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# HOSPICE Management Advisor™

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## IN THIS ISSUE



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# Hospices start their trip down the road of quality improvement

*QAPI requirements go into effect as hospices figure out how to meet them*

A group of 15 Indiana hospices has a two-year head start on all other hospices to meet the Quality Assessment and Performance Improvement (QAPI) requirements of the new Conditions of Participation (COP). The COPs, which were introduced in June 2008, require the collection and use of data to conduct studies designed to evaluate quality **(see "Hospice Conditions of Participation focus on quality, patients' rights," *Hospice Management Advisor*, July 2008, p. 73)**.

"We anticipated implementation of the COPs in 2007; so, in 2006, we developed a benchmarking project that would help our member agencies meet the requirements," says **Todd Stallings**, executive director of the Indiana Association for Home and Hospice Care (IAHHC) in Indianapolis. Because the implementation of the quality assessment requirement was delayed until February 2009, the participating hospices began 2009 with a lot more experience at collecting, analyzing, and using data, he says. "The problem with being proactive in this instance is that we went through a lot of effort, then nothing happened with the

### EXECUTIVE SUMMARY

The new Conditions of Participation from the Centers for Medicare & Medicaid Services require hospices to implement a Quality Assessment and Performance Improvement (QAPI) program that provides an ongoing evaluation of the agency's outcomes.

- Hospices must standardize data to enable benchmarking with others.
- Relevant measures are to be studied, and improvement plans are to be developed.
- Staff members' involvement is necessary for success.
- Use existing tools and resources whenever possible.
- Start small and work your way up to more complex studies.

COPs," he laughs. "The good news is that the project is working well, and the participating hospices have learned a lot prior to implementation."

Each participating hospice enters data through an online system, then submits them to the vendor with whom IAHHC contracts, Outcome Concept Systems in Seattle. "The hospices receive a report that compares their results within their own peer group, as well as with national data," Stallings says. The four categories of information collected are quality outcomes, quality practices, patient volume and mix, and quality operations. **(See p. 27 for measures.)**

Participating hospices do pay an annual fee to the contractor, but IAHHC negotiated a reduced rate specifically for its members, says Stallings. "It was important to make the cost as reasonable as possible to encourage participation," he explains. "Hospices now realize that the fee is a good investment and is helpful."

Not only are participating hospices using the data to identify areas in which they are below the national or local peer group median, but IAHHC has used the results to develop educational programs for hospices, says Stallings. "When we began collecting data, we realized that our hospices had almost no nurses who were certified for hospice and palliative care," he says. "We began sponsoring certification exam programs twice a year, and we've seen the number steadily grow. In fact, one hospice sent the entire nursing staff to the program."

## Some hospices starting from scratch

Most hospices don't have the history of quality improvement programs such as the one in Indiana, and the new QAPI requirements are a shock, says **Lynda Laff**, BSN, principal with Laff Associates, a home health and hospice consulting firm in Hilton Head, SC. "Everyone is capable of more sophisticated data collection and reporting, but it has not been a priority until now," she explains.

The reality is that the QAPI requirements are not onerous, says Laff. "They are standard performance improvement activities, but CMS [Centers for Medicare & Medicaid] does require that the studies and the program be ongoing, not just periodic," she says. "Most hospices have pieces in place; they just don't know where to start." Hospices that are affiliated with a home health agency, which already has been meeting this requirement, are 70% ready for QAPI, Laff says. "Hospices that are community-based and self-contained have more work to do," she adds.

The first step in developing a performance improvement program is to evaluate the data you are collecting, suggests Laff. "Look at your current weekly, monthly, or quarterly reports," she says. You should have information on days on service, length of stay, diagnosis, and age groups by length of stay, "then look at symptom management and adverse events that you want to monitor," Laff adds.

This point is where it becomes overwhelming for some hospices, says Laff. "Don't try to eat the elephant in one bite," she says. "Pick one symptom or event to monitor, then decide what information you need to collect." Falls will be a common first study for many hospices, because it is possible to collect the information, and reducing the number of falls is important to improvement of quality of life for patients, Laff points out.

Pain also is a key symptom to monitor for

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hospices, says Laff. Whichever symptom you select for your study, be sure your nurses are collecting information in the same manner, she warns. Develop a data collection tool that is very specific about how questions are asked, what is documented, and where the information should be kept in the chart, Laff suggests. Don't just ask if pain was controlled, she says; instead, ask about pain in 24- or 48-hour segments. "We don't just want to know about symptoms at the moment the nurse sees the patient; instead we want to know what happened before the visit," she says.

