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INSIDE

■ **Complementary therapies:**

Hospices should consider increasing their stable of complementary therapies to meet the needs of diverse patient populations 136

■ **Physician marketing:**

Treat referring physicians like customers to boost physician satisfaction and increase referrals 139

■ **Pain management:** Practical reimbursement advice for referring physicians 140

■ **News from the End of Life:**

Elizabeth Dole named to key NHPCO post; firefighters' union seeks counselors in the wake of Sept. 11 142

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(pages 133-144)

Medical directors can be ambassadors to spread the benefits of hospice

Hospices are on the front lines in battle to raise palliative care awareness

Efforts to raise awareness of palliative care are often seen as a global enterprise, one that should only be undertaken by large organizations with Donald Trump-size coffers. But in truth, it is individual hospices that shoulder the burden of educating physicians about the benefits of palliative care.

From primary care to oncology, these physicians play a pivotal role in influencing patient attitudes toward hospice and palliative care. It is thus incumbent upon physicians to initiate a dialogue with each patient and his or her family about hospice and palliative care when it is appropriate. The problem is that physicians are either reluctant to do so or are not well-informed enough to speak confidently about it.

Hospice medical directors play a pivotal role in familiarizing physicians with end-of-life care, says **Charles F. von Gunten**, MD, PhD, FACP, chairman of the American Board of Hospice and Palliative Medicine and medical director for the Center for Palliative Studies at San Diego Hospice.

Medical expertise provides 'potent marketing tool'

According to von Gunten, medical directors can advance the cause of palliative care and hospice by displaying professionalism and leading by example. "When a hospice medical director is seen as an expert, it's a potent marketing tool," says von Gunten.

In the absence of end-of-life training in medical schools, hospice medical directors must fill in the information void for their colleagues. That can be done through one-on-one consultation with referring physicians who seek advice regarding difficult cases.

"The majority of physicians learn from direct patient care," says von Gunten. "Medical directors can help other physicians learn through consultation."

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Through this relationship, von Gunten says, hospice medical directors can show physicians how to use palliative care in their own practices and how it helps improve patient care. As physicians become more comfortable with palliative care and hospice care and more knowledgeable about them, recommending these modalities will come as a matter of course.

Consultation is the best model for passing along palliative care information, says **Martha L. Twaddle**, MD, FACP, medical director for the Hospice of the North Shore and the vice president of medical affairs for its sister organization, the Palliative Care Center of the North Shore, both in Chicago.

With most physicians uncomfortable about discussing palliative care with their patients, hospices must encourage physicians to consult hospice medical directors. The consultation fosters a team atmosphere between the patient family and involved physicians.

Directors must earn physicians' trust

Unfortunately, it's not often that physicians seek the advice of medical directors, and medical directors haven't made physician outreach a priority. In the few cases in which physicians seek consultation with a hospice medical director, it most likely is because the medical director has a reputation as an expert in palliative care. Getting to that point, however, is a combination of trust and experience. Trust is fostered over time, and experience must be proven.

Because of the lack of formal medical school training in palliative care, hospice medical directors must prove that they are experienced clinicians in caring for chronically ill and dying patients, and they must convince physicians that palliative care is a specialty.

"Hospice administrators must understand that palliative care is developing into a specialty and that they need to promote their medical directors as leaders in this specialty," says **Dale Ellen Lupu**, PhD, president and chief executive officer of the Silver Spring, MD-based American Board of Hospice and Palliative Medicine (ABHPM), which certifies physicians in palliative care.

Lupu says certification in palliative care medicine goes a long way toward proving a physician's expertise and lends legitimacy to the fledgling specialty. To date, ABHPM has certified nearly 1,000 physicians, but Lupu says with more than 2,200 hospices around the country,

there is a long way to go to get all hospice medical directors on board.

Another project that is attempting to increase palliative care awareness is Education for Physicians on End of Life Care (EPEC) in Chicago, which seeks to train physicians to teach other physicians about end-of-life care. EPEC officials have stressed that hospice medical directors are prime candidates for this train-the-trainer approach.

Teaching physicians how to teach

Dissemination of the EPEC curriculum began with two national conferences in the spring of 1998 to introduce an abbreviated version of the curriculum to national leaders in medicine. In the first half of 1999, six regional conferences presented the EPEC to a select group of 500 physician educators for implementation in their own institutions or communities. Since then, more than 1,000 physicians have been trained to teach their colleagues, says **Jeanne Martinez**, RN, MPH, CHPN, associate director for outreach and technical assistance with EPEC in Chicago.

Trained physicians are taught fundamental skills in communication, decision-making, medical ethics, legal issues surrounding palliative care, palliative medicine and hospice care, psychosocial management, and pain and symptom management, which applies to both terminal and non-terminal conditions. While hospice medical directors may be well-versed in these areas, the course also instructs physicians on teaching approaches.

Upon completion of the program, participants are able to:

- define advance care planning and explain its importance;
- counsel patients on the creation and use of advance directives;
- identify the six-step protocol for delivering "bad" news;
- describe and assess the elements of suffering and the role of the interdisciplinary model;
- compare and contrast symptoms, physiology, and treatment of nociceptive pain and neuropathic pain;
- define physician-assisted suicide and describe its current legal status;
- distinguish terminal sedation from assisted suicide;
- recognize terminal illness;
- enhance effective teaching skills.

