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Hospice agencies provide more services than agencies mixed with home health

Transition from home health to hospice requires collaboration

With both types of services focused on providing care to patients in their own homes, it makes sense that an agency offer home health and hospice services. In fact, as of January 2007, 21% of hospices were part of an agency that was certified as a hospice and a home health agency.¹ But, is an agency that provides both services able to offer all services that a hospice patient needs?

Not necessarily, according to **Shayna E. Rich**, MA, an MD/PhD candidate and **Ann L. Gruber-Baldini**, PhD, an associate professor at Maryland School of Medicine in Baltimore. Rich and Gruber-Baldini are co-authors of a study that evaluated the level of hospice services provided in mixed (home health and hospice) and nonmixed (hospice only) agencies.² A total of 760 Medicare- and/or Medicaid-certified hospice agencies were surveyed, with administrators answering questions about services provided. Study participants represented 393 mixed agencies and 367 nonmixed hospices.

EXECUTIVE SUMMARY

Although 21% of hospices were part of a home health agency as of January 2007, not all of those hospices offered the same level of hospice service as agencies that are hospice-only, according to a recent study. Experts point out that there are disadvantages and advantages with mixed agencies, but both services need to take steps to improve transition of care.

- Services such as pastoral care, volunteers, and bereavement support were offered more frequently by nonmixed agencies.
- Transition to hospice requires joint visits by the home health nurse to whom the patient has formed a relationship and a hospice nurse.
- Hospice-only agencies can improve transitions with outreach to community home health agencies and assistance with palliative care cases.

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"We expected to find that mixed agencies offered more services because they represented a larger pool of patients, but the data showed the opposite," says Gruber-Baldini. The data show that on average, mixed agencies provided about 19 of the 26 services evaluated by the study, while nonmixed agencies provided about 22 of the services, she points out. **(For a list of services examined in the study, see p. 51.)**

Pastoral care and volunteers were more frequently offered by nonmixed agencies, while skilled nursing care and physical therapy were more common with mixed agencies, says Rich. "Hospices that were not a part of a home health agency tended to offer more complex, focused care for hospice," she says. "Nonmixed agencies seemed to offer more support for the patient and family for the bereavement aspect that is unique to hospice."

Although her agency is hospