed. A post-incident analysis should also be performed, to evaluate whether the plan of care should be revised to address any additional fall prevention strategies. The organization should look for trends or common factors in reported falls that might provide strategies for safer delivery of patient care. It may not be possible to totally eliminate fall events, but there should be a continuous goal to provide a safe environment, make wise decisions related to the delivery of safe patient care, and educate the patient/family/caregivers about the risk of falls and prevention strategies. ♥

Resources:

HCCIS Video: Patient Transfer – This 11-minute training video provides safety tips, as well as demonstrations of correct patient transfers in a number of different scenarios. There is an emphasis on taking the time to prepare the patient and the environment before any transfers begin. Order form can be found on our website, www.hccis.com.

The VA National Center for Patient Safety website (www.patientsafety.gov)

The Institute for Healthcare Improvement website (www.ihl.org)



COMPLIANCE CORNER:

Hospice Benefits and Care

Barbara Stover Gingerich RN MS FACHE CHCE

There has been increasing scrutiny recently regarding the consistency of the care plan and services provided to hospice patients, regardless of where hospice care is being provided. One prime area of scrutiny is the care of hospice patients residing in nursing facilities. The 2011 Office of the Inspector General (OIG) Work Plan listed two hospice studies, both of which focused on hospice care within nursing facilities. The first study is a utilization review of hospice Medicare Part A claims. This study focused on utilization patterns and provider characteristics of hospices serving patients in nursing facilities as well as hospice business relationships and marketing. A second study looked beyond the overall utilization comparison to specifically focus on the level of hospice-based home health aide care being provided to nursing facility hospice patients versus that provided to hospice in-home patients. It also studies how care is coordinated and how service and payment arrangements are established. These two studies came about as a result of a MedPAC study, which found 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. The MedPAC study also detailed hospice and nursing facility incentives to admit nursing facility patients to hospice.

While the 2011 studies continue, the 2012 OIG Work Plan continues its hospice focus, listing two additional hospice studies. The first study focuses on analysis of marketing programs and relationships between hospices and nursing facilities. Hospices selected for participation in this study will be those with a large census of hospice patients who are residing in nursing facilities. The second study focuses on Medicare Hospice General Inpatient Care, with emphasis on utilization review of hospice general inpatient care from 2005 to 2010. This study is addressing the appropriateness of hospices' general inpatient claims and the hospice beneficiaries' Part D drug claims billed.

Service and Staffing Appropriateness

The State Operations Manual provides guidance to surveyors and forms the interpretive foundation for staffing and service levels. This manual interprets the Conditions of Participation for surveyors and providers so there is a clear understanding of compliance requirements.

§418.110(a) Standard: Staffing

The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided (State Operations Manual, Appendix M - Guidance to Surveyors: Hospice, p.131).

The interpretive guidelines, procedures and probes to use in evaluating compliance with this standard are provided. The hospice is responsible to ensure that adequate and competent staff (inpatient unit numbers and types of qualified, trained and experienced staff on the inpatient unit) are on duty around the clock, weekends and holidays. This responsibility includes looking at staffing schedules, staff-to-patient ratios, as well as clinical record reviews and observations and interviews of families, patients and staff.

§418.110(b) Standard: Twenty-four hour nursing services

§418.110(b) (2) - If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

The hospice nursing facility must meet the nursing needs of all patients in keeping with the patient's individual plan of care, and must keep the patients clean, safe, well groomed and comfortable. In addition, the hospice nursing facility must have a registered nurse on duty each shift where there is a hospice patient receiving general inpatient care within the facility.

Surveyor guidelines further spell out nursing staffing requirements in facilities where hospice patients are receiving only

respite or routine levels of care. It might not be necessary to have an RN on each shift, but rather staffing should be in keeping with each patient's individual care plan and care needs. Respite care nursing service standard requirements are located at §418.108(b) (2), page 128 of the State Operations Manual, Appendix M - Guidance to Surveyors: Hospice.

✓ Preventive Actions

Hospice providers need to conduct self-audits of hospice patients in nursing facilities as well as self-audits of hospice patients within their own homes. Audit findings should then be studied to find areas of dissimilarities that could lead to potential hospice level of care provision issues. In the agreement between the hospice and the nursing facility, one individual must be identified as the primary contact. The agreement must detail this individual's responsibility to implement the agreement provisions for hospice care in compliance with the patient's individual plan of care. Conducting comparative audits (in-home versus nursing facility hospice care) is only the first step in a comparative analysis. By examining the audit findings to identify inconsistencies in care and services provided, creating a corrective action plan and conducting ongoing monitoring of potential inconsistencies, hospices can assure that their care and services meet standards regardless of the care setting.