In addition to instructing other physicians, hospice medical directors should help EPEC-trained physicians reach out to the rest of the health care industry.

Once physicians are under the guidance of hospice medical directors, it is much easier to help them become more aware of palliative care and more comfortable talking about the subject with their patients. According to a paper published in the May 1999 issue of the *Annals of Internal Medicine*, physicians need to be taught how to:

- elicit patients' concerns, goals and values;
- acknowledge patients' emotions and explore the meaning of these emotions;
- screen for unaddressed spiritual and existential concerns.¹

Short-term emotional pain can aid in growth

As if the challenges facing physicians in reaching these goals aren't enough, they also face greater challenges once they are able to effectively achieve their communication goals. According to the paper's authors, entering this level of relationship with a patient can increase the patient's short-term suffering. However, raising painful emotions can lessen a patient's loneliness and provide new opportunities for comfort, growth, and resolution.

Physicians must be reminded to clarify their own roles and expectations and to call on their colleagues among physicians, nurses, and other disciplines for assistance, the paper says.

"Interviewing techniques, such as asking open-ended questions about end-of-life issues, building on and exploring patient responses, and addressing the associated emotions can help initiate difficult discussions about palliative care," the authors write.

The paper offers practical advice on how physicians can better handle what promises to be a difficult conversation. Specifically, the authors point out that:

- **Physicians should help facilitate a discussion about palliative care with their patients.**

Educating physicians on this point will primarily focus on skills they already have. Using open-ended questions during clinical encounters is a skill that physicians have honed since medical school. But when it comes to prompting discussions about palliative care, physicians are often reluctant to engage their patients about hospice or palliative care, fearing the topic would cause

the patient to lose hope.

Consequently, if a physician shrinks from discussing palliative care because a patient has expressed fear regarding life-threatening illnesses, the patient's emotional and spiritual needs will likely be left untreated.

- **To help patients talk about palliative care, physicians should use open-ended questions and ask follow-up questions that incorporate the patient's own words.**

Hospice medical directors must remind physicians to use open-ended questions to gauge the patient's concerns about his or her illness. The patient's own language should dictate the direction of the questions.

- Examples of open-ended questions include:
 - What concerns you most about your illness?
 - How is treatment going for you and/or your family?
 - As you think about your illness, what is the best and the worst that might happen?
 - What has been most difficult about your illness?
 - What are your hopes and expectations of the future?
 - As you think about the future, what matters to you most?

Discuss palliative care before clinical options

Once the patient has begun to discuss his or her concerns and emotions, physicians need to be taught not to begin discussing clinical options before the discussion of palliative care. For example, the discussion may lead to a decision to draw up a do-not-resuscitate order. If, however, specific treatment management options are discussed before palliative care, it could deter the patient from deciding whether to limit life-prolonging intervention.

One objection to the approach of using open-ended questions is that it can be seen as a distancing technique on the part of the physician and that, in certain segments of our multicultural society, patients and families may object to the discussion of death at this level. If, however, the physician focuses on using patients' own words, allowing patients' concerns to drive the discussion, and respecting patients' values, the objection is addressed.

- **Involve close family members in discussions about palliative care.**

In addition to the patient's concerns and emotions, family members often raise issues of

their own. Physicians will hesitate to discuss palliative care with family members because their concerns — such as being able to handle care of the patient during the final stages of death — may not be solvable. But physicians must be reminded that getting to the heart of a family's fears and concerns is essential if the physician expects to meet the needs of the patient.

- **Ensure a common understanding of terms associated with palliative care by providing specific examples of palliative care, such as pain management.**

Patients and family may never have heard about palliative care. Physicians' basic knowledge of palliative care should be shared with patients and family by providing definitions of terms such as "pain management."

- **During emotionally intense encounters, physicians must remember to ask directly about the patient's symptoms and functioning.**

Physicians should review common problems that dying patients face, such as pain, fatigue, and shortness of breath. Quantify the pain felt by patients by using a numeric scale. Also, don't overlook depression, and remind physicians that they should screen for the disorder.

Ask about spiritual needs

- **Physicians and other health care providers should screen for unaddressed spiritual issues.**

While physicians may feel uncomfortable with spiritual matters, hospice medical directors must point out that many patients desire a physician who is spiritually attuned to them. The following series of open-ended questions will help physicians gain a better understanding of their patients' spiritual needs:

- Is faith important to you in this illness?
- Has faith been important to you at other times in your life?
- Do you have someone to talk with about religious matters?
- Would you like to explore religious matters with someone?

Developing closer relationships with end-of-life patients may result in patients directing difficult statements and questions toward physicians. For example, a patient with only a few weeks to live may express a desire to attend an event he or she will likely not live long enough to see. Physicians can be trained to handle these difficult situations by keeping these three points in mind:

1. While uncovering painful emotions does seem to increase short-term suffering, exploring difficult issues will have long-term benefits.

2 Physicians should share their emotions with patients, because that could lessen the patient's feelings of isolation.

3 There is therapeutic value in simply listening to patients' problems, even when the problems are unsolvable.

Medical directors should see themselves not only as experts in end-of-life care, but also as reformers who have the skill and opportunity to affect the behavior of their colleagues.

"What we are trying to do is undo the lack of education that has occurred in medical schools for generations," Lupu says.

Reference

1. Lo B, et al. Discussing palliative care with patients. *Ann Intern Med* 1999; 9:744-749. ■

Complementary therapies enhance hospice care

Address diverse patient needs with alternatives

There are a host of complementary therapies available to hospices, ranging from common art therapy to not-so-common dolphin therapy. As the needs of patients become more diverse, hospices may feel compelled to expand their stable of complementary therapies. The question then becomes: Which therapies are best suited for your hospice?

"We checked out a number of therapies," says **Heather Kantor**, assistant director of foundation and complementary therapy administrator for Nathan Adelson Hospice in Las Vegas.

As late as 1999, Nathan Adelson employed no complementary therapies; now it uses seven and is planning to add more. "It's better to have a lot rather than a few," says Kantor. "We're always looking into other therapies."

For hospices with one or two complementary therapies to offer patients, Kantor suggests they consider adding more to broaden their ability to manage pain and stress.

Kantor says hospices starting from scratch as Nathan Adelson did should start slow and build

upon the success of one or two therapies at the start. After considering a number of therapies, Nathan Adelson started the Comfort Care Program with pet therapy and has since added six more, including aromatherapy, music therapy, water therapy, reminiscence therapy, massage therapy, and therapeutic touch.

Pet therapy, also known as "visiting pets," "therapy dogs," and "animal-assisted therapy," holds that by simply petting animals, patients and family members will experience lower blood pressure.

Nathan Adelson uses volunteers who handle certified therapy dogs. The therapy can involve formal care plans or can occur as informal visits. The handler and the hospice nurse may consult on specific goals to be accomplished and plan how to accomplish those goals. The preferred use, however, is for more informal activities.

An animal visit can offer entertainment or a welcome distraction from pain and infirmity. Visiting with animals can help people feel less lonely and depressed; for instance, people often talk to the dogs and share thoughts, feelings, and memories with them. Many people in hospitals or group homes have had to give up pet ownership, and they miss the unconditional acceptance a pet gives them. The pet also makes it easier for two strangers to talk, because it gives people a common interest and provides a focus for conversation. Patients become more active and responsive during the visit, and this change often lasts for some time after the visit is over.

Addressing patient needs through music

Music therapy is the specialized use of music to improve or maintain functioning in the following areas: motor, physiological, social/emotional, sensory, communicative, and cognitive functioning. The purpose of music therapy is to help individuals attain and maintain their maximum levels of functioning. This is achieved by addressing the client's needs and problems through music. The following three professional credentials are recognized by the Silver Spring, MD-based American Music Therapy Association: MT-BC (music therapist-board certified), RMT (registered music therapist), and CMT (certified music therapist).

At Nathan Adelson, each inpatient unit facility offers a library of music, videotapes, and books on tape. Musicians also come to inpatient units to

play for patients and their families. Music is used in conjunction with medications to alleviate pain, elevate the patient's mood, counteract depression, induce sleep, decrease fear, and lessen tension, Kantor says.

The Colorado Association for Music Therapy in Fort Collins provides the following information about music therapy provided by certified therapists:

1. Music therapy is prescribed by members of the client's treatment team. Members can include doctors, social workers, psychologists, teachers, case workers, or parents.

2. Music is the primary therapeutic tool. Using music to establish a trusting relationship, the music therapist then works to improve the client's physical and mental functioning through carefully structured activities. Examples can include singing, listening, playing instruments, composition, moving to music, and music and imagery exercises.

3. Music therapy is administered by a trained music therapist. A music therapist's education and training are extensive. Musical interventions are developed and used by the therapist based on his/her knowledge of the music's effect on behavior, the client's strengths and weaknesses, and the therapeutic goals.

4 Music therapy is received by a client, and it targets a wide range of clinical populations and client ages.

5. Music therapy works towards specific therapeutic goals and objectives. Goal areas include communicative, academic, motor, emotional, and social skills. It is important to be aware that while clients may develop their musical skills during treatment, these skills are not the primary concern of the therapist. Rather, it is the effect such musical development might have on the client's physical, psychological, and socioeconomical functioning.

Essential oils have variety of uses

Aromatherapy is a treatment based on the application of essential oils obtained from plants. In aromatherapy, trained nurses and volunteers use essential oils and aromatic diffusers to make a difference in the quality of life for patients. For instance, aromatherapy can help a patient sleep, assist in memory recall, or help with depression.

The therapeutic properties of plant oils have been studied for thousands of years. All the

great ancient civilizations — Persian, Egyptian, Greek, and Roman — used plant oils for their healing properties. It was French chemist Rene Gattefosse who first coined the term “aromatherapie” in the early part of the 20th century. Gattefosse accidentally burned himself one day while working in the family perfume business. In pain, he plunged his hand into a container of lavender oil, and found that his hand healed quickly and with minimal scarring.

The use of essential plant oils has been popular simply as a beauty treatment, but with the increasing recognition of its therapeutic aromatic qualities by the medical establishment, it is now a vital complementary therapy in many health care units.

The main benefits of aromatherapy in palliative care are:

- reduction of anxiety, stress, tension, and fear;
- promotion of a feeling of well-being;
- relief from constipation, headaches, muscular pain, and insomnia;
- elevation of the pain threshold level, which sometimes enables a reduction in analgesics;
- improvement in circulation;
- reduction in limb swelling where lymphoedema is present.

Story-telling overcomes negative emotions

Nathan Adelson Hospice gives patients the opportunity to share their memories, special messages, or thoughts or feelings with and about those they love. The patient's thoughts are recorded, written, or videotaped for patients' family or friends or for the hospice's web site. Hospice social workers or volunteers meet with patients to reminisce about their lives and share important messages.

Reminiscing allows patients and families to overcome negative emotions surrounding the patient's impending death, says **Howard Thorsheim**, PhD, professor of psychology at St. Olaf College in Northfield, MN, and co-author of *I Remember When*, a book on how to employ reminiscing as a therapy.

Thorsheim says story-telling is a valuable therapy for patients who are near death because it creates an opportunity for social support from family and friends. Thorsheim's research showed that as people get older, they have fewer opportunities to feel supported by family and friends. The same can be said for the dying, who often feel isolated and angry.

As a result, self-esteem is affected due to the lack of support. Self-esteem is even more dramatically affected in dying elderly patients. The authors noted that men of retirement age experience drops in self-esteem because they feel their life has lost meaning. If a terminal illness is thrown into the mix, the patient's ability to have a meaningful death can be hindered by her perception that her life has lost meaning and by her perception of diminished support from friends and family.

The goal of hospice workers is to help patients wade out of the sea of negative emotions and get them to a place where they begin addressing their social and spiritual needs. According to Thorsheim, story-telling provides four elements that promote life affirmation and help patients along the road:

1. A sense of belonging. Telling stories helps people feel closer to their families, communities, and surroundings.

2. An introduction. Story-telling promotes an emotional connection between people who otherwise would be strangers. It can help hospice workers break through walls and nurture a familiarity that precedes trust.

3. A sense of caring. Sharing stories promotes a closeness among individuals through sharing details of one's life and perceiving that others are listening and interested.

4. A context for care. Story-listening is a skill that sets the stage for giving care, while story-telling fosters trust and intimacy that allow one to be cared for.

Massage therapists treat symptoms

At Nathan Adelson Hospice, massage therapy is used to bring stress relief, ease aches and pains, and bring general comfort to patients. According to Kantor, massage relieves stress, headaches, backaches, anxiety, fatigue, and sleeplessness.

“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 hospice patients. Instead, their goal is to treat symptoms.”

The role massage plays in pain reduction is not well-understood, says Basayne. But experts have theorized that massage promotes relaxation and relaxation reduces anxiety. This reduction in anxiety in turn lowers pain intensity. ■

Treat referring physicians like other customers

Provide support and communication

Here is a single-question pop quiz: List three of the most important groups of customers your hospice serves.

Patients. That one is pretty obvious.

Caregivers. They often need as much spiritual and emotional care as patients.

The third group is . . . **physicians.** Did it take a little longer to come up with the last group? That by itself may be an indication that your hospice is not doing enough to nurture its relationship with physicians.

There is a tendency, perhaps, to view physicians as colleagues or partners in treating dying patients. But, in fact, they are customers who must be cultivated and nurtured through various forms of marketing. While efforts won't include mass media campaigns one would normally associate with marketing, physicians do require a host of customer service-related approaches to ensure overall satisfaction following the referral of a patient.

Hospice of the Valley in Youngstown, OH, takes the business of physician marketing seriously. In the past year, the hospice was able to increase its referrals by 30% as a result of its multifaceted physician outreach program, says **Bridget Romeo, RNCG**, director of community education for Hospice of The Valley.

Romeo insists that hospices can achieve similar results if they think of physician marketing as a discipline that requires the simultaneous use of several different approaches. Traditionally, hospices have used low-key approaches that don't require the budget-strapped organizations to spend too much. Hospices focused mainly on physicians and hospitals by sending out volunteers to tout the value of hospice and preach the hospice philosophy.

The marketing strategy now employed by Hospice of the Valley assumes that marketing hospice services in a competitive health care marketplace requires more than a jar of cookies sent to physician offices and handing out black-and-white brochures at a local health fair. The goal for hospices is to increase referrals significantly and to ensure the referrals are made in a timely fashion. That's done through a combination of physician

relations, support, and education.

Hospice of the Valley is a typical hospice, experiencing the same challenges that face other hospices around the country. One of the hospice's greatest challenges is to increase admissions in each of the three counties it serves.

In the year since the hospice adopted its global marketing strategy, admissions have increased in all three of the surrounding counties it serves, including a 50% increase in Columbiana County and a 30% increase in its base market, Mahoney County, where it was once thought to have saturated the market.

Setting aside the cookies-and-brochure approach to gain referrals, Hospice of the Valley treated physicians as if they were as much a customer of hospice services as patients and families themselves.

Like patients and families, physicians have a set of expectations regarding their dealings with hospice and hospice staff. According to Romeo, those expectations include the following:

- The hospice will keep physician paperwork to a minimum.
- The physician will be able to trust hospice staff to make sound, independent decisions regarding the care of their patients without having to consult the physician for minor questions.
- When physician consultation is needed, staff will provide detailed information and propose specific solutions.
- There will be good communication between the physician and the hospice, including regular updates from hospice staff regarding their patients' condition.

Ask physicians if they are satisfied

Most hospices may think they are regularly doing the things that encourage physicians to refer patients to their hospice. But the only way to find out whether or not those needs are being met is to actually ask physicians if they are satisfied with the care provided to their patients and with the support given to them.

Officials at Hospice of the Valley start by tracking referrals by physician. Using a computer spreadsheet, referrals of about 300 physicians are monitored. "We watch for trends," says Romeo.

The trends Romeo looks for are physicians whose referrals have dropped off from month to month or over the course of a year. "If they aren't using us as much as they used to, we need to

know why. It could be that they just have not had as many dying patients as before. If not, we need to know if we dropped the ball."

If the hospice's tracking system identifies a physician whose referrals have decreased over several months, a Hospice of the Valley representative is dispatched to speak with the physician to find out why this is so.

There is nothing terribly sophisticated about Hospice of the Valley's tracking system. Each time a physician makes a referral, the date of the referral is entered into a spreadsheet program. This allows hospice workers to search the database by physician to determine the number of referrals made during a given time period.

The hospice also tracks the length of service of each referral by physician. If a physician's referral resulted in an unusually short stay, it prompts a visit by Romeo, who emphasizes the need for earlier hospice admission.

Another low-tech approach is the use of questionnaires. Physicians who refer patients to Hospice of the Valley are sent quarterly surveys that contain brief, pointed questions to help determine whether communication and services are meeting physicians' needs. The questionnaire seeks physician opinions about perceived communication between the hospice and physician and the timeliness of its on-call service.

In addition to tracking referrals and physician questionnaires, Hospice of the Valley builds upon its physician communication efforts by providing a quarterly newsletter. The newsletter is intended to be a forum for new information, such as changes in payer requirements and protocols.

Other physician marketing approaches used by various hospices include the following:

- **Marketing to increase physician referrals and promote physician satisfaction with services.**

Under this approach, each member of an administrative team is assigned to a group of referring physicians. The team is responsible for establishing a working relationship with doctors or key members of their staffs.

How the team communicates with each physician is determined between staff members and the physician or physician's staff. Communication revolves around patient care issues and physician/patient needs, relates new program ideas, and reinforces established guidelines. Each month, team members report their findings to an operations committee.

- **Increasing staff awareness of referral sources.**

Provide clinical and administrative staff with feedback from all referral sources, such as changes in managed care policies and procedures, physician feedback, and updates on changes in the marketplace. The purpose is to help staff realize that referral sources are important to the program.

- **Sending family letters to physicians.**

When families send letters of appreciation to the hospice with information such as "we wish we were referred sooner" or "hospice really helped," send copies -- with the family's permission -- to the physician who referred the patient, or to referring physicians generally, to not only encourage more referrals but more timely ones as well.

- **Assigning primary RN case managers to high-referral physician practices and clinics.**

One of the obstacles to good physician-hospice relationships is the glut of phone calls from staff requesting various things, ranging from orders to signatures. By assigning a case manager to referral sources, the number of phone calls between physicians and nurses can be dramatically reduced. This practice can also help develop mutual understanding of practice patterns and increase physician loyalty. ■

Take the pain out of pain management coding

Follow pain guidelines for payment

Pain management payment policies can be vague, sometimes leading to denials, despite a physician's best efforts to follow a Medicare carrier's medical review policy.

If, however, physicians follow the Agency for Health Care Quality and Research (AHCQR) cancer pain guidelines, they can make their pain management claims virtually bulletproof. These standards not only mirror Medicare policy, but also provide a more detailed process for determining medical necessity.

"If you follow [AHCQR] guidelines and document each step, I think the guidelines will lend credence to appropriate coding," says **Terence Gutgsell, MD**, medical director for the Hospice of the Bluegrass in Lexington, KY. Gutgsell often provides palliative care advice to his hospice's

referring physicians.

There are a number of pain management options available to treat cancer pain, ranging from nonsteroidal anti-inflammatory drugs (NSAIDs) to opioids. In addition, there are a variety of delivery options, including oral drugs, injections, and infusions.

With so much to choose from, how can practices be assured the drugs and procedures they choose will be reimbursed? For Medicare, local medical review policies (LMRPs) determine whether any given pain management regimen will be reimbursed. In most cases, LMRPs include themes similar to AHCQR guidelines. But LMRPs can be vague at times, opening the possibility for payment denial.

Policies leave room for interpretation

For example, code 62318 (injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance(s) [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; cervical or thoracic) or 62319 (lumbar, sacral [caudal]) are used to report epidural injections. While these injections and nerve blocks are considered to be medically necessary for the management of chronic pain, including severe cancer pain, the procedure could be deemed medically unnecessary if the practice cannot show that it followed a series of steps before choosing an epidural injection.

Medicare guidelines instruct physicians to evaluate the patient thoroughly and to provide the modality most likely to establish or treat the presumptive diagnosis. If the first procedure fails to produce the desired effect and rules out that possibility, the provider may proceed to the next logical treatment.

In addition, the patient's medical record should document the presence of radicular pain and the neuropathic diagnosis being treated. The record should establish the failure of conservative management and the fact that the patient is a poor surgical risk or does not wish to have surgery.

The policy leaves room for arbitrary decisions, such as which drugs or modalities should be used before moving to epidural injections. But AHCQR guidelines can fill in the details not included in carrier policies. In addition, proof

that AHCQR guidelines were followed is the best defense against a denied claim during the appeal process, Gutgesell says.

The AHCQR (formerly called the Agency for Health Care Policy Research) recommends physicians follow these guidelines when determining the type and scope of pain therapy (the entire guideline can be viewed on the agency's web site, www.ahcqr.gov):

- An essential principle in using medications to manage cancer pain is to individualize the regimen to the patient.
- The simplest dosage schedules and least invasive pain management modalities should be used first.
- Pharmacological management of mild to moderate cancer pain should include an NSAID or acetaminophen, unless there is a contraindication.
- When pain persists or increases, an opioid should be added.
- Treatment of persistent or moderate to severe pain should be based on increasing the opioid potency or dose.
- Medications for persistent cancer-related pain should be administered on an around-the-clock basis with additional "as-needed" doses, because regularly scheduled dosing maintains a constant level of drug in the body and helps to prevent a recurrence of pain.
- Patients receiving opioid agonists should not be given a mixed agonist-antagonist, because doing so may precipitate a withdrawal syndrome and increase pain.
- Meperidine (J2175) should not be used if continued opioid use is anticipated.
- Opioid tolerance and physical dependence are expected with long-term opioid treatment and should not be confused with addiction.
- The oral route is the preferred route of analgesic administration because it is the most convenient and cost-effective method of administration. When patients cannot take medications orally, rectal and transdermal routes should be considered because they are also relatively noninvasive.
- Intramuscular administration of drugs should be avoided because this route can be painful and inconvenient, and absorption is not reliable.
- Failure of maximal systemic doses of opioids and co-analgesics should precede the consideration of intraspinal analgesic systems.
- Because there is great inter-individual variation in susceptibility to opioid-induced side

effects, clinicians should monitor for these potential side effects.

— Constipation is a common problem associated with long-term opioid administration and should be anticipated, treated prophylactically, and monitored constantly.

— Naloxone (J2310), when indicated for reversal of opioid-induced respiratory depression, should be titrated in doses that improve respiratory function but do not reverse analgesia. Placebos should not be used in the management of cancer pain.

— Patients should be given a written pain management plan.

— Communication about pain management should occur when a patient is transferred from one setting to another.

The above guidelines have particular significance for choosing the appropriate drug. With the growing number of pain drugs and the off-label use of drugs, choosing the appropriate drug can pose reimbursement problems because many policies do not mention use of drugs such as methadone (used to treat heroine addiction), J1230; ketamine (anesthesia); and pamidrinate (bone resorption in metastatic breast cancer), J2430.

While these drugs are effective, physicians have the burden of proving medical necessity, Gutgsell says. This is especially important for expensive drugs such as pamidrinate, which can cost \$600 to \$1,200 for a single injection.

In the event of a payment denial, Gutgsell says data published in journals provide validation for drug choice. Guidelines, however, suggest that the physician consider other drugs, including less powerful drugs or less invasive modes of delivery.

In addition, the American Society of Clinical Oncology's public policy and practice department recommends following Medicare regulations for off-label use of drugs and biologicals. Off-label use of drugs is covered when all of the following conditions are met:

— The drug meets the definition of drugs and biologicals.

— The drug is the type that cannot be self-administered.

— The drug meets all the general requirements for coverage of items as incident to a physician's services.

— The drug is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered according to accepted standards of medical practice.

— The drug is not excluded as an immunization.

— The drug has not been determined by the FDA to be less than effective.

Following AHCQR guidelines will bolster medical necessity for invasive procedures, such as epidural injections and infusion pumps (codes E0779-E0791).

Following guidelines will keep practices in line with carrier policies that include these requirements:

— The patient's history must indicate that he/she would not respond adequately to noninvasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated reaction to pain).

— A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and patient acceptance. ■

News From the End of Life

Grief group aids families of terrorist victims

Grief support for families that lost loved ones in the terrorist attacks on New York City and the Pentagon on Sept. 11 is available from the nearly 600 chapters of The Compassionate Friends, a national bereavement self-help organization.

COMING IN FUTURE MONTHS

■ Tips for making effective use of the Internet

■ Making managed care work for you

■ Building strong community awareness programs

■ Proven marketing strategies

Compassionate Friends was established to help families resolve their grief following the death of a child of any age and to provide information to help others be supportive.

"Thousands of people have had to face the fact that their child, sibling, or grandchild has died because of these terrible acts," says **Patricia Loder**, executive director of The Compassionate Friends. "We have to remember that everyone who died was someone's child. The time will come when many of these parents and family members will want to talk with others who have also faced the grief of losing a child and can help them travel this long journey. That is why we exist."

In the states including and surrounding New York and Virginia, where the attacks took place, Compassionate Friends has 137 chapters. In California, the destination of the four jetliners, there are an additional 36 chapters.

Within days of the terrorist attacks, brochures and national Compassionate Friends magazines were shipped into New York City and Washington, DC. "Along with this came the promise to our chapters that whatever they needed to serve the victims of these catastrophic events, the national organization would find the means to supply them," says Loder.

For more information about the national Compassionate Friends organization and locations of local chapters, people can call (877) 969-0010 or visit the organization's web site at www.compassionatefriends.org. ▼

Elizabeth Dole named to NHPCO post

The Alexandria, VA-based National Hospice and Palliative Care Organization (NHPCO) has named former presidential candidate Elizabeth Dole to serve as the organization's National Director for Hospice Education and Information.

Among Dole's top priorities in her new position will be to work with the nation's hospices to assist families affected by the Sept. 11 terrorist attacks in New York, Washington, DC, and Pennsylvania. As a first step, Dole is highlighting the hospice role as a community resource for grief and bereavement services and reminding

Americans that hospice professionals across the country are available to help grieving individuals and families.

The NHPCO is banking on Dole's high visibility to raise public awareness of hospice care and spark household conversations about end-of-life care. By further heightening national attention on the benefits and availability of hospice care, Dole's efforts will complement the community outreach activities of hospices across the country.

According to the NHPCO, hospices are expected to play a significant role in the healing of Americans following the terrorist attacks.

"Hospices have long served as community resources for grief and bereavement services," the organization said in a press release announcing Dole's appointment. "Now is certainly no exception. In addition to sending help to the affected areas, hospices from across the country are helping their own communities come to terms with the immense loss."

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Editorial Questions

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

People seeking help or hospice information can call NHPCO's toll-free Helpline at (800) 658-8898 and search the NHPCO's "Find A Hospice" feature on its web site, www.nhpco.org. ▼

Firefighters' union seeks volunteer grief counselors

The Uniform Fire Officer Association, Local 854, the union that represents firefighters who are officers in New York City, has asked for help in providing counselors for the survivors of the members it lost in the Sept. 11 terrorism attacks.

There are over 160 children left without a parent among these officers alone. The Professional Staff Congress (PSC) of the City University of New York has been working with the staff of the union to coordinate help.

The union needs counselors living or working in Nassau, Suffolk, and Westchester Counties. The fire officers' union has counseling centers in Manhattan, Queens, and Staten Island, but many of the families of the bereaved are finding it too difficult to uproot children and travel to these centers.

Specifically, there is a need for counselors who specialize in bereavement, but also for all counselors, including those experienced in working with children and adolescents. Those who would like to volunteer can call the PSC office at (212) 354-1252. ▼

Michigan groups publish end-of-life guide

A coalition of health care groups in Michigan has begun the distribution of a new physician guide aimed at providing the best possible end-of-life care for Michigan residents.

The 48-page booklet, *The Michigan Physician Guide to End-of-Life Care*, written by Michigan experts in end-of-life care, was created to help physicians, patients, and families — the word "family" being understood in the broadest sense — deal more effectively with dying and

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death. The book was mailed to every licensed physician in Michigan and will also be delivered to all medical students in Michigan's four medical schools. About 40,000 booklets in all will be handed out.

The book was developed by the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Department of Community Health, and American Physicians Assurance. It contains seven chapters on topics including communication, advance care planning, pain and other symptoms, palliative care, withdrawing or withholding care, hospice, and emotions and spirituality. Also included are "For My Patients" pages that physicians may photocopy and give to patients to help them with a variety of sensitive end-of-life situations.

"Focusing on communication with patients, advance care planning, and spirituality, the guide effectively deals with the complex issues of end-of-life care," says **James K. Haverman Jr.**, director of the Michigan Department of Community Health.

The entire text of *The Michigan Physician Guide to End-of-Life Care* can be downloaded from the Michigan State Medical Society web site at www.msms.org under "End-of-Life Care." ■

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December 1, 2001

Dear Readers:

We at *Hospice Management Advisor* would like to take the time to thank you for your support in the last year. We, along with our excellent editorial advisory board, strive to bring you the best, most useful newsletter each month that we possibly can.

Over the last year, here are some of the special features included in *Hospice Management Advisor*:

- Bereavement outreach roles that hospices have played in incidents such as school shootings in San Diego and the Sept. 11 terrorist attacks.
- Insights into how to deal with the shortage of nurses.
- How telemedicine may change the face of hospice care.
- Proven advice on how to develop effective marketing and fundraising strategies.
- The latest research on palliative care, pain management, and other key issues.

As we approach 2002, you can look forward to 12 more issues of incisive, up-to-date strategies for handling the challenges of hospice care. We will continue to add "extras" that make your newsletter subscription an even greater value.

Our most important tool in keeping *Hospice Management Advisor* relevant to your needs, as always, is the feedback that you give to us. Thank you to all who filled out and returned to us a reader survey. This helps us a great deal. We'd like to hear about the issues that are important to you so that we can provide the most relevant information to help you do a better job. Please direct your comments to Glen Harris, Editorial Group Head, at glen.harris@ahcpub.com, or call him directly at (404) 262-5461.

Thank you again for your support.

Sincerely,

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Hospice Management Advisor

2001 Index

Administration

Accreditation takes on a whole new meaning, MAY:55
Baseline audit critical to compliance program, JUN:64
Not-so-new technology can help hospice, MAY:52
Target your marketing efforts at consumers, JUL:78
Use cost accounting to boost hospice efficiency, FEB:16

Alternative therapies

Complementary therapies enhance hospice care, DEC:136
Massage therapy reduces pain for many, APR:43

Bereavement programs

America mourns, hospices respond, NOV:121
Bereavement outcomes measurement still a distant goal, SEP:97
Consider extending bereavement care, MAR:28
Firefighters' union seeks volunteer grief counselors, DEC:144
Grief group aids families of terrorist victims, DEC:142
Hospices expand outreach after San Diego school shooting, MAY:49
Steps to take to monitor bereavement, SEP:99

Fundraising

E-philanthropy: Reaching new donors, SEP:105
Raising funds in a softened economy, JUN:66
Tips for raising the fundraising bar, MAR:30

