

HOSPICE Management ADVISOR

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

INSIDE

■ **Retention strategy:** Focusing solely on increasing salaries only partly addresses the challenge of keeping employees. A sound strategy also emphasizes social aspects of the job. 88

■ **Networks:** Hospitals aren't the only providers seeking consolidation. Postacute networks may be on the horizon for providers who want to become part of an organization that strives for a seamless continuum of care. 91

■ **News From the End of Life:** San Francisco-area jury awards hefty judgment for failure to ease pain; number of physicians certified to practice in hospice and palliative medicine increases; one of four in the U.S. suffer from chronic pain. 94

AUGUST
2001

VOL. 6, NO. 8
(pages 85-96)

Don't try to treat children with the adult hospice model

Effective pediatric hospice care requires specialized program

Hospice care is not a "one size fits all" proposition. No two patients receive exactly the same care or have the exact same needs. That philosophy rings especially true when it comes to hospice care for children. The needs of dying children and their families are significantly different from those of adults, but most hospices are not equipped to care for children and support their families.

Children's deaths are never easy to contemplate. Just when a child should be looking forward to a healthy and productive life, an injury or a diagnosis of a terminal illness shakes the foundation upon which family and friends stand.

"Children aren't supposed to die," says **Ann Armstrong-Dailey**, founder of Children's Hospice International in Alexandria, VA. "You're supposed to send children to a Children's Hospital, and miracles are supposed to take place. Even adults who are beautifully trained in hospice and palliative care for adults have problems when it comes to helping kids."

Pediatric hospice can drain coffers

Most hospices try to apply their traditional model of care to children, when instead they should have policies and procedures that account for the unique nature of caring for terminally children and their families, says **Kim Oberst**, RN, BSN, pediatrics director for the Hospice of Michigan in Southfield.

Hospices that commit to creating a pediatric care program will quickly find out that caring for dying children and their families is a financially draining proposition that must be subsidized by charitable contributions. Most children in hospice suffer from long-term illnesses, such as neurological disease or renal failure. So the commonly used criterion

NOW AVAILABLE ON-LINE: www.ahcpub.com/online.html
Call (800) 688-2421 for details.

that a patient has to have a six-month prognosis to be eligible for hospice care is difficult to apply in the cases of children, because they can be amazingly resilient.

“Pediatricians rarely can say categorically that a child has only six months to live,” says Armstrong-Dailey. “Kids can be literally at death’s door today, and three days later be in remission.”

Another typical hospice policy that doesn’t fit children is the cessation of all curative treatment. “Few pediatricians, let alone parents, are going to stop curative treatment for a child. Even if the chances for cure are one in 10 million, parents and physicians will pursue the treatment rather than accept the inevitable,” Armstrong-Dailey observes.

Hospice care often precedes diagnosis

Children generally need hospice care before the terminal diagnosis is actually made, says Oberst. Doctors usually are reluctant to certify that a child is terminally ill until mere days before the child dies. Most parents aren’t willing to choose palliative care over curative efforts, believing that doing so is tantamount to giving up. True pediatric care programs take these and other factors into account by providing palliative care and family support long before a terminal diagnosis is confirmed. Unfortunately, this kind of care often falls outside what insurers — government and commercial — consider to be covered services.

Many factors other than denial can hinder caring for the terminally ill child. “The current model of end-of-life care was designed for adult cancer patients and included the expectation of Medicare reimbursement,” says Armstrong-Dailey. “This model does not translate well to caring for children.”

In the United States alone, 75,000-100,000 children die each year, and an additional 1 million are seriously ill with progressive medical conditions. Despite these numbers, too little is known about treating the dying child outside the major children’s medical centers, and very few end-of-life programs target children’s special needs.

But the costs to hospices are high, says Oberst. Hospice pediatric programs require staff dedicated solely to caring for children, but the cost of care is likely to exceed reimbursement because of low caseloads and the amount of non-reimbursable care given.

With the cost of caring for children so high and reimbursement limited, why should hospices retool their programs only to lose money in the long run? “Because we are the experts,” says **Stacy Orloff**, LSW, child & family support program manager for Hospice of the Florida Suncoast in Largo.

Under an adult hospice model, patients must choose between curative treatment and palliative care. Choosing hospice signals the patient’s desire to be cared for in a way that emphasizes quality of life in his or her final weeks or days.

A study published in the Feb. 3, 2000, issue of the *New England Journal of Medicine* reported that many children dying of cancer suffer greatly because they are not given adequate treatment for pain, shortness of breath, profound fatigue, nausea, and other distressing symptoms. Although treatments for those symptoms exist, the doctors in the study were hesitant to treat the children.

Keep primary doctors involved

Children who suffered the most were those whose primary doctors were no longer involved in their care during the final stages. Children who had the most peaceful final month were those whose parents discussed hospice care with doctors earlier in their treatment, rather than later.

Introducing support and palliative care into a child’s final journey early in the process is crucial to alleviating distress for both children and parents. In an article published in the May/June 2000 issue of the *American Journal of Hospice & Palliative Care*, researchers advocate this approach so that both the physical and psychological needs of children suffering from a life-threatening illness can be addressed.

Children also die quite differently from adults, says Oberst. Most adults die from heart failure, while children often succumb to their diseases more slowly as a result of respiratory failure. While most adults die from a handful of diseases, cancer and congestive heart failure among them, children die of wide variety of diseases.

Aside from the illnesses themselves, the family dynamic is different. Caregivers of adults are traditionally spouses, siblings, or grown children. Caregiving is often looked upon as a burden in these instances. On the other hand, parents or guardians of dying children have a strong desire to continue caring for their children. As a result, families of dying children are usually reluctant to

Following the right PATH to better pediatric care

St. Louis program shows the way

It is financially impossible for some hospices to make the policy changes necessary to accommodate terminally ill children. These hospices should consider aligning with a local hospice or hospital that has pediatric palliative care expertise, says **Kim Oberst**, RN, BSN, pediatrics director for the Hospice of Michigan in Southfield.

One program that takes this approach can be found at SSM Cardinal Glennon Children's Hospital in St. Louis. In 1998, the Pediatric Approach to Hospice Support (PATHS) program began to evaluate and assess pediatric end-of-life care through clinical application, education, and the development of best practices in dealing with terminally ill children.

One PATHS component is its Footprints project, which focuses on the need for advance care planning and continuity of care, starting with the child's diagnosis all the way through to the end stages. According to project director **Suzanne S. Toce**, MD, a neonatologist, "For

families to experience a peaceful death with their child, we need to share their burden."

This pilot program, one of 22 Promoting Excellence in End-of-Life Care projects sponsored by The Robert Wood Johnson Foundation, highlights anticipatory guidance and continuity of care as two critical factors that benefit the child. "We have found that the best way to help a terminally ill child is to provide a way for one doctor to follow the child throughout the course of the illness," says Toce. "We also emphasize the family's values in the treatment approach."

A by-product of this program is the development of the Just In Time educational curriculum. "This training is offered to any professional — hospice nurses, emergency room physicians, pediatric nurses, and general practitioners — who will be providing care to a terminally ill child in a community," says Toce.

Similar to the Education for Physicians on End-of-Life Care program in format, the training introduces palliative care principles into clinical practice. "We are aiming for the child to be cared for in the community," says Toce. The team currently is developing an evaluation tool to assess quality of life for terminally ill children. ■

contemplate hospice as an alternative to curative treatment.

Children communicate differently from adults, making it difficult for them to tell adults the degree of pain they are experiencing. Communication differences make it a challenge to discuss death, as well.

Steps to take

Hospices should take the following steps when implementing a pediatric hospice program:

- **Determine the need for the program.**
- **Identify staff who are suited to work exclusively in care for dying children and their families.**
- **Set cost limitations by determining a target cost that your hospice is willing to accept for individual cases.**
- **Develop an educational program for physicians and social workers who will in turn educate parents who could benefit from a pediatric hospice program.**

- **Develop relationships with pediatricians, and appoint a pediatric medical director.**

"A hospice has to make a decision at the highest level to create a pediatric team," Oberst says. "Treating children and treating their grieving families is a specialty."

The decision must be made at the highest level of the organization, including members of the board. The decision to create a pediatric program must include a financial commitment from the hospice's charitable foundation to subsidize the cost of care. It is equally important for hospice leaders to be willing to adopt the following principles to govern the program:

- **Admission criteria for a pediatric palliative care program should be unlike admission criteria for adult patients.**

Rather than requiring a six-month terminal illness diagnosis, children should be admitted based upon the prediction that the child will not survive into adulthood.

- **The unit of care is the child and the family.** Family is defined as the people who provide

physical, psychological, spiritual, and social comfort to the child, regardless of genetic relationships.

- **Care should focus on relief of physical, social, psychological, and spiritual pain experienced by the child and family, despite not choosing to end life-sustaining care.**

This is one of the biggest reasons why caring for dying children is different from, and more difficult than, caring for adults. Hospice workers must walk the fine line between encouraging parents and helping them accept the inevitable. Despite hospice workers' own feelings about whether life-prolonging efforts are no longer working, workers still must respect the wishes of the parents and support their decisions while continuing to provide palliative care.

- **Pediatric interdisciplinary team members must have pediatric knowledge.**

Hospices need to provide substantial training to nurses, physicians, social workers, spiritual counselors, and volunteers.

Seven challenges to face

According to the palliative care handbook of the National Hospice Association and Palliative Care Organization in Alexandria, VA, there are seven challenges in creating a course to train interdisciplinary team members in pediatric palliative care:

- defining educational objectives;
- determining the content of training;
- selecting teaching methods;
- exploration of personal attitudes about death, dying, and bereavement;
- promoting interdisciplinary collaboration;
- evaluating training;
- choosing educators who are experienced in pediatric palliative care.

The handbook stresses the need to approach pediatric palliative care education from a practical perspective, highlighting specific knowledge, skills, and attitudes needed to deliver proper care, rather than hours of classroom lectures.

Training must include interactive methods of teaching. With all that hospice workers must internalize — pediatric palliative care goals, understanding personal feelings about childhood death, and ways to interact with patients and their families — learning is facilitated through hands-on methods, such as role-playing and active participation in palliative care activities.

- **Regardless of cause of death, supportive**

and bereavement care should be provided to all those who are affected by the child's death, for as long as they need it.

Of course, bereavement care is the hallmark of hospice care. Grief following the death of a child can be prolonged and can require longer and more intense periods of follow-up care. Bereavement care for parents, siblings, and others following the death of a child should be expected to go beyond the traditional one-year period that adult-focused hospices employ. ■

Pay hikes alone won't halt turnover

Comprehensive plan includes support

Keeping valued employees isn't just about money. Worker retention strategies that focus primarily on salary may prove to be shortsighted. In addition to satisfying staff financial needs, hospices must provide support to their workers similar to the support they show to their clients.

As hospices try to find ways to keep nurses, social workers, and other employees from leaving for higher-paying hospital jobs or less stressful hospice positions, or from leaving the health care profession altogether, their leaders must consider workers' spiritual, social, and professional needs.

Aside from complaints about low salaries compared to their counterparts in other segments of the health care industry, hospice workers seem to be consistently frustrated by increasing patient caseloads, emotional stress, spiritual issues, and cumbersome documentation requirements.

Experts say that if hospices can address these needs along with hospice workers' salary concerns, they will have gone a long way toward reducing turnover and keeping employees professionally satisfied.

Specific strategies include:

- support groups;
- employee ministry;
- manageable caseloads and scheduling;
- more efficient documentation procedures.

The classic tool for addressing staff emotional reactions to their work is a support group that meets regularly. Support groups normally are either self-directed or led by a professional facilitator. What they are not, however, is psychotherapy

or grievance sessions. Instead, support groups should address personal issues surrounding care for the dying and feelings of grief following the death of a patient.

A couple of years ago, **Claire Tehan**, MA, vice president of Trinity Care Hospice in Torrance, CA, noticed what she thought was a disturbing trend: hospices cutting back on employee support groups in response to mounting financial pressure.

Abandoning employee support groups may actually work against the goal of staying financially secure. If worker stress goes unchecked and an outlet for their stress and concerns is not provided, a hospice could find itself the victim of high turnover, which can impede its ability to grow.

“As short-staffed as we are, support groups are sacred,” says Tehan.

In addition to support groups, hospices also should provide orientation programs as its first line of support for new employees. Orientation programs can include a series of videotapes of speakers from various disciplines and should include someone schooled in workplace safety.

The orientation program Tehan uses includes the following topics:

- **Organizational philosophy.** Recently hired workers are schooled in the hospice philosophy and the hospice’s mission.
- **Hospice basics.** For nurses who have never worked in hospice, there is a need to become familiar with ideas such as the interdisciplinary team, palliative care, spiritual care, advance directives, and other 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 and perhaps revisit 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 alone.

The overall message nurses should be given is that if they don’t take care of themselves, their work will suffer — and that there are resources available to help them.

In addition to support groups and orientation programs, hospice workers often need the same kind of spiritual care their patients need. Occasionally, hospice workers can benefit from the services of hospice chaplains. While chaplains consider the emotional and spiritual well-being of their colleagues a priority, they must also walk a thin line between supporting staff and allowing a staff member to become too dependent on chaplain services, says **Jay Stark-Dykema**, MA, pastoral counselor with Seasons Hospice in Park Ridge, IL.

Chaplains can provide support in the following ways:

- pitching in when families are demanding too much of the nurses’ time, especially when a nurse is being called upon by the family to address more psychosocial issues than clinical ones;
- direct spiritual care;
- affirmation. Nurses and social workers deal with very complicated and difficult matters, but often don’t receive the credit they deserve.

Nurses may try to do too much for families

In their zeal to care for their patients, hospice workers run the risk of neglecting their own well-being. This can manifest itself in a number of ways. A common example is when a nurse tries to provide the lion’s share of the care and support to the patient and family.

For example, families in emotional crisis may rely heavily on the nurse for support, which results in the nurse having a hard time leaving the patient’s home. Rather than fostering independence and teaching the family and patient how to deal with emotions, the nurse falls into the trap of trying to do everything for them.

“Hospice families can require a lot of energy from a nurse, which can lead to burnout,” says Stark-Dykema.

Aside from teaching nurses to rely on other members of the interdisciplinary teams to keep stress to a minimum, hospice chaplains should recognize situations in which the nurse may be too involved.

As part of the interdisciplinary team, it’s easy and appropriate for chaplains and other members of the team to develop close collegial relationships. After all, co-workers in other walks of life develop friendships that blossom outside the context of work. The relationship between chaplains and their team members is unique, however. In times of personal or professional crisis, the

hospice chaplain is often the first person other hospice workers turn to for emotional or spiritual guidance.

Because chaplains have a predisposition to reach out to help, it's easy for workers to seek their counsel. In most cases, when the loss of a patient triggers strong feelings of grief, ministering to employees is acceptable up to a point.

But one expert warns that hospices should evaluate chaplain-employee relationships to ensure the chaplain is not overburdened and that workers don't cross ethical boundaries that could impede the team approach to hospice care.

It's the blurring of boundaries that can cause problems between chaplains and their co-workers, says Stark-Dykema. He offers these warning signs:

- A chaplain finds himself or herself counseling a worker on an ongoing basis.
- Workers without a support system continually seek the chaplain's counsel.
- A chaplain notices that he or she is spending more time with one team member than others, perhaps diminishing his or her availability to other staff or patients.
- If a chaplain too often plays the role of counselor with a worker, the chaplain runs the risk of diluting his or her effectiveness with the very people he or she is trying to help.

This does not preclude chaplains from ministering to their co-workers. In fact, chaplains play a key role in meeting the spiritual and emotional needs of co-workers as well as patients and their families.

While the feelings of grief experienced by hospice workers are strong, they often are not enough to prompt the worker to seek counseling through the hospice employee assistance program. An observant chaplain will likely notice the signs of grief the worker is experiencing, or the worker will seek out the chaplain's help.

Experts say chaplains should feel free to help a worker identify the underlying issues at the root of their problems, but they also should encourage the staff member to seek counseling outside the hospice.

This is especially true in situations where the problem lies outside work but is affecting performance at work, such as marital problems, caring for a chronically ill relative, or parenting issues.

Acting as a resource for workers in need is an excellent way to minister to employees. In cases where co-workers have questions about their own spirituality, for example, chaplains should

encourage the worker to seek the guidance of their own minister, priest, or rabbi.

Chaplains can use team meetings to openly discuss feelings of grief or distress that arise from a patient loss or other situations that may effect morale. For instance, the death of a patient who has had a significant impact on staff could be addressed during a team meeting where each staff member is allowed to light a candle in memory of the patient and share personal memories about the deceased patient.

"You need to ask how you can love and support your fellow team members," Stark-Dykema says. "You need to promote the sense that everyone is in it together."

Chaplains also can minister to their co-workers' spiritual needs by holding educational inservice training on religious issues, such as different types of faiths. Chaplains can use the opportunity to get workers to reflect on their own spirituality by talking about how their own spiritual beliefs interact with those of a patient or a patient's family, Stark-Dykema says.

Strive for efficiency

In addition to spiritual and psychological issues, mundane aspects of the job can cause stress. Providing documentation to ensure Medicare reimbursement is a good example. With fraud and abuse never far from the minds of those who administer government-funded health care services, proving medical necessity is key to getting paid — and to avoiding the scrutiny of government auditors.

The increased emphasis on documenting details of a hospice patient's care from the point of referral to the moment of death is taking its toll on hospice workers who were drawn to the profession because it harkens back to the days of old-fashioned nursing, which emphasized hands-on care. But documentation requirements are demanding more of nurses' time, which takes away from the time they spend with patients.

"The process of collaboration is the difficult and time-consuming part of documentation," says Tehan. "We've got a lot of people complaining."

According to Tehan, documentation is cumbersome because all members of the interdisciplinary team must document their own work, such as assessments, and they also must obtain information from other team members to fulfill their documentation responsibilities.

While at a loss for a specific solution, Tehan says the answer lies in making documentation more efficient. Home care agencies and hospices have dabbled in using the latest technology to help alleviate administrative burdens.

Software developer **David Tripp**, president of Tripp Consulting in Reading, PA, says the key to making the documentation process more efficient is to give members of the interdisciplinary team access to the same set of information and prevent the need for lengthy meetings where team members compare information.

To that end, Tripp has developed Hospiceware, database software that allows nurses, social workers, chaplains, and others to enter information into a computer and have that same information automatically entered into electronic forms shared by other interdisciplinary team members.

Tripp says the most practical way to facilitate the sharing of information is to equip workers with laptop computers that would allow them to enter data from the patient's bedside and download the data at the end of the workday using a dial-up Internet connection.

The last component of this retention strategy has to do with showing workers their worth by investing in their professional growth. Experts say allowing nurses time to pursue professional growth by attending conferences and seminars shows support for their work and places a premium on their desire to improve as professionals.

"We are always looking for ways that show how much we value them," Tehan says. "You want to be able to show that you value their work and you need to be willing to help them grow professionally." ■

Are post-acute networks on the horizon?

Hospices could benefit from strategic alliances

In this age of mergers and consolidations, the health care industry is no different from the likes of media conglomerates and high-tech industry. As its components strive for market share and efficiency, providers of health care services have been joining forces to make their mark on a rapidly changing health care landscape.

Acute care hospitals have led the way by

forming integrated delivery systems. But the continuum of care doesn't stop with a hospital discharge. Providers of post-acute care are seeing the advantage of forming networks that address the care continuum outside the hospital.

Although hospices have seen reimbursement rates rebound, they and other post-acute providers struggle to make ends meet with government-sponsored programs. As a result, hospices and others will have to rely on managed care for a greater portion of their overall revenue. That means hospices, along with home care agencies and skilled nursing facilities, will have to compete for managed care contracts.

Contracting with fewer entities

Managed care organizations have shown that they prefer to contract with providers who can provide a broad range of care, thus eliminating the need to have to contract with several smaller providers.

Hospice leaders looking for ways to promote referrals could benefit from collaborations with other post-acute providers. A post-acute network, in turn, would market the entire network's services to managed care providers who favor contracting with larger entities rather than individual providers.

In its broadest sense, the term post-acute care includes all health care services delivered outside the acute hospital setting, says **Gail Currie**, MS, ABD, founder and president of Critical Edge, a health care consulting firm in Far Hills, NJ.

From her firm's web site (www.criticaledge.com), Currie says post-acute care generally refers to a network within a given market encompassing a broad range of health care services in a variety of care settings outside the hospital, including primarily subacute medical and rehabilitative care and home health care.

In addition to these core services, an integrated post-acute network may extend its service capacity with selected outpatient services such as family medicine practices or diagnostic or surgi-centers that meet key health care needs of the population served. They may also provide pharmacy or other consumer health products to patients.

What is included in the working definition of an integrated post-acute care in any given market will ultimately depend on the needs of the covered population and the opportunities of a given community marketplace.

Whatever services are encompassed in the offering, integrated post-acute care must be provided by a goal-oriented, physician-directed, interdisciplinary team with specialized skills for treating patients with complex medical and/or rehabilitative needs who require less intensive care than that available in traditional acute care or rehabilitation hospitals.

Having a continuum of services that has effective linkages for coordinated discharge planning will be more important to managed care companies, experts say. What is important to managed care companies, as well as to Medicare, is the provider's ability to manage a patient's care cost-effectively across the entire continuum.

'They have to align themselves soon'

But in many communities, post-acute providers are still a collection of independent providers who treat patients from the narrow scope of their own company. To be competitive, post-acute practices will have to form their own post-acute continuums, says **Ann Keillor**, EdD, vice president of Superior Consultants, a health care consulting firm in Ann Arbor, MI.

"They have to align themselves soon," Keillor says. "They can take referrals from everyone for a while, but eventually, alignment will have to take place."

Further, for the sake of the continuum's success, some providers will have to shed some of their independence for the larger organization to succeed. "Their independence will diminish somewhat — everyone's will," Keillor says. **(For a list of the components of an effective network, see p. 93.)**

Keillor has found that as managed care exerts greater influence on a market, patient care is managed more aggressively. This means providers will need to develop programs to allow patients to be admitted directly to post-acute facilities rather than entering them from an acute hospital, because it is more cost-effective.

"As markets go through this transition, what they need to look at as a system is to be able to move patients directly into these levels of care," Keillor says. "An individual provider will either have to develop these programs alone or have to develop formalized relationships with those who do have these programs."