Hospices must be assured that nursing facility staff that have the potential to come in contact with hospice patients have been provided with education regarding hospice philosophy, the multidisciplinary team approach, and provision of care that is consistent with the hospice plan of care. In order to monitor the nursing facility's ongoing compliance with hospice standards, hospice providers will be well served to conduct their own onsite survey of the nursing facility. The onsite survey should look at facility staffing, safety, infection control, emergency and disaster management and other critical standard compliance elements. Nursing home staff that have been involved in caring for a hospice

patient should be matched to the list of staff that have attended hospice provider training and education sessions.

Personal Care Support and Caregiver Burnout

The primary caregiver in the home can find that the role is around the clock, and it can be increasingly intense. Caregiver burnout is not an uncommon occurrence and while hospice respite care can be utilized for short-term relief, caregivers often need a more long-term solution. Services to assist caregivers are available in most communities. The cost of these services are often based on ability to pay or covered by the patient's insurance.

§418.76(i) (3) - The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.

Community care-giving services can include adult day care centers, home health aides, home delivery of meals, respite care, transportation services and skilled nursing. In some cases, personal care service needs exceed the scope of the Medicare hospice benefit as determined by the hospice assessment and plan of care. In states where the Medicaid personal care benefit is more comprehensive, Medicaid personal care services are provided to augment Medicare hospice personal care services. Medicaid homemaker/hospice aide services are covered and paid for by the State Medicaid Benefit. In addition, families might choose to pay privately for services that augment hospice care and assist the primary caregiver.

✓ Preventive Actions

Within §418.56(b) Standard: Plan of Care, it is stated that hospice must ensure that each patient and the primary caregiver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care (State Operations Manual, Appendix M - Guidance to Surveyors: Hospice, p. 53). This section defines the hospice's responsibility for care coordination and education, including training of personnel assigned to

provide homemaker/personal care and services and any volunteers who provide support within the home setting. Communication is the essential element of successful care coordination and assuring that care is consistent with the patient's hospice plan of care. Section 418.56(e) (4) and §418.56(e) (5) further expand on the ongoing sharing of information between all disciplines, including non-hospice healthcare providers who are providing care and services (Ibid. p. 59),



whether the care and services are provided directly or under arrangement and even if the care and services are unrelated to the terminal illness and related conditions (Ibid. p. 60).

These standards support the need to ensure that all healthcare providers and primary caregivers are educated regarding hospice philosophy, care coordination, care planning and role responsibilities. Surveyors will examine documentation, seeking to find evidence of information sharing, such as care plan revisions and updates, and they will interview staff and patients relative to the hospice's level of compliance with this standard. In addition, surveyors will seek to identify the systems and processes in place that assure information exchange and care coordination.

Hospice Continuous Home Care

The hospice continuous home care benefit is another area of Medicare scrutiny. Comparisons between the provisions of the hospice continuous home care benefit versus continuous care provided in a nursing facility are being challenged. Continuous home care is only intended for brief crisis periods and can include hospice aide and homemaker services, but

must be primarily nursing care. The continuous home care benefit is employed when necessary to achieve palliation or management of acute medical symptoms for the purpose of maintaining a terminally ill patient at home.

The continuous home care benefit is only paid when care exceeds eight hours in any 24-hour period. Continuous care periods can be broken down into shorter blocks of time, but must meet the eight-hour minimum, and at least half of the total hours provided must be at the RN or LPN service level.

✓ Preventive Action

As noted above, hospice providers should conduct self-audits of hospice patients in nursing facilities as well as hospice patients within their own homes. To address this area of concern, the audits need to focus on the continuous care provision. Since this is a less frequently provided benefit, it might be possible for the hospice to conduct a 100% review of patient records where continuous care was provided. However, this is only one part of the equation. Other aspects

are patients with similar diagnoses and assessments who did not receive continuous care. These records should be identified and audited to assure the hospice that the continuous home care benefit is being applied consistently and appropriately to all hospice patients who need it.

Summary

While the Conditions of Participation and Surveyor Interpretive Guidelines form the structure within which the hospice provider operates, these sources do not provide all the answers. For example, while it is clear that hospices are responsible for services provided by hospice staff and nursing facility staff, there is a lack of clarity relative to those individuals brought in by the family to augment the caregiver and hospice staff roles. In order for the hospice to reduce its risk and exposure, it is a good business decision to include all individuals providing care and services to hospice patients in the education and communication process. It is also important that all interactions, including those with non-hospice staff, are clearly and accurately documented within the patient's record.

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Hospice Benefits and Care *Continued from page 7*

When conducting utilization and quality audits, hospices should look closely at areas identified by government committees and departments, such as those contained in the OIG's Work Plan each year. Audit tools can be revised to focus on the areas contained in the Work Plan, and data can be tracked and aggregated according to patient care team and patient care setting, as well as care acuity. As the hospice is better able to use its own audit findings to identify and compare areas of dissimilarities or unusually high volumes, it is better able to develop corrective action plans that clearly target findings. This proactive approach prepares the organization, its staff, volunteers, patients and families for external surveyor's questions and scrutiny. ♥

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Who to Contact

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