Managed care contracting

Contracts should include non-negotiable points, NOV:127
Define your terms in an MCO contract, NOV:125
Determine the right commercial rate, NOV:123

Health system requires info from advance directives, JUN:70
Speed up MCO payment by educating staff, JUN:68

Medicare reimbursement

Do Medicare rules block hospice access?, JUL:82
HCFA issues new codes for plan oversight billing, JAN:10
MDs can be confused about pain care payment, JAN:7
Medicare errors total \$12 billion in 2000, MAY:56
Take the pain out of pain management coding, DEC:140

Mission and strategic planning

Don't try to treat children with the adult hospice model, AUG:85
Following the right PATH to better pediatric care, AUG:87
Get aggressive with public awareness, NOV:128
Rural hospice challenge: Bring services into underserved communities, FEB:13

National Hospice and Palliative Care Organization

Elizabeth Dole named to NHPCO post, DEC:143
NHPCO offers three new products, JAN:11
NHPCO: Unfair coverage hurts hospice, OCT:112

Outcomes measurement

Bereavement outcomes measurement still a distant goal, SEP:97
Steps to take to monitor bereavement, SEP:99

Pain management

1 in 4 in the U.S. suffer from chronic pain, AUG:95
AHCPR guidelines, OCT:111
Canadian Pain Society launches 'manifesto,' SEP:108

Failure to ease pain brings large jury award, AUG:94
JCAHO now monitoring new pain initiative, MAR:33

Lancet: Dying patients willing to tolerate pain, JUL:81

Massage therapy reduces pain for many, APR:43

NHPCO: Unfair coverage hurts hospice, OCT:112

Nursing home patients in pain: Study, JUL:83

OxyContin abuse causes chilling effect in pain management, OCT:109

Pain study: Family expectations high, FEB:22

Search here for good pain management standards, OCT:113

Take the pain out of pain management coding, DEC:140

Use ladder approach for pain management, OCT:110

Palliative care

ACP joins opposition to physician-assisted suicide, OCT:119

Advance directives ease family stress, MAY:59

Book helps people prepare for death, OCT:118

CA high court limits families' rights, OCT:119

Caregiver training manual available, MAR:27

Certified palliative medicine docs on the rise, AUG:94

Class facilitates dying at home, FEB:20

Culturally diverse care requires openness and understanding, JAN:1

End-of-life care in nursing homes still needs improvement, APR:37

Funding end-of-life care education for social work, JUN:71

Hospitals increase end-of-life discussion, SEP:102

Hospitals urged to adopt new end-of-life approach, MAR:34

How perspectives on death vary by culture, JAN:3
Inpatient palliative care is the next frontier for hospices, JUN:61
Michigan groups publish end-of-life guide, DEC:144
Most Kevorkian patients were depressed, FEB:23
New book documents dying first-hand, SEP:107
Physicians know more about palliative care, FEB:21
Reach caregivers before loved one is eligible for hospice, MAR:25
Spiritual matters take precedence, FEB:22
VA picks care sites for end-of-life project, SEP:106

Patient care

Alzheimer's drug may be more beneficial, NOV:131
Get a grip on the proper way to wash your hands, JUL:80
Patients not told about hospice, APR:46
Pressure ulcers found in 9% of new home patients, MAR:35
Study: Chemo given when patients don't respond, JUL:82

Pediatric care

Don't try to treat children with the adult hospice model, AUG:85
Federal study focuses on pediatric palliative care, NOV:129
Following the right PATH to better pediatric care, AUG:87
MDs should focus on dying children's quality of life, NOV:132

Pediatric end-of-life improvements sought, SEP:104

Physician relations

Foundation focuses on pass-along knowledge, OCT:113
Help educate doctors on getting what they deserve, OCT:115
MDs need support with suicide requests, MAY:57
Medical directors can be ambassadors to spread the benefits of hospice, DEC:133
Treat referring physicians like other customers, DEC:139

Referrals

Sincere efforts to reach African-Americans may not be enough, JUL:73
Symposium examines end-of-life care for blacks, JUL:75
Treat referring physicians like other customers, DEC:139

Regulatory issues

Baseline audit critical to compliance program, JUN:64
Be wary of OIG concerns, APR:40
Bush may reverse drug act, APR:45
Choose compliance officer from hospice leaders, FEB:18
Feds release \$125M for caregiver services, MAR:34
HCFA clarifies 'homebound' status, APR:45
JCAHO now monitoring new pain initiative, MAR:33
OIG 2001 work plan includes focus on hospice, JAN:6

Salaries

Pay hikes alone won't halt turnover, AUG:88
Salary or per diem? Which is best?, APR:41

Staffing

Pay hikes alone won't halt turnover, AUG:88
Salary or per diem? Which is best?, APR:41
Shortage of hospice nurses continues to worsen, JUL:76
Telehospice can boost access for limited staff, MAY:53
Wanted: A hospice nurse, any hospice nurse, JAN:4

Training

Caregivers need training and education, MAY:58
Training program tells if volunteers are able, SEP:101

Trends

Are post-acute networks on the horizon?, AUG:91
Geographic variation in hospice use, APR:47
HIV-positive people may be likely to seek euthanasia, OCT:117
Post-acute networks cover a wide spectrum, AUG:93
Study: Don't cut back on social work services, JUN:70

Volunteer programs

Don't ignore volunteer screening process, SEP:100
Training program tells if volunteers are able, SEP:101