These formalized relationships will constitute the beginning of continuum development. The hospital usually takes the lead in forming a post-

acute network because it has greater access to money and contracts. Hospitals also see network formation as a way to control patient flow and to lower their own cost by moving patients to less expensive postacute care.

The best way to bring all of the above services together is a formal organization, such as a health care system that integrates not only post-acute providers but physicians and hospitals as well.

But the reality may be that unless market forces push post-acute providers into mergers or consolidations, most post-acute providers will remain independent businesses. So building a continuum will hinge on providers' ability to form joint ventures or create an organization of loosely affiliated providers, similar to independent practice associations for physicians.

"It is extremely difficult to integrate a number of different proprietary entities into a streamlined continuum," Keillor says. "What we find is that programs will compete for the same patient population."

Difficult, but not impossible. Hospitals will not have enough money to buy all the post-acute services in a market, so the chances are strong that a continuum will include providers who have only an operational commitment.

"You have to be clear about what the mission is," Keillor says. "You have to have willing participants. You need post-acute providers who are willing to take more patients and take them at a higher level of care."

Organization interests vs. Individual interests

In forming an organization of independent providers, the larger organization risks territorial battles and infighting when the individual interests of providers clash. For example, if a post-acute organization takes capitation from an HMO for the entire post-acute continuum and distributes the per-member per-month payment among the various providers, conflicts could arise as a result of patients moving along the continuum. A home care provider may find itself at odds with the subacute provider because patients are being discharged to home care too early, causing the home care provider to expend more money to care for the patients.

Diminished independence will also come in the form of abdicating responsibility for patient

(Continued on page 94)

Post-acute networks cover a wide spectrum

Acute care hospital usually drives system

Developing a post-acute continuum begins with identifying the components that exist within a community and gauging each provider's willingness to participate. A post-acute network may include the following providers:

- **Acute care hospital.** Most likely, the acute care hospital will be the driver of the system because that facility will have greater access to money, managed care contracts, and patients. The hospital will act as a referral source to post-acute providers along the continuum. In many cases, it will act as the central case manager, working with case managers of the other post-acute providers to move patients along the continuum.

Providing care for 25 days or longer

- **Long-term care hospital.** This is an acute care licensed facility that serves patients who require an average length of stay of 25 days or longer. These patients usually experience many comorbid or coexisting conditions along with the primary reason for the hospital admission. Patients requiring a long-term hospital stay need daily medical surveillance, 24-hour professional nursing care averaging from seven to 10 hours per patient day, and one to two hours of therapy intervention per day five days a week.

- **Subacute care.** A facility for less intensive monitoring and assessment than an acute hospital stay, subacute care facilities provide continuous nursing services and more skilled medical services and procedures, such as rehabilitation. The care may occur before, after, or in lieu of an acute rehabilitation stay. Subacute care can be delivered in a hospital-based unit or in a skilled nursing facility.

- **Skilled nursing facility.** These sites provide skilled nursing care to residents needing continuous nursing, rehabilitative, and other health or social services. The facility may be free-standing or part of a hospital. All Medicare-eligible skilled nursing facilities require a three-day hospital

stay within the last 30 days prior to skilled nursing facility admission. Medicare reimbursement pays up to 100 days per episode of illness; however, most nursing home patient days are not paid for by Medicare.

- **Assisted living.** This is a specialized combination of housing, personalized supportive services, and health care services designed to respond to the individual needs of those who require help with activities of daily living but do not need the skilled medical care provided in a nursing home. While many facilities are freestanding, many others are part of retirement communities that include skilled nursing facilities, independent living facilities, and geriatric centers. Health care services can be provided internally or contracted from a health care provider.

- **Home health care.** These facilities provide complex medical services to homebound patients who do not require an acute facility stay and who may have difficulty obtaining access to outpatient services. Services include nursing services, home health care, personal care, social services, and other ancillary services, as well as home medical equipment, infusion therapy, enteral therapy, and clinical respiratory therapy.

Day care promotes independence

- **Adult day care.** This kind of site provides programs committed to helping families care for older adults, allowing seniors to continue to live with their families. Day care's primary emphasis is on promoting independence, self-esteem, and health. Adult day care programs provide needed emotional support and respite for families. Program components include health monitoring, exercise retraining, community outings, group activities, hot lunch, and morning snacks.

- **Comprehensive rehabilitation facility.** These Medicare-funded facilities are required by the federal government to provide physical therapy, social services, and physician services. Optionally, the facility may also provide occupational therapy, respiratory therapy, and speech therapy. Hospitals sometimes place comprehensive rehabilitation facility within a long-term care facility, which includes hospital-based therapists delivering therapy services. ■

flow to one central authority: a case manager. Central case management involves guiding patients from one point in the continuum to the next, working closely with case managers at the individual provider level. While it would be difficult to develop clinical paths that cover the entire continuum, the central case manager will have to work with provider case managers to develop clinical paths for each provider site.

