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INSIDE

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End-of-life care in nursing homes still needs improvement

Hospices slow to reach out to nursing homes, achieve common ground

Hospices are not the only health care providers caring for the dying. More people die in hospitals and nursing homes than under the care of hospice workers. Still, end-of-life care remains an afterthought as clinicians focus on keeping people alive rather than shifting their approach when death is imminent.

While nursing homes struggle with improving end-of-life care for its residents, hospices have struggled too — not with improving end-of-life care for patients, but with bridging the gap between them and their nursing home counterparts. In short, their expertise remains largely inaccessible to those outside their industry.

"End-of-life care needs to be improved everywhere," according to **Ernestine Pantel**, DrPH, director of administrative service programs in occupational and physical therapy at Columbia University's College of Physicians and Surgeons in New York City. "Hospices have the expertise in palliative care, and they need to bring that expertise to nursing homes."

While this proposition is logical and simple, hospices and nursing homes have been slow to join forces. Regulatory restrictions and divergent approaches have been significant hurdles for both sides. The challenge is for the two disciplines to coordinate care while reconciling differences in policies and procedures.

Last year, the Office of Inspector General singled out hospice and nursing home relationships as having potential for fraud and abuse, raising the barrier that prevents more hospice-nursing home arrangements. **(See related story on p. 40.)**

Hospices must contend with the six-months-or-less diagnosis requirement for hospice admission, while nursing homes must comply with strict requirements that focus on curative efforts. Nursing homes operate under strict assessment schedules that are tied into reimbursement,

while hospices are not. Even though a nursing home resident is under the care of hospice, the nursing home is still responsible for submitting routine patient assessments, called the Minimum Data Set (MDS). Because hospice staff are not experienced in using the MDS, proper filing of the MDS is made difficult.

"Hospices have to understand the world view of nursing homes. They are understaffed, and they are one of the most regulated industries," says **Joan Teno**, MD, associate professor of community health at Brown University and associate medical director of Hospice Care of Rhode Island in Providence. "Hospices need to build a bridge so that there is shared ownership of patient care and mutual respect of what each other does."

Hospices can be guilty of being insensitive to the plight of nursing homes, says Pantel. While hospices have developed a reputation for being experts in end-of-life care largely by promoting the importance of palliative care, hospice workers providing patient care in nursing homes sometimes leave the impression that care was substandard until the hospice team arrived.

"Nursing homes also see themselves as providers of end-of-life care," says Pantel.

For hospices, nursing homes represent an underutilized referral source. An estimated 13,369 Medicare hospice beneficiaries reside in Medicare/Medicaid-certified facilities on any given day. For the most part, hospice beneficiaries are being served in nursing homes that do not have specialized hospice units because only about 1.3% of nursing homes have such units. Nursing homes with higher percentages of residents receiving the hospice benefit are more likely to be for-profit, belong to a chain, and not provide full-time physician coverage. The proportion of residents receiving the hospice benefit has increased in counties with fewer certified nursing home beds and areas with more certified hospices, for-profit hospices, or larger hospices.

A 1998 five-state study underscored the need for hospice expertise in nursing homes. It showed widespread instances of untreated daily pain among elderly nursing home residents with cancer, especially among the oldest and minority patients. The study, which was published in the *Journal of the American Medical Association*, concluded that there was dramatic room for improvement when it comes treat and managing pain in nursing home populations.[1]

Researchers examined data collected on 13,625 cancer patients aged 65 and older discharged from hospitals to 1,492 nursing homes from 1992 to 1995. In total, 4,003 patients reported daily pain. Of those, 16% received a simple analgesic such as aspirin or acetaminophen. Thirty-two percent were given codeine or other weak opioids, and 26% received morphine. However, 26% of patients with daily pain received no analgesics, not even an aspirin or acetaminophen tablet. Patients who were 85 or older and experienced daily pain were about 50% less likely to receive any analgesic than those aged 65 to 74 years. Only 13% of patients aged 85 years and older received codeine or other weak opiates or morphine, compared to 38% of those aged 65 to 74 years.

African-Americans were 50% less likely than Whites to receive any analgesics. Although not statistically significant, a similar trend in the data was noted for Hispanics, Asians, and American Indians.

Education will bring disciplines together

Both Teno and Pantel agree that educating nursing homes about hospice care is the key to bringing the two disciplines together. For hospices, that can translate into increased referrals from nursing homes.

Hospices must understand that nursing home staff not only lack training in palliative care, but that strict regulations prevent them from using drugs the same way hospices use them.

In addition to regular inservice training, hospice workers need to have an ongoing training component. For example:

- Bring written literature about your hospice and its mission to the nursing home when visiting a patient to help educate new nursing home employees who have not yet sat through hospice inservice training.
- Invite nursing home staff to your hospice's hospital inservice training.
- Make your palliative care services available to nursing homes. Even though a hospice cannot receive payment unless the patient has a terminal illness diagnosis, this is excellent goodwill that can lead to future referrals.

Hospices can stand some education of their own. Nursing home staff are often frustrated by hospice's staff seemingly cavalier attitude toward nursing home policies. For instance, hospices sometimes do not appreciate the strict schedule of patient assessments required by Medicare. The Minimum Data Set (MDS), a lengthy patient

assessment form, must be completed every 30 days for the first 90 days of care and every 60 days after that. Even though the hospice has clinical management of the patient, the nursing home must still complete the MDS because the patient is still a resident of the nursing home. Because hospice is providing a significant portion of the care, their input and assistance is needed to complete the assessment.

Beware these 10 areas of conflict

Christine Johnson, RN, MS, executive director of The Inn at Barton Creek, an assisted living facility in Bountiful, UT, identifies 10 areas in which nursing homes and hospices can become entangled in conflicting policies and regulations. They include:

1. Coordination of billing. The two organizations need to work out who is going to bill for which services. This includes understanding the responsibilities of clinical management of the patient and distinguishing routine care provided by nursing home staff.

2. Patient self-determination and advance directives. Both organizations are responsible for ensuring the patient's rights to informed consent are being respected. To ensure the patient's wishes are being carried out, nursing homes are required to inform patients of their right to formulate an advance directive that establishes special power of attorney, a living will, and a medical treatment plan. For the hospice's part, it should ensure that an informed consent form specifying the type of services that could be provided by the hospice is obtained for each patient.

3. Resident assessment. As mentioned earlier, hospices must cooperate with nursing home staff to ensure timely completion of the MDS, either by agreeing to complete the form based on their working knowledge of the patient or providing the needed information to nursing home staff responsible for completing the MDS.

4. Comprehensive care plans. While both hospices and nursing homes have care plans, they come with different requirements. For example, nursing homes are required to review and update their care plans every 30 days for skilled nursing patients and quarterly for long-term care patients. Hospices do not have the same requirement. The result can be two care plans for one patient evolving in two very different ways. Both organizations must strive to coordinate their care plans so they account for each other's goals and are updated at the same time. "Work toward mutual support and understanding," Johnson says.

5. Professional communication. To facilitate the coordination of care plans, there should be standard mechanisms in place to notify each provider of changes in the care plan or changes in the patient's condition. Johnson suggests each organization designate a staff member as the person to call when changes are made and who will coordinate how changes will be handled. For example, a hospice might designate the on-call nurse as the liaison so the nursing home is assured of reaching a nurse who is able to make sure changes are noted and care is provided in a timely manner.

6. Interdisciplinary team. Both nursing homes and hospices use a variety of disciplines to treat their patients. Each organization depends on the interaction of these disciplines to help determine the best course of care. When a hospice comes into a nursing home, the need to recount observations and communicate changes in care does not diminish. There is a need for both interdisciplinary teams to work together. Johnson suggests that each organization include a representative from the other's team to act as a liaison between the two groups.

7. Physician services and visits. Hospices need to teach nursing homes that an essential component of hospice is physician-directed interdisciplinary care. The nursing home physician must clarify his or her role with hospice, including whether the physician or the hospice medical director will certify the care plan and services to be given.

8. Medications. This area has the greatest potential for conflict. Nursing homes must follow specific regulations for certain drugs, such as psychotropic and antipsychotic drugs. Before nursing homes can use them, there must be a specific diagnosis, such as depression or mental illness. Hospices, on the other hand, use some of these drugs routinely as part of their pain management arsenals. A conflict can arise when a hospice has placed a resident on one of these drugs to manage pain, but a nursing home nurse refuses to administer the drug because the patient doesn't have the required diagnosis. If the nursing home nurse would have been properly educated about the hospice's pain management plan and told why the drug in question was being used, the patient would not have been forced to suffer needlessly while the two sides straightened out

their differences.

9. Clinical records. When a hospice comes in to treat a nursing home resident, it must establish a patient record. But that record also represents care delivered while the patient is a resident of the nursing home. Nursing homes and hospices must agree on how they will share their records, including which organization keeps the original copy.