Although tracking your own trends and results is important, look for ways to compare yourself to other hospices, suggests Stallings. His benchmarking project is limited to his membership, but he recommends that hospice managers approach their associations about a similar project. Even if you can't find an overall QAPI benchmark project, look for symptom-related projects as well, Stallings suggests.

"In addition to the QAPI project for hospice, our association is participating in a pressure ulcer reduction project as part of a comprehensive program coordinated by the State Health Department," he says. Also, look for existing tools, studies, and research that can give you a reference point for your own data, Stallings recommends. **(See resources, p. 28.)**

One of the hospices that Laff advises is Tidewater Hospice in Bluffton, SC. "We are a small hospice, but I have a home health background, so I am familiar with performance improvement," says **Susan E. Saxon**, RN, administrator and principal of the hospice. "We have been conducting patient care and clerical audits to identify adverse events such as falls or issues such as timeliness of documentation or physician orders," she says.

Even with a small staff, Saxon's agency is able to use multiple performance improvement teams to address issues such as falls or documentation. "You should use as many staff members as possible in the quality improvement process to improve understanding of the process and to make the program successful," she says. **(See p. 28 for other tips for success.)**

With QAPI in place, Saxon has expanded her studies to address constipation, shortness of breath, and pain. "We have some information on these symptoms, but we've developed a tool to standardize the information that we capture and to give us data that we can use to identify areas of improvement," she explains. All three of these affect quality of life, and all three can be affected by staff members' actions, she adds.

Hospice managers shouldn't panic, Laff says. "Just read the COPs carefully, and pay close attention to QAPI," she adds. As you select outcomes to measure and studies to conduct, choose items that prove quality care, Laff suggests.

Why should hospice managers take QAPI seriously? Not only are they a COP that affects your reimbursement, but Laff believes this is a first step to further changes. "I foresee a standardization of information collected by all hospices, much like the OASIS [Outcome and Assessment Information Set] data collection tool that is required of all home health agencies," she says. ■

## Data collected for Indiana QAPI project

*Outcomes, operations, and practices monitored*

The Indiana Association for Hospice and Home Care (IAHHC) in Indianapolis initiated a benchmarking project in 2007 to help hospice members meet the Quality Assessment and Performance Improvement (QAPI) requirements of the new hospice Conditions of Participation. Working with an outside vendor, the association and member hospices identified the following data to collect and measure against other hospices:

- **Quality outcomes:**
  - — comfort within 48 hours of admit;
  - — percent avoided unwanted hospitalizations;
  - — falls with injury per 1,000 patient days;
  - — percent caregivers willing to recommend;
  - — percent caregivers rating weekend and evening response excellent.
- **Patient volume and mix:**
  - — average daily census;
  - — total admissions;
  - — average length of service;
  - — median length of service;
  - — cancer percent of total admissions;
  - — percent of patients admitted by location: home, inpatient facility, hospice unit, hospital nursing facility, and assisted living facility;
  - — live discharges as a percent of total discharges.
- **Quality operations:**
  - — percent of total revenue from fundraising;
  - — average daily census per FTE by discipline: nursing, social services, home health aide, chaplain, physician, nonclinical, and total;

— weekly visits per FTE by discipline: nursing, social services, home health aide, chaplain, physician, and nonclinical.

• **Quality practices:**

— percent of physicians certified by American Board of Hospice and Palliative Medicine (ABHPM);

— percent of nursing certified by Hospice and Palliative Nurses Association (HPNA);

— routine patient record review percent;

— compliance meeting guidance from Office of Inspector General;

— date of last review against standards;

— bereavement to community;

— ethics committee access.

An advantage to using these data is that they reflect those already collected on a national level by the National Hospice and Palliative Care Organization (NHPCO), so there are national data against which the Indiana group can be compared, says **Todd Stallings**, executive director of the IAHHC. "There is no need to reinvent the wheel," he says. ■

### Need More Information?

For more information about quality improvement and assessment, contact:

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- **Susan E. Saxon**, RN, Administrator and Principal, Tidewater Hospice, Bluffton, SC 29910. Telephone: (843) 757-9388. E-mail: SusanSaxon@TidewaterHospice.com.
- **Todd Stallings**, Executive Director, Indiana Association for Home & Hospice Care, 6320-G Rucker Road, Indianapolis, IN 46220. Telephone: (317) 844-6630. Fax: (317) 575-8751. E-mail: todd@iahhc.org.

For tools, sample studies, and other performance improvement ideas, go to:

- **Indiana Association for Home and Hospice Care.** Web: www.iahhc.org. On the right side of the home page, click on the "We Will Prevent Pressure Ulcers" logo, then select "Forms and Handouts" to see a list of assessment tools and questionnaires.
- **Institute for Healthcare Improvement.** Web: www.ihi.org. On the left navigational bar, select "topics," then choose "Last Phase of Life" for literature, tools, and guidelines related to palliative care.
- **National Hospice and Palliative Care Organization.** Web: www.nhpco.org. On left navigational bar, select "Quality Partners Home" to access tools and resources for quality improvement.

## Involve employees in quality efforts

*Ask for input, oversight to improve acceptance*

No one wants to feel as if they are being given busy work, but if a performance improvement study isn't presented correctly to staff members, the data collection tool will feel like busy work. If this happens, you might not collect the information you need for the study.

There are several ways to ensure that you get the data you need in a timely, accurate manner, says **Lynda Laff**, BSN, principal with Laff Associates, a home health and hospice consulting firm in Hilton Head, SC. "Work the questions you need answered into a normal assessment so that it is a part of the overall visit, not something extra," Laff suggests. Test your tool carefully, she says. Make sure that it collects the information you need, but also make sure it is easy for the nurses to include in their assessment, she adds.

Staff input into the development of tools and performance improvement activities is critical to success, says **Susan E. Saxon**, RN, administrator and principal of Tidewater Hospice in Bluffton, SC. "I suggest using as many different employees as possible on different performance improvement teams," she says. When employees have a chance to see why different projects are selected, how the data are analyzed, and how plans for improvement are developed, they are more likely to be supportive of the effort, Saxon explains.

When Saxon had an employee come to her with some information and say, "This has to do with your study," she knew that she had to improve communication with staff members, Saxon says. "Be sure you explain that these are the agency's studies, and they benefit everyone," she adds.

Also, when selecting measures to study, be sure to pick measures that are relevant to your employees, Saxon suggests. "Explain how improvement of the outcome will improve patients' quality of life, improve family satisfaction, and improve employee satisfaction," she says. ■

# High use rate is result of multifaceted marketing

*Follow through on promises made in promotions*

How does a hospice located in a county facing high unemployment and a population of only 63,000 become and stay one of the highest-utilized hospices in the state, with a 55% utilization rate?

Ask people what they want, then tell everyone what you have, suggests **Heidi Owen**, MBA, CFRE, director of community services for the Hospice of Rutherford County in Forest City, NC.

"We've had a successful patient satisfaction survey program for many years, and we've received a number of good ideas about new services or programs needed in the community," she reports. Agency management decided something else needed to occur because after a 24-hour admission program was implemented, a number of surveys came back identifying 24-hour admission as a needed service. "We had the service, but we hadn't publicized it so no one knew we offered it," Owen says.

The hospice has stepped up marketing efforts to include new services and to emphasize quality care in all marketing materials, she says. "Twice a year, we publish a 16-page insert in the local newspaper that includes articles about the hospice and its services," Owen says. When introducing a new service, Owen uses the phrase: "You said you wanted . . . " to emphasize the fact that surveys are read and good ideas are acted upon.

## EXECUTIVE SUMMARY

Achieving a 55% utilization rate was a matter of diligence and listening to the community, according to leaders of the Hospice of Rutherford County in Forest City, NC. The hospice has a multifaceted marketing program that uses a variety of techniques to make sure that the agency stays top-of-mind for the service area.

- Twice a year, newspaper insert highlights services of hospice.
- The revamped web site is user-friendly and interactive to enable contact for information and donations online.
- Satisfaction surveys are reviewed for trends that identify potential new services.

## Need More Information?

For more information about successful marketing, contact:

☎ **Heidi Owen**, MBA, CFRE, Director of Community Services, Hospice of Rutherford County, 374 Hudlow Road, Forest City, NC 28043. Telephone: (828) 245-0095, ext. 105. E-mail: heowen@hospiceofrutherford.org.

"We are very specific when we describe our services; we don't just use quality to describe everything," she says. "We do emphasize changes we've made to improve care and services we've added to better meet the community's needs."

Other services added in response to community suggestions include crisis care and grief counseling for the school system, says Owen. "We rely upon donors to support programs such as the grief counseling, so we publicize our work in the community," she adds.

In addition to the newspaper insert, the hospice has produced a brochure that is distributed through the hospice's faith-in-action representatives, volunteers who visit local churches to educate pastors and church members about hospice services. "We also place the brochure in physician offices," adds Owen.

A major change in marketing for the hospice involved revamping the web site to make it more interactive and allow visitors to donate to the hospice online or to inquire about services online, says Owen. "We are seeing an increase in activity on the web site, with more visitors and people using it to contact us," she says.

To make sure that staff members know what the community is seeing and hearing, communication is maintained with all staff members through newsletters, staff education programs, voice mail, and e-mail, Owen notes. "You must keep your staff informed so that they are saying the same thing to the community as your publicity," she says.

"Don't forget to evaluate your communications and surveys," says Owen. When the satisfaction survey return rate leveled off at 37%, Owen put volunteers to work to call family members to remind them about the survey and to ask them to remember to return it. The tactic worked with the return rate rising to 60%, she says.

Owen believes that her hospice's marketing efforts have worked because the hospice doesn't

just talk about providing services, it provides what it promotes. When the hospice established the crisis care program to send nurses to homes when patients experienced unanticipated crises, managers made sure they could staff the service by identifying 22 on-call, part-time nurses who were available to take calls when they came in to the agency, she explains. "Just be sure that you do what you say you're going to do, and your marketing is effective." ■

# Case managers can help with end-of-life situations

*What can be done when physician resists hospice*

It's a situation case managers encounter with agonizing frequency: Physicians who keep pumping medication into patients who are terminally ill, or families who insist on continuing treatment when the clinical picture indicates that the patient's condition is terminal.

"I have seen a tremendous number of patients who die a very cold, sterile, and unfulfilled death in the ICU and have seen their families struggle with it. It's a heartbreaking experience," says **Pam Seaver**, RN, BSN, MTS, CCRN, PCC, pastoral care nurse with Medical City Dallas Hospital's surgical intensive care unit and Hospice of Grayson County in Sherman, TX. "We focus so much on just medical care, and many patients get very little care for their palliative needs and spiritual needs,"

Doctors aren't trained in death. They're trained in life, and they don't feel comfortable with end-of-life (EOL) issues. Many of them keep on trying to treat patients even when there is no hope left, says **B.K. Kizziar**, RN-BC, CCM, health care consultant and life care planner at BK & Associates, a Southlake, TX, case management consulting firm. "Health care in general has an aversion to end-of-life issues. Our job is to make people well, and we see it as a failure when we can't do that," she says. "Even oncologists, whose primary practice involves dying patients, are reluctant to stop active treatment and refer patients to hospice."

Kizziar knows the situation firsthand. She has found that the caregivers for her terminally ill mother are reluctant to talk openly about EOL issues. "I'm the one who brings it up, and they look kind of shocked," she says.

Because a physician has to certify that a patient is expected to live six months or less for hospice services to be covered by Medicare, "that in itself makes physicians reluctant to order hospice because it signals that they think the patient is at the end of life," says **Catherine M. Mullahy**, RN, CRRN, CCM, president of Mullahy & Associates, a health care case management training and consulting firm in Huntington, NY. "There are too many people who could benefit from hospice care who do not get it or who get it only in the last few weeks of life," she adds.

**Jan Tichenor**, RN, MSN, CNS, OCN, oncology care coordinator at Medical City Dallas Hospital, says, "The worst-case scenario is when the patient and family are saying, 'Enough is enough,' and the doctor just keeps on trying. As the patient advocates we all are, we hate to see that happen."

As a nurse, it's challenging to be in the middle between the physician who wants to keep treating and the patient and family who want quality time together, Tichenor says. "Sometimes, the family is ready for hospice before the physician," she adds.

In such cases, Mullahy urges case managers to talk to the physician. "Someone has to be an advocate for the patient and take the first step to talk to the physicians," she says. "So often, medical professionals are so busy trying to pull another rabbit out of a hat that they are hurting people. Case managers are ideally positioned for the conversation with physicians since they are advocates for the patient."

Sometimes it's the family who just isn't willing to let go and who wants to continue treatment so they can have more time with the person they love, Seaver adds. "As long as the physician is getting cues from the family that they don't want to stop treatment, they have to continue to treat the patient. I see the spiritual and emotional turmoil in the physicians in these situations," she says.

It helps to get together and talk about the patient's expectations, Tichenor suggests.

"Patients and family members may have heard different things from different physicians, and often what they heard isn't what the physician actually said. They're under stress, and a lot of things don't sink in," she says. "It's helpful to get everybody in the same room to ask and answer questions and clarify the situation."

Many times, the situation can be resolved by a discussion about the patient's condition and outlook for the future, Tichenor says. "When everybody hears the same information and the family members have a chance to vent their feelings and ask questions, things usually get resolved and

everyone can agree on what to do next."

Often family members think that if the patient isn't receiving aggressive care, he or she might not receive pain control. The family might need reassurance that removing aggressive therapy or turning off the vent in no way takes away pain management. Having the family, the case manager, the social worker, and key physicians sit down and talk about it can allay those fears, Tichenor adds.

Because case managers develop rapport with their patients and gain their trust, they might be the best people to introduce the patients and family members to someone who can talk about end-of-life opportunities such as hospice care, says **Cathy Follmer**, RN, BSN, MBA/HCM, CHCE, CRNI, corporate director of continuum of care services for Catholic Healthcare Partners, a multistate health care system with headquarters in Cincinnati.

Case managers don't necessarily have to be the ones to have that difficult conversation, she says. There might be someone else who is more knowledgeable about the subject and can support case managers when they identify a patient or family who would be an appropriate candidate for a discussion. Not every case manager is comfortable talking about EOL issues, Follmer says. "If they try to have a conversation and they aren't comfortable with the subject, it won't work," she says.

In many of the Catholic Healthcare Partners hospitals, the case managers have incorporated the palliative care coordinator into the multidisciplinary rounds in the intensive care unit, as well as on the medical surgical units. "When the case manager knows that a family is struggling with decision making, the palliative care coordinator can go in and start that delicate discussion," Follmer says.

Kizziar says, "If you bring up things in a conversational way, rather than a clinical way, people will open up about their feelings."

Seaver suggests case managers invite a family member for coffee to talk about his or her feelings without approaching the topic of palliative care or hospice. After you've developed trust and the family members starts to feel as if you are compassionate and sympathetic about their loved one, then you can approach them and talk about their options, she says.

"Help them see that they are struggling with the same choices and decisions that families struggle with in a hospice situation," Seaver says.

Start by talking with the family about their feelings. Offer to help in any way you can. Every situation is different, Seaver points out. Recognize that some people have a tremendous difficulty in letting go, she says.

Case managers can find out up front what the patient's wishes are, whether they have advance directives, and if they understand the ramification of code status, Tichenor advises. "There's such a need for closure, to repair relationships, and complete unfinished business. When people are in hospice, hopefully they can be lucid and cognitively aware so they can make amends and take care of business as opposed to being in the ICU on a respirator and sedated," she says.

Case managers can ask the family member what they think the patient would like his or her final days to be like. Does the patient want to be in the hospital on a machine or at home with hospice? "Asking them what they would want if they were the patient helps them look at it from both sides," Tichenor says.

Don't wait until the patient is unresponsive or so sick he or she can't make a choice, Follmer advises. Case managers should try to identify patients who are likely to have EOL issues before they get to the intensive care unit, she suggests. "Once patients are put on a ventilator, families struggle with taking them off. It's more effective to give them the education they need before then," Follmer says. ■

## Case managers must face feelings about EOL

If case managers want to effectively help patients and family members with end-of-life (EOL) issues, they need to examine their own feelings about death and dying, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president, Mullahy & Associates, a health care case management training and consulting firm in Huntington, NY.

"If we don't have a comfort level with death and dying, how can we expect our terminally ill patients to bring up the subject?" she asks.

Health care providers often are reluctant to speak with patients and family members about hospice care because they themselves are uncomfortable with EOL issues, adds **B.K. Kizziar**, RN-BC, CCM, health care consultant and life care planner with BK & Associates, a Southlake, TX, case management consulting firm.

"Case managers need to come to grips with

their own feelings about end-of-life issues and deal with them, then seek opportunities to learn more about what hospice can do and its benefits to patients and family members," she says.

When Mullahy presents her seminar "Death and Dying in America" to health care professionals, she asks the audience how many people have signed advance directives and have completed EOL planning. Only about one-third replies yes.

## Education on hospice dated

Medical education programs typically don't include hospice care experience as part of their clinical training, Mullahy points out. "The information many medical professionals have about hospice is dated. Many people tend to have a very dismal and negative view about hospice care," she says.

Mullahy suggests that hospitals invite nurses and social workers from a local hospice program to talk to the case managers and nurses on staff. Case managers could take a field trip to a hospice facility or shadow a hospice nurse as part of their continuing education, she adds. "Case managers need to see and understand what hospice is all about," Mullahy says. "It's not rushing people off to death. It's not taking life away. It's giving them the kind of life we would want for ourselves and the members of our family."

Catholic Healthcare Partners in Cincinnati offers its Angel Program, an educational program on palliative and EOL care, to clinicians twice a year, says **Cathy Follmer**, RN, BSN, MBA/HCM, CHCE, CRNI, corporate director of continuum of care services for the health care system. It includes topics such as pain management, how to talk to people about their choices, advance directives, and alternative methods such as massage, healing touch, and other measures. "We teach our associates to look at each situation, not only from the standpoint of the patient who is nearing the end of their life cycle, but from the perspective of the family and what they are going through," she says.

Case managers need to be familiar with the hospice services available in their communities and what benefits are covered by private insurance, Medicare, and Medicaid, Kizziar says.

## Understand limits of hospice care

Be familiar with the limitations of hospice care, Kizziar advises. For example, her mother's Medicare benefits provide a nurse's aide one hour a day and nursing visits as needed.

"Medicare furnishes a hospital bed, wheelchair, bedside commode, and other equipment, along with supplies and medications, but the families do much of the work," she says.

Private fee-for-service agencies are available in most communities for hospice care and will provide staff ranging from sitters to nurses, Kizziar says.

Case managers should inform family members of all the options so they can make educated decisions about what care to seek for their loved ones, she says. Include information on free options, insurance options, Medicare options, and fee-for-service options. "Case managers have an obligation to know everything that is available in the community and to inform the family. Even if we believe the patient can't afford a private agency, it's not up to us to make those decisions. Our role is to make them aware of every single option that is out there," Kizziar says.

Case managers might be tempted to hand off the difficult work to a social worker, she suggests. "Too often, I hear case managers say they'll let the social workers handle it. Case managers are the ones who have the relationship with the patient and family. They can collaborate with the social worker, but it's not right to say that end-of-life situations are not part of the job," Kizziar says.

Hospitals should start to take a proactive approach to the subject and introduce advanced care planning and EOL options to patients who are frequently hospitalized with chronic diseases, Follmer suggests. In some regions, Catholic Healthcare Partners staff make presentations at senior citizen centers to educate people on advance care planning and "conversations before the crisis."

"Many people say they want 'everything done,' but they don't know what 'everything' means. They and their families need to be educated about what 'everything' means," Follmer says.

Case managers should be involved in making sure patients and families are aware of the importance of advance directives, but the process of filling out the paperwork should be according to hospital policy, Kizziar says. "It's a tragic situation for everybody when no one knows what the patient's wishes are and the family members disagree. Nobody is happy, and nothing ends well," she says.

Don't be afraid to seek professional help if the stress and sadness start to get to you, says **Pam Seaver**, RN, BSN, MTS, CCRN, CCC, pastoral

care nurse with Medical City Dallas Hospital's surgical intensive care unit and Hospice of Grayson County in Sherman, TX. Take advantage of the counseling services offered by your employee assistance programs, she suggests. "Seeing a counselor is extremely effective for anyone in health care. It's even more important when you deal with death and dying on a day-to-day basis because it can help you avoid compassion fatigue," Seaver says. ■

## Involve pharmacists in a pain management team

Hospitals need a pharmacist who specializes in pain management on board, although this model hasn't taken off as a trend as quickly as many experts in the field believe it should.

"There really wasn't a lot of recognition of health systems even needing pain services until the 1980s with the hospice movement," says **Virginia Ghafoor**, PharmD, a clinical pharmacy specialist in pain management at the University of Minnesota Medical Center — Fairview in Minneapolis and a clinical pharmacy specialist in pain/palliative care at Fairview Ridges Hospital in Burnsville, MN.

As hospice and palliative care programs began to grow, there was an evolution in health systems offering pain management services, she adds. "In the 1990s, we started seeing the impact of the aging population having pain problems, including degenerative joint diseases, neuropathic pain, and other types of chronic pain," Ghafoor recalls.

This trend led to the development of new drugs for treating neuropathic pain, including gabapentin (Neurontin) and pregabalin (Lyrica), she notes. "So, what has happened is there's a growing demand to have people who are specializing in chronic pain for both pain management and for a multidisciplinary approach," Ghafoor explains.

Pain is a significant topic, says **Lee Kral**, PharmD, BCPS, a clinical pharmacy specialist in pain medicine at the University of Iowa Hospitals and Clinics in Iowa City. Pain medication management involves psychosocial, substance use, regulatory, and diversion/abuse issues, making it a very complex pharmacy specialization, the experts say. While every pharmacist should have a basic knowledge about pain medicine, there's also a need for pharmacists who are specialists in pain medicine, Ghafoor says.

Hospitals increasingly are asking pharmacists to start pain services, and the pharmacists' role in pain services needs to grow, but there also needs to be more resources budgeted to train pharmacists in this practice, she says. "A lot of pharmacists have learned about pain medicine on the side, and they really don't have a lot of formal training," Ghafoor adds. "They need more structured training before they take on a service like this all by themselves."

The problem is that pharmacists traditionally receive only a few hours of pain medicine education as students, so most of the training comes post-graduation, notes **David S. Craig**, PharmD, BCPS, a clinical pharmacist specialist and residency director in psychosocial, palliative care, and integrative medicine at Moffitt Cancer Center in Tampa, FL. "There's a big movement in hospitals to incorporate palliative care in end-of-life care and pain management, and this is one of those areas where hospital pharmacists can get involved with patients," he says.

However, the pharmacists will need to be trained in pain medicine, Craig adds. Hospital pharmacists often are too busy to obtain the training on their own, and hospitals typically do not invest in creating a role for a pharmacist pain medicine specialist, he says. "We have a pharmacy pain management program here, and there are two others in the United States," Craig says. "So, that makes three pain management pharmacy programs in the United States."

Hospitals are recognizing the need for better pain management, however.

**Christopher Herndon**, PharmD, BCPS, an assistant professor at Southern Illinois University — Edwardsville, says, "What you find is that hospitals have been forced into looking at pain management in a much more serious light because of recent Joint Commission standards," he says. "This makes it a perfect storm for pharmacists to be involved," he adds.

The American Society of Health-System Pharmacists (ASHP) featured an all-day session on pain management at its 43rd Mid-Year Clinical Meeting, held Dec. 7-11, 2008, in Orlando, FL. Craig, Ghafoor, Herndon, and Kral spoke about pain management at the conference.

ASHP is working to develop pain medicine residency standards for pharmacists, Craig says. "ASHP is trying to highlight and inform hospital pharmacists who are out of school and practicing now to give them the tools they need to incorporate these standards into their own practices," he

says. "But this is only for the pharmacists who are motivated and interested in the pain medicine field; it'd be nice if there were standards for all hospital pharmacists."

The University of Iowa Hospitals and Clinics has about 100 pharmacists, including many who are involved in internal medicine and patient care issues that also involve pain management, Kral notes. "But what's unusual is we actually pay one pharmacist, me, to do nothing but pain management full time," Kral says.

At the minimum, it's important to have a pharmacist involved in the pain management team, Kral and other experts say. Hospitals are beginning to create teams of pharmacists and nurses to run inpatient pain and symptom management programs, and a number of larger teaching institutions now have pharmacists involved in their pain teams, Herndon says.

However, this change hasn't translated into creating pain management pharmacy specialists, as is ideal, he notes. "We did a large survey of hospitals three or four years ago, asking what is the largest thing precluding hospitals from assigning a pharmacist either full-time or part-time to pain management, and it all came back to resources and budget," Herndon explains. "The doctors are all for it and the directors are for it, but it's a soft cost service because we can't bill for it." **(For reasons pain management should include pharmacy input, see story, below.)** ■

## Reasons pain services should include pharmacists

There are a number of reasons pain management should include pharmacy input, including the following:

**• Hospitals are enhancing palliative care services.**

Many hospitals are starting to add or enhance their palliative care services, says **Christopher Herndon**, PharmD, BCPS, an assistant professor at Southern Illinois University — Edwardsville.

"A large reason for this is to provide better patient care," he adds. "This is a way for pharmacists to get involved in an area where hospitals already are putting resources."

**• Physicians need assistance.**

Physicians might decide to make changes to a patient's opioid use and, if they do, the pharmacist is the person they might call for assistance.

**• Pharmacists can help with patient screenings and monitoring.**

It helps to have a pharmacist on board, particularly in the more complicated pain medicine cases.

Some patients with little opioid experience could become oversedated, a problem that easily could be prevented if a pharmacist were involved to evaluate and monitor the patient's situation, says **Lee Kral**, PharmD, BCPS, a clinical pharmacy specialist in pain medicine at the University of Iowa Hospitals and Clinics in Iowa City. ■

## Respiratory depression linked to opioids

As a growing body of evidence suggests that aggressive treatment of pain, by intravenous or neuraxial opioids, might be associated with respiratory depression, the American Society of Anesthesiologists has released updated *Practice Guidelines for the Prevention, Detection and Management of Respiratory Depression Associated with Neuraxial Opioid Administration*.

The updated practice guidelines include new survey data and recommendations pertaining to monitoring for respiratory depression. "As more patients seek treatment for acute and chronic pain, it is important that physicians recognize and manage possible adverse effects of these pain treatments, including the serious occurrence of respiratory depression," said **Terese T. Horlocker**, MD, chair of the American Society of Anesthesiologists Task Force on Neuraxial Opioids.

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receiving epidural or spinal administration of opioids in ambulatory or inpatient settings, the guidelines are outlined in four key areas with specific treatment recommendations:

- Identification of patients at increased risk of respiratory depression, including recommendations for focused history and physical examination.
- Prevention of respiratory depression after neuraxial opioid administration, including recommendations for noninvasive positive pressure ventilation, drug selection, and dose selection.
- Detection of respiratory depression and management, including recommendations for patient monitoring for adequacy of ventilation, oxygenation, and level of consciousness.
- Management and treatment of respiratory depression, including recommendations for supplemental oxygen, reversal agents, and noninvasive positive pressure ventilation to improve respiratory rate and reduce adverse outcomes.

The updated guidelines can be found in the February 2009 issue of *Anesthesiology*. Copies of the guidelines can be found on the web site www.anesthesiology.org. ■

# Study indicates reasons for racial disparities

Investigators at the University of Pennsylvania in their study found that hospice services have restrictions that reduce usage by many patients who are most in need, particularly African-Americans, according to the American Cancer Society.

The research is published in the Feb. 1, 2009, issue of *Cancer*, a peer-reviewed journal of the American Cancer Society.

According to a release by the University of Pennsylvania, racial disparities in end-of-life cancer care might be caused by a preference for continuing aggressive treatment, which is a decision that blocks enrollment in hospice care.

The study was developed and conducted by **Jessica Fishman**, PhD, and **David J. Cassarett**, MD, MA, of the University of Pennsylvania School of Medicine and Veterans Affairs Center for Health Equity Research and Promotion, and colleagues. The study, published online in December 2008, "indicates that the eligibility criteria for hospice services should be reconsidered," the release states. ■

# Joint Commission: No new patient safety goals

*Organization is conducting extensive review*

There will be no new National Patient Safety Goals (NPSGs) established in 2009 for implementation in 2010 as The Joint Commission performs an extensive review of the current goals and the process to develop goals.

NPSGs have evolved over time, becoming more specific and detailed in some cases, and therefore, require more time and resources to implement. The field is struggling to meet some of the current NPSGs, according to The Joint Commission.

The review will include a baselines survey, a review of potential changes by the Patient Safety Advisory Group and the Standards and Survey Procedures Committee, and final approval by the board of commissioners. The process will incorporate feedback from health care organizations. The goal is to clarify language, ensure that NPSGs are program-specific, delete NPSGs that are redundant or nonessential in specific programs, and consolidate similar NPSGs. Revisions to the NPSGs will be effective in 2010. ■

## JOURNAL REVIEWS

## Phase 1 oncology trial patients don't ask for palliative care

Phase I oncology trial participants often are excluded from hospice services. However, a recent study shows that although they do suffer the same symptoms of patients undergoing traditional cancer therapy, they are less likely to indicate a need for hospice or palliative care-related services.[1]

In the study, 297 patients undergoing cancer therapy and 69 patients enrolled in Phase 1 trials were interviewed to assess the patients' perceived need for services provided by hospice. Patients were asked if they needed a chaplain, a counselor, a home health aide, or a visiting nurse. Although the Phase 1 trial patients reported more

severe symptoms than patients in the cancer patients, they were less likely to ask for hospice-related services. Only 6% of Phase 1 patients indicated a need for a home health aide, compared to 67% of oncology patients; 10% asked for a chaplain, compared to 45% of oncology patients; and 16% perceived a need for a counselor, compared to 54% of oncology patients. When asked about a visiting nurse, both groups were comparable with 44% of Phase 1 patients and 48% of oncology patients indicating a need.

### *Reference*

1. Finlay E, Lu HL, Henderson H, et al. Do Phase 1 patients have greater needs for palliative care compared with other cancer patients? *Cancer* 2009; 115:446-453. ▼

## Hospice agency provides more than mixed agency

It is not uncommon for an agency to offer home health and hospice services because patient populations are similar and regulations favor the mix of two services in one agency. While it is operationally efficient for the agency, patients might not be receiving the highest quality hospice care from a mixed agency as they would from a hospice-only agency, according to a study published in *Medical Care.*[1]

Using data from the 2000 National Home and Hospice Care Surveys, a total of 760 Medicare and Medicaid certified hospice agencies' services were studied. Of the agencies studied, 393 were mixed agencies, and 367 were hospice-only agencies. Hospice-only agencies were significantly more likely than mixed agencies to provide many types of services, including volunteers (96.1% vs. 77.4%), social services (96.1% vs. 93.5%), spiritual care (95.1% vs. 77.8%), bereavement care (93.5% vs. 79.8%), counseling (89.5% vs. 70.2%), and physician services (87.2% vs. 52%).

The authors concluded that mixed agencies provide a narrower range of services to hospice patients, including services that are considered cornerstones of hospice care.

### *Reference*

1. Rich SE, Gruber-Baldini AL. Differences in services provided by hospices based on home health agency certification status. *Med Care* 2009; 47:9-14. ■




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