As managed care proliferates and Medicare reimbursement is reduced, the knee-jerk reaction of some post-acute providers may be to focus on reallocation of costs to compensate for reductions in payment. But the key to long-term success lies in managing costs by placing patients in the most appropriate setting. ■

News From the End of Life

Failure to ease pain brings large jury award

CA doctor hit with \$1.5 million judgment

A jury in California awarded \$1.5 million to a family of a deceased cancer patient who died while experiencing severe pain. The jury agreed that Wing Chin, MD, failed to address the patient's pain adequately, but it did not rule that he acted with malice or had intentionally caused emotional distress, so there was no award of punitive damages.

In a trial that became a forum for the debate over how pain is treated in American medicine, an Alameda County jury on June 14 found that Chin, an internist, committed elder abuse and reckless negligence by not giving enough pain medication to William Bergman, who died in 1998.

The case is a major victory for patients' rights advocates who argue that many doctors don't

treat pain adequately, said **Barbara Coombs Lee**, president of Compassion in Dying, a Portland, OR, advocacy group that provided legal assistance for the lawsuit.

"It's a good day for us," Lee stated after the decision was handed down. "This case was against all odds. . . . This is a precedent-setting case because, to our knowledge, never before has undertreating pain been defined as elder abuse."

The suit was brought by Beverly Bergman, 45, the daughter of the retired railroad detective. ▼

Certified palliative medicine docs on the rise

835 now are credentialed

The American Board of Hospice and Palliative Medicine (ABHPM) granted certification to an additional 56 physicians as of July 1, bringing the total number of physicians certified in the specialty of hospice and palliative medicine to 835 worldwide.

The medical specialty of palliative medicine is devoted to achieving the best possible quality of life for patients and their families faced with a life-threatening or terminal illness. Physicians who achieve certification from ABHPM are recognized as experts in the practice of palliative medicine.

"The art and science of care for patients who are not likely to be cured has always been an important part of the physician's role," observes **Ronald Schonwetter**, MD, chairman of the ABHPM.

"Unfortunately, for the last generation of physicians, training in palliative care was not considered important. Physicians had to keep up with all of the technological advances in curative medicine. But all patients die eventually. And unless the physician is skilled in providing pain control and symptom relief, and in working with

COMING IN FUTURE MONTHS

■ Are doctors really learning about pain management?

■ Evaluating your volunteers

■ Alternative therapies with promise

■ Using innovative marketing techniques

■ How to measure bereavement outcomes

a palliative care or hospice team, patients generally will not have the opportunities for comfort, dignity, and closure that they deserve. ABHPM diplomates are the physicians helping medicine realize the importance of high quality end-of-life care.”

Eligibility requirements for certification from ABHPM are significant. Applicants for certification must have received prior major specialty certification, practiced at least two years following residency, worked as a member of an interdisciplinary team for at least two years, and directly participated in the active care of at least 50 terminally ill patients in the preceding three years.

Applicants who meet these requirements are then permitted to sit for the annual certifying examination, which covers pain in cancer and noncancer patients, management of non-pain symptoms, hospice and palliative approach to care, ethical and legal decision making at the end of life, death and dying, and communication and teamwork.

ABHPM will offer the certifying examination next on Oct. 13. Applications to sit for the examination must be received by Aug. 31.

[Editor's note: A handbook for examination applicants as well as other information on the American Board of Hospice and Palliative Medicine may be obtained from the organization's web site at www.ABHPM.org or by calling (301) 439-8001.] ▼

1 in 4 in the U.S. suffer from chronic pain

Pain perception a diagnostic problem

Chronic pain affects 86 million Americans, causing the brain to constantly and mercilessly fire pain signals to the nervous system for weeks, months, even years. This condition, which is associated with several other conditions, is difficult for medical personnel to detect. It can be surprisingly resistant to modern medical treatments. Amazingly, chronic pain has only recently been classified as a disorder by health care organizations.

“Pain is the No. 1 reason people go to see their physician,” says **R. Norman Harden, MD,**

a neurologist and medical director of the Rehabilitation Institute of Chicago's Chronic Pain Care Center. “The prevalence of chronic pain and the range of diseases that are associated with it have forced the medical community to finally acknowledge the fact that chronic pain is a serious problem, one that requires a unique set of treatments.”

Until recently, health care organizations have treated pain as a symptom of a larger problem. In many cases, pain was considered to be the result of an injury or disease and merely a part of the healing process. Due to the subjective nature of pain, the medical community faced several challenges in both evaluating the disorder and pinpointing its causes.

“The biggest obstacle we have to overcome is assessing a patient's pain, because each person's perception of pain is different,” says Harden. “The only way to ‘measure’ someone's pain is by measuring their improved functions and decreased

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to Hospice Management Advisor™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.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), \$319. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Two to nine additional copies, \$191 per year; 10 to 20 additional copies, \$128 per year. For more than 20 copies, call customer service for special handling. 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 \$53 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

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.

Editor: **Eric Resultan**, (770) 329-9684, (eric_resultan@msn.com).

Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).

Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).

Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).

Production Editor: **Brent Winter**.

Copyright © 2001 by American Health Consultants®. Hospice Management Advisor™ is a trademark of American Health Consultants®. The trademark Hospice Management Advisor™ is used herein under license. All rights reserved.



Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

disability, depression, and anxiety. That's why we tailor pain management therapy for each individual patient, as opposed to a one-size-fits-all approach.

"Another huge obstacle to overcome is gaining the patient's trust," Harden adds. "Many come to the Chronic Pain Care Center after going through multiple tests, doctors, and treatments with no clear answer to the cause of their pain. Most important, they are still in serious discomfort and feel that it is something they will have to live with."

Part of the confusion regarding chronic pain is the fact that it is tied to several other disorders such as fibromyalgia, lower back pain, migraines, and arthritis. Some of these disorders are a direct result of another disease the patient is suffering. However, fibromyalgia, for instance, has no known cause, which makes it difficult to diagnose. Many patients see several doctors and try several treatments before they are correctly diagnosed and treated.

Breaking the vicious cycle

In addition to affecting the patient physically, chronic pain may cause mental anguish. Many researchers have found a connection between mind and body in which misery leads to stress, and stress leads to pain. This cycle can be repeated over and over again unless the patient breaks through the cycle by using appropriate pain management methods.

"Many chronic pain patients have been suffering for so long, they'll try almost anything to relieve their pain," notes Harden. "Therefore, most of my patients are receptive to what might be considered unconventional pain management treatments, including occupational therapy, exercises that focus on the mind-body connection, and social setting therapy."

Today, medical professionals are required to assess and treat a patient's pain. Just last January, the Joint Commission on Accreditation of Healthcare Organizations, a national accrediting board, defined pain as the "fifth vital sign" along with heart rate, pulse, body temperature, and blood pressure.

The center has adopted an interdisciplinary approach to treating chronic pain that teams physicians specializing in neurology, physical medicine, and rehabilitation; physical therapists; occupational therapists; and psychologists. The team customizes programs for each individual that focus on a combination of exercises, physical

EDITORIAL ADVISORY BOARD

Consulting Editor:

The Rev. Jeanne Brenneis,
MDiv, STM
Director, Bioethics Center
Chaplain, Hospice of Northern Virginia
Falls Church, VA

Gretchen M. Brown, MSW
President and CEO
Hospice of the Bluegrass
Lexington, KY

Pamela S. Melbourne, RN, MN
Director of Clinical Services
Hospice Atlanta
Atlanta

Earl Ash Evens, MSW, MBA
President and CEO
AdvaCare Inc.
Pittsburgh

Peggy Pettit, RN
Vice President
Patient/Family Services
Vitas Healthcare Corporation
Miami

Marilyn Hannus
Director
Hospice of Cape Cod
Yarmouthport, MA

Claire B. Tehan, MA
Vice President, Hospice
Hospital Home Health Care
Agency of California
Torrance, CA

Bonnie Kosman,
MSN, RN, CS, CDE
Director of Patient Care
Lehigh Valley Hospice
Allentown, PA

therapy, medication, and patient education.

"Doctors no longer believe that treatment for pain comes exclusively in the form of a pill or injection," says Harden. "We are not trying to mask the pain or give instant gratification with medication. We teach techniques that our patients can do at home, are affordable, and promote self-management of the disorder. Patient education is our most valuable resource and one of the reasons why so many of our patients are able to live normal lives."

The center designs programs for each patient that could include nontraditional methods such as yoga and psychological techniques for how to deal with pain at work and home. Because of the center's interdisciplinary approach and the simplicity of its techniques, more than 90% of the center's patients have said they would recommend the center to others, and 60% report a significant decrease in their pain, according to Harden.

"The goal of the Chronic Pain Care Center is to bring the best quality of life to our patients by teaching them how to manage their pain at home," says Harden. "They no longer have to feel isolated from their family and are able to enjoy their lives again." ■