10. Nursing home staff training. Hospices need to establish a collaborative training program with their nursing home partners. Hospices often treat facility staff training as a work in progress, says Johnson. In order for training to take root, hospices must make sure nursing home administration is taking part. With high-level management participation, it is more likely that the concepts taught will remain with the organization despite the high turnover rate of nurses and aides.

Perhaps the most significant conflict between nursing homes and hospices that prevents better end-of-life care in nursing homes is the interpersonal conflicts that may arise as a result of the differences in the two disciplines.

Hospice workers who value the input of family caregivers must realize that nursing home staff are the closest thing to family that many of their elderly residents have. Nursing home staff should be afforded the same respect as family, Pantel says.

References

1. Cleeland CS. *JAMA* 1998; 279:1914. ■

Be wary of OIG concerns

Avoid these four nursing home-specific risk areas

While education and cooperation should be priorities of hospices and nursing homes trying to work together, organizations must still be concerned with federal investigators who are on the lookout for fraud and abuse among the two provider types.

Specifically, the Office of Inspector General (OIG) compliance program cites the following hospice/nursing home risk areas:

- overlap in services that a nursing home provides, which results in insufficient care provided by a hospice to a nursing home resident;
- hospice incentives to actual or potential referral sources that may violate the anti-kickback statute or other similar government regulation;
- improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals;
- providing hospice services in a nursing home before a written agreement has been finalized;
- hospices that overlap services provided by nursing homes. According to the OIG, this often leads to hospices providing insufficient care to nursing home residents.

OIG: Care should be coordinated

"Recent OIG reports found that residents of certain nursing homes receive fewer services from their hospice than patients who receive hospice services in their own homes," the compliance program guidelines stated. The guidelines were published in the *Federal Register* (64 *Fed Reg* 39,155-39,168 [July 21, 1999]).

The OIG continues: "Upon review, it was found that many nursing home hospice patients were receiving only basic nursing and aide visits that were provided by nursing home staff as part of room and board when hospice staff were not present."

The answer, OIG says, is for hospices and nursing homes to coordinate care and for hospices to retain professional responsibility for services furnished by nursing home staff. This would include the dispensing of medication and personal care.

The OIG identified many risk areas in its explanation of why hospices should implement a compliance program. These risk areas include the following:

- **Incentives to referral sources.** Some hospice incentives to actual or potential referral sources, such as physicians, nursing homes, and hospitals, may violate the anti-kickback statute or government regulations.

According to the OIG, investigators have observed instances of potential kickbacks between hospices and nursing homes where unlawful influence can affect patient referral.

OIG is concerned that hospices are paying nursing homes more for "room and board" than the nursing homes would receive if patients were not enrolled in hospice. In Medicaid programs, for example, the normal procedure should be

that Medicare pays the hospice at least 95% of the daily nursing home rate, and the hospice is responsible for paying the nursing home for patient room and board.

"Any additional payment must represent the fair market value of additional services actually provided to the patient that are not included in the Medicaid daily rate," instructs the OIG.

The compliance program guidelines also included concern over arrangements with nursing homes because a nursing home can choose which hospices it wants to partner with, leaving the arrangement vulnerable to fraud and abuse.

Hospice must provide core services

• **Improper relinquishment of core services and professional management.** OIG reminds hospice providers that core services — nursing, medical, social services, and counseling — must be provided directly to the patient by employees of the hospice. And while other non-core services may be provided under contractual arrangements, the hospice still must retain professional management of those services.

• **Providing hospice services in a nursing home before a written agreement is finalized.** According to the OIG, a patient residing in a skilled nursing facility or nursing home may elect the Medicare hospice benefit if:

1. The residential care is paid by either the beneficiary / private insurance or Medicaid if the patient is dual-eligible.

2. The hospice and nursing facility have a written agreement that clearly states the hospice takes full responsibility for the professional management of the patient's hospice care and the facility agrees to provide room and board.

The OIG compliance guidelines also offer specific examples that might cause investigators to believe there is cause for fraud and abuse concern. These include:

— offering gifts or providing free services to patients or their relatives, physicians, or nursing facilities;

— offering nursing homes below-market-value goods;

— paying above market value for room and board in a nursing facility;

— offering free care to patients in a nursing home;

— providing and paying staff to provide services to nursing homes that otherwise should be performed by nursing home staff. ■

Salary or per diem? Which is best?

Non-salary has a place, but shouldn't be the norm

As hospices try to cope with shrinking bottom lines and nursing shortages, many are looking for ways to reduce costs or creative measures to attract qualified nurses. One of the ways has been to pay nurses per diem or by the visit, rather than the traditional salary and benefits.

The financial impact can be significant, says **Peggy Pettit**, RN, senior vice president for patient / family services at Vitas Healthcare in Miami. In terms of money paid directly to nurses, the amount is about the same. But hospices can save 25% to 40% in benefits because they would no longer be obligated to pay for items such as health insurance and retirement savings plans.

Per diem basis might hinder relationships

But the savings can come at a price, says Pettit, whose company has studied the pros and cons of a per diem-paid nursing staff. In general, she says, a staff made up mostly of per diem nurses can have a detrimental effect on quality of care and productivity. Per diem nurses, who are paid by the hour for each day they work, often work fewer days than their salaried counterparts, which can hinder the bond established between nurse and the patient.

"We think quality is enhanced when you use full-time, salaried employees," says Pettit. "It is important to establish continuity of care. Full-time nurses are able to establish relationships with patients that some per diem nurses can't, because they don't see the patient as often or because they don't see the same patients regularly."

But that doesn't mean per diem nurses don't have a place in hospices. While Vitas has chosen to keep most of its nursing staff on salary, it uses per diem nurses to fill gaps created by vacationing nurses and to provide continuous care, where demand is difficult to predict.

Haven Hospice in Atlanta employs 20% of its total nursing force using non-salaried nurses. It also uses a payment form more associated with home health agencies — per visit payment, which is based on the number of visits a nurse performs. The hospice, however, doesn't use per visit nurses

to reduce its costs. Instead, the strategy is part of the hospice's attempt to attract qualified nurses and allow the hospice to increase its caseload.

"Some of our employees want benefits," says **Metta G. Johnson**, RN, BSN, OCN, ACRN, executive director and owner of Haven House. "Others want the flexibility of getting paid by the visit."

Need for continuing education

Whether the motivation is saving money or filling job positions, quality of care should be foremost in the minds of hospice leaders who are considering making similar moves.

Vitas officials believe a per diem-driven work force would be detrimental to overall quality. Instead, the organization chooses to balance its needs by using per diem nurses strategically. Despite the limited use of per diem nurses, there should be a program in place that routinely trains and educates per diem nurses to ensure quality of care does not decline, says Pettit.

As an example, per diem nurses should be exposed to the following topics:

- **Organizational philosophy.** Recently hired workers are schooled in the hospice philosophy and mission.
- **Hospice basics.** Nurses who have never worked in hospice need to become familiar with ideas such as the interdisciplinary team, palliative care, spiritual care, advance directives, and other unique tenets of hospice.
- **Communication.** New nurses are taught how to listen to patients and take clues from patient interaction.
- **Death and dying.** New hires are asked to explore their own feelings about death and dying, perhaps revisiting their own loss of a loved one.
- **Stress management.** The hospice stresses the importance of communication, not only for the sake of patient care but also for the mental well-being of its nurses. New nurses are taught the importance of using resources available through the interdisciplinary team, such as other team members who can provide additional support to the patient and alleviate the stress of having to support the patient on their own.

In addition to the above items, per diem nurses need continuing education and training in patient care, assessing emerging patient needs, and improved communication with other members of the interdisciplinary team, says Pettit.

While Johnson agrees that routine training is a must, she says diminished quality is not an issue among her non-salaried nurses. "We are very selective so that we can trust our staff," she maintains.

Johnson acknowledges the seeming contradiction between an incentive to squeeze in as many visits as possible under per visit payment and the mission of each hospice nurse visit to provide compassionate care irrespective of the time spent in the patient's home. But she says her per visit nurses provide quality care that puts the patients' needs ahead of the need to make more visits. Home health agencies have employed per visit payment to boost nurse productivity by encouraging them to take on as many visits as possible.

From a hospice perspective, a system that has nurses running from one visit to the next is not compatible with its mission. This is a principle not lost on Johnson. Rather than setting nurses loose to see as many patients in a day as they can, nurses are assigned a caseload much like salaried nurses are. While the incentive to make numerous and shorter visits is not eliminated, it is blunted by their caseload responsibilities. Like salaried nurses, per visit nurses are responsible for the case management of each of their patients, including spending the appropriate amount of time with each patient and his or her family.

To promote flexibility, per visit nurses at Haven decide on their caseload, taking on as much or as little as they feel suits them. In general, per visit nurse caseloads range from four to seven cases. It is the nurse's responsibility to schedule visits for his or her assigned cases.

"It's something you need to monitor," Johnson says of nurse visits. "But by and large, nurses want to be with patients, and there has to be that level of trust that your nurses want the best for their patients."

Better documentation skills

Although time spent with patients is a priority, there are other tasks in which per diem or per visit nurses must be proficient. A growing challenge for hospice nurses in general has been the increasing amount of documentation tied to reimbursement.

Pettit warns that non-salaried nurses need continued documentation training. Aside from basic training in proper documentation, Pettit advises training nonsalaried nurses to provide story-oriented documentation. "Per diem nurse documentation is often task-oriented," she adds "While they are very good at describing what

services were provided, they don't always provide the same depth as full-time nurses. They miss describing the big picture."

Because non-salaried nurses may not have the advantage of treating the same patients on a regular basis, they are at a disadvantage in developing skills to help them assess a patient's emerging needs.

Both Johnson and Pettit agree that it would be ill-advised to convert a nursing staff from salary to per diem or per visit. Pettit fears such a hospice would be staffed by nurses whose loyalty and commitment might be lessened.

In that same vein, Johnson says nurses who want to work fewer than four cases could have questionable commitment. "If you have someone who wants to work sporadically, I don't think that would work," she says. ■

Massage therapy reduces pain for many

Study points to the benefits of alternative care

Most people know massage therapy for its relaxation benefits. Now there is growing evidence that massage therapy can reduce pain, a hallmark of hospice and palliative care. Based on these measurable clinical benefits, hospices may want to include massage therapy as part of its stable of alternative therapies.

"Massage therapy is very compatible with hospice care," says **Adela Basayne**, LMT, a private practice massage therapist in Portland, OR. "Massage therapists aren't looking to change the health status of patients. Instead, their goal is to treat symptoms."

Hospices that are not yet offering massage therapy along with other alternative therapies, such as art therapy, should consider the results of a recent study published in *Hospice Journal*.[1]

Researchers studied 56 hospice patients whose average age was 64. Patients were randomly assigned to receive either massage therapy or usual care that did not include massage therapy. Those receiving massage therapy were given the therapy twice weekly for two weeks by a licensed massage therapist.

When the study began, about half of the patients had constant pain. Massage therapy and normal care both reduced patients' pain to episodic or intermittent pain in 14% of the patients in each group. Overall, patients suffered half as much pain by the end of the study as they had at the beginning.

But pain intensity decreased more in the massage group than in the usual care group — a 42% decrease in the massage group vs. a 25% decrease in the usual care group. Nearly three-quarters of the patients receiving massage — compared with only 57% of the usual-care patients — reported pain levels of 0 or otherwise lower than at the beginning of the study. About one-third of the massage patients received massages in between the sessions scheduled as part of this study. The effect of massage on pain intensity was immediate, according to researchers, decreasing the pain scores after each massage. Pulse rate and respiratory rate also fell, indicating a relaxation response.

The therapists followed a standardized protocol for the massage, specifying full-body massage, when possible, and the types and duration of the strokes to be used, such as effleurage strokes and others. The massages lasted 30 to 45 minutes. About half of the patients could not complete the study because death intervened or their condition deteriorated to an extent that precluded their completing the study questionnaire.

There is also a psychological benefit, Basayne says. Sadly, many dying patients are touch-deprived as a result of their disease. Friends and family members are less inclined to embrace, caress, or even hold hands out of irrational fear of contracting the same disease or some other personal reasons. Massage therapy brings back the human touch that patients are craving, says Basayne.

The reasons behind the effect massage has in reducing pain is well known, says Basayne. Experts have theorized that its relaxation effect reduces anxiety, which in turn lowers pain intensity.

Massage therapy is a broad term that describes a discipline that encompasses a number of techniques, Basayne says.

The type of massage therapy most commonly used to treat anxiety and pain is traditional European massage, which includes methods based on conventional Western concepts of anatomy and physiology and soft tissue manipulation. There are five basic kinds of soft tissue manipulation techniques:

• effleurage (long flowing or gliding strokes, usually toward the heart, tracing the outer contours of the body);
• petrissage (strokes that lift, roll, or knead the tissue);
• friction (circular strokes);
• vibration;
• tapotement (percussion or tapping).

Swedish massage is the most predominant example of traditional European massage and is the most commonly used method in the United States. It was developed by Per Henrik Ling in Sweden in the 1830s and uses a system of long, gliding strokes, kneading, and friction techniques on the more superficial layers of muscles. It usually goes in the direction of blood flow toward the heart because there is an emphasis on stimulating the circulation of the blood through the soft tissues of the body. Swedish can be a relatively vigorous form of massage, sometimes with a great deal of joint movement included.

Oil is usually used, which facilitates the stroking and kneading of the body, thereby stimulating metabolism and circulation. Its active and passive movements of the joints promote general relaxation, improve circulation and range of motion, and relieve muscle tension. Swedish massage is often given as a complete, full-body technique, though sometimes only a part of the body is worked on.

Hospices, however, may encounter more recently developed disciplines. Among them is contemporary Western massage. This includes methods based primarily on modern Western concepts of human function, anatomy, and physiology, using a wide variety of manipulative techniques. These may include broad applications for personal growth, emotional release, and balance of mind-body-spirit in addition to traditional applications. These approaches go beyond the original framework or intention of Swedish massage. They include Esalen or Swedish/Esalen, neuromuscular massage, deep tissue massage, sports massage, and manual lymph drainage. Most of these are American techniques developed from the late 1960s onward, though the latter was developed in the 1920s.

• **Esalen and Swedish/Esalen.** Esalen massage is a modern variation that focuses not so much on relieving muscle tension or increasing circulation as on creating deeper states of relaxation, beneficial states of consciousness, and general well-being. Swedish is more brisk and focuses on the body; Esalen, on the other hand, is more slow, rhythmic, and hypnotic and focuses on the mind/body as a whole. Esalen massage is not widely taught as a pure form. Rather, a marriage of sorts has been formed by the integration of Swedish and Esalen as a way of incorporating the strengths of each. Many massage therapists describe their method as Swedish/Esalen, and this hybrid is commonly taught in massage schools.

• **Neuromuscular massage.** This is a form of deep massage that applies concentrated finger pressure specifically to individual muscles. This is a very detailed approach, used to increase blood flow and to release trigger points, which are intense knots of muscle tension that refer pain to other parts of the body (they become trigger points when they seem to trigger a pain pattern). This form of massage helps to break the cycle of spasm and pain and is often used in pain control. Trigger point massage and myotherapy are varieties of neuromuscular massage.

Deep tissue work focuses on specifics

• **Deep tissue massage.** This approach is used to release chronic patterns of muscular tension using slow strokes, direct pressure, or friction. Often the movements are directed across the grain of the muscles (cross-fiber) using the fingers, thumbs, or elbows. This is applied with greater pressure and at deeper layers of the muscle than Swedish massage, which is why it is called deep tissue. It is also more specific. For example, in the case of someone with a sore shoulder, the practitioner may focus on the trapezius and the rhomboid underneath, trying to work in all the layers of muscle that might be involved. Deep tissue massage lends itself to being more focused on a problem area.

Basayne warns that there is opportunity for untrained practitioners of massage to pass themselves off as trained massage therapists. Hospices should require national certification in massage therapy and/or proof of licensure in states that require massage therapists to be licensed.

"You want a massage therapist with training in pathology," Basayne says. "They need to understand the disease process and have an understanding of end-of-life care."

This is important because a poorly trained massage therapist can add to a patient's pain rather than help relieve it. Basayne recalls an AIDS patient she treated a few years ago who

benefited from massage in the early stages of therapy. But as the disease progressed, she was limited in the places she could manipulate.

"By the end, I was just caressing his head and neck," she says. "A therapist is trained in informed touch. A therapist has to determine tolerance to touch."

Reference

1. Wilkie DA, Kampbell J, Cutshall S, et al. Effects of massage on pain intensity, analgesics and quality of life in patients with cancer pain: A pilot study of a randomized clinical trial conducted within hospice care delivery. *Hospice J* 2000; 15:31-53. ■

News From Home Care

HCFA clarifies 'homebound' status

The Health Care Financing Administration says patients can still be considered homebound if they attend religious services or go to adult day care as long as they attend the day care program to receive "therapeutic, psychosocial or medical treatment."

A HCFA memo released Feb. 6 clarifies circumstances under which a patient may leave the home and still be considered homebound and eligible for Medicare home health services.

The new provision expands the list of circumstances in which absences from the home would be consistent with a determination that the patient is "confined to the home" or "homebound" for Medicare purposes. It does not change the existing homebound guidelines beyond the two specific provisions below. The new provisions include:

• Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited, to furnish adult day care services in the state shall not negate the beneficiary's homebound status for purposes of eligibility.

• Any absence for religious service is deemed to be an absence of infrequent or short duration and thus does not negate the homebound status of the beneficiary.

Home health agencies enrolling patients eligible for these new provisions are responsible for demonstrating the adult day care center is licensed or certified / accredited as part of determining whether the patient is homebound for purposes of Medicare eligibility. Examples of information that could demonstrate licensure or certification / accreditation include: The license / certificate of accreditation number of the adult day care center, the effective date of the license / certificate of accreditation, and the name of the authority responsible for the license / certificate or accreditation of the adult day care center. ■

News From the End of Life

Bush may reverse drug act

President Bush might issue an executive order that would undo the Clinton administration's interpretation of a federal drug statute and block Oregon's law allowing physician-assisted suicide, an Oregon senator says.

Sen. **Gordon Smith** (R-OR) said he discussed the order with Bush a few days after his inauguration, then followed up with a letter Jan. 25, hoping to ensure that Oregon doctors are not prosecuted retroactively.

At issue is the administration's interpretation of the Controlled Substances Act, which regulates strong drugs, such as barbiturates. In 1998, former Attorney General Janet Reno ruled that the federal law did not apply to medicinal uses of listed drugs.

Reno's ruling allowed Oregon doctors to continue prescribing lethal doses of controlled drugs to terminally ill patients. But Bush said during the campaign that he disagreed with Reno. Assisted suicide was not a "legitimate" medical use of controlled drugs, he said.

Opponents of physician-assisted suicide hope the recent confirmation of John Ashcroft as attorney general will lead to the overturning of Reno's opinion. But Smith said Bush is more likely to move slowly and deliberately.

In his letter, Smith urged Bush to include three specific provisions if an order is issued. They are:

• assurances that federally controlled drugs can be used to treat pain, even in instances when their use might increase the risk of a patient's death;

• expansions and modifications to the authority of the Drug Enforcement Administration not to include federally controlled drugs;

• prohibition of retroactive prosecutions of doctors who use federally controlled drugs in an assisted suicide.

The provisions listed in Smith's letter coincide with the Pain Relief Promotion Act sponsored by Sen. Don Nickles (R-OK), which would amend the Controlled Substances Act to prohibit the use of listed drugs for assisted suicide. While a House version of this bill was passed, the Senate has not voted on it. ▼

Hospital nurses don't discuss hospice option

Although most hospital nurses say they provide comfort and support to their dying patients, more than half of the nurses in the hospital setting never discuss hospice care, a Yale study has found.

More than 80% of the nurses surveyed reported using a range of palliative care practices in caring for terminally ill patients in the hospital. However, more than half reported that they never discuss hospice with these patients. Further, many reported large gaps in knowledge about hospice and palliative care.

"These results underscore the importance of including curriculums related to the care of the dying in nursing programs," said **Ruth McCorkle**, director of the Center for Chronic Illness Care in the Yale School of Nursing and a co-author of the study published in the February issue of the *Journal of Professional Nursing*. "The content needs to be integrated across nursing specialties and concentrated as core content that meets the standards of good practice. Hospice care is an important part of health care delivery today and all professionals need to be able to discuss it as an option for patients and their families."

The researchers surveyed 180 nurses at six randomly selected hospitals in Connecticut. Nearly two-thirds of the nurses surveyed had some hospice training, but less than 30% felt they were knowledgeable enough to discuss hospice care with patients. Many did not know when a patient can become eligible for hospice care and other basic information that might be needed by patients and their families considering care alternatives for their terminal illness.

The research suggests that there are significant gaps in knowledge about hospice among nurses in the acute care setting, while only a minority of nurses feel capable of caring for terminally ill patients or knowledgeable enough to discuss hospice with those patients and their families, researchers concluded. ▼

Patients not told about hospice

Researchers at Yale University have found that about 45% of terminally ill patients are not receiving hospice services, according to a report in the Dec. 22 issue of the *Journal of Palliative Care*.

Elizabeth Bradley, assistant professor in the Yale Department of Epidemiology and Public Health, and her co-authors evaluated the results of a cross-sectional survey of over 200 Connecticut physicians to determine the number of terminally ill patients who were referred for hospice.

"The study indicates that physicians refer only 55% of their eligible, terminally ill patients for hospice care and that many physicians lack knowledge about basic facts concerning hospice, such as patient eligibility criteria," says Bradley. "For instance, many physicians reported that a patient must be expected to die within two

months to be eligible for hospice, whereas the law states one must be expected to die within six months to be eligible for hospice."

Physicians included in the survey gave many reasons for not referring patients to hospice care, including patient refusal or lack of interest; family refusal or lack of interest; and the physician's own belief that hospice care was inappropriate or inapplicable, the Yale report adds.

"We saw that physicians' knowledge level concerning hospice, board certification, and specialty were each independently associated with the proportions of terminally ill patients referred for hospice," says Bradley. "One unexpected finding was that having had previous training regarding hospice care was not associated with improved knowledge of hospice or increased propensity to refer patients for hospice care. While it's possible that specific types of training do affect physician knowledge and/or behavior, our findings reveal that physician training, as measured broadly in this study, may not influence physician knowledge regarding hospice or physician referral practices substantially."

The Yale researchers say the results offer information that can be used to develop interventions and educational efforts aimed at improving physician knowledge about hospice care, resulting in increased hospice care referrals. ▼

Geographic variation in hospice use

Fifteen out of every 100 deaths in the United States occurred in a hospice setting, according to a study published in the Dec. 21 issue of the *Journal of the American Geriatrics Society*.[1]

Demographic characteristics such as age, race, and area income influenced hospice utilization. Specifically, younger people, black people, people from wealthier areas, and patients who paid their own Medicare premiums were more likely to use hospice services before death.

Researchers analyzed 1996 Medicare and hospice data. They looked at the use of hospice within geographic constructs known as hospital service areas, which are local units of health care services based on ZIP codes. There are a total of 3,436 hospital service areas in the United States. The researchers analyzed the impact on hospice utilization of managed care markets, the number of hospital beds and physicians, reimbursements, and the number of in-hospital deaths in the area.

Although the national rate of hospice use averaged 10.9 hospice users per 100 deaths, the rates were higher in urban areas than in rural areas (15.6 vs. 11.4). Some areas of the country had rates as high as 25 per 100, while in others the rate was less than 10 hospice users per 100 deaths.

Portland, ME, had the lowest usage rates (3.5), and comparatively low rates were found in New York City and Albuquerque, NM. The highest rates were in Denver (28.6), Phoenix (30.3), and Ft. Lauderdale, FL (39.7).

Cancer patients use hospice the most, but in areas of high hospice use, non-cancer patients are also well-represented. In addition, hospice use is lower in areas where there are higher rates of in-hospital deaths.

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In areas where a large proportion of the population is enrolled in HMOs, hospice use is high, but not only among the HMO enrollees. Where health care reimbursements are higher and there are greater numbers of physicians available, hospice use also is higher, regardless of patient characteristics.

The authors concluded that all of these variations suggest "tremendous potential for growth of the Medicare hospice benefit." Its use could increase by 15,000 or even 250,000 individuals per year. Increased hospice use is not by itself a necessary goal, but a variety of factors would influence how its growth might occur.

Reference

1. Virnig BA, Kind S, McBean M, Fisher E. Geographic variation in hospice use prior to death. *J Am Geriatr Soc* 2000; 48:1112-1117. ▼

Periodical offers CME and CEU credit

Physicians can receive 1½ prescribed credit hours from each bimonthly issue of the *American Journal of Hospice & Palliative Care*. The content of the program was approved by the American Academy of Family Physicians (AAFP).

A full-year subscription can yield 9 of the required 30 hours of CME credit.

Currently, credit is available for board-certified family physicians through the AAFP and reciprocally through the American Medical Association. The *Journal* has applied for approval for accreditation from other clinical specialties, including hospice and palliative medicine.

The *American Journal of Hospice & Palliative Care*, founded in 1984, is the oldest peer-reviewed, multidisciplinary professional journal devoted to hospice, palliative medicine, pain and symptom management, and end-of-life care.

Subscription to the journal is $174 per year. To receive 1½ CME credit hours or continuing education units (CEUs) for reading the journal, physicians must complete and mail the post-test printed in each issue. The physician will receive a CME/CEU certificate in the mail after successfully completing the post-test with a passing score of 70%. ▼

Funding boost may aid telemedicine expansion

In the flurry of changes to the health care budget bill passed by Congress late last year, lawmakers passed legislation increasing Medicare reimbursement for telemedicine services.

Among other things, the bill:

- expands eligible service areas for covered telemedicine services from restricted rural health shortage communities to include all non-metropolitan counties and existing urban Medicare demonstration sites;
- expands the services that can be billed to Medicare;
- eliminates a required fee splitting requirement between presenting health professionals at the local and referring sites;
- includes a new $20 facility fee;
- keeps in place existing Medicare reimbursement for teleradiology, remote cardiac monitoring and related services that are available throughout the country.

The provisions are scheduled to go into effect Oct. 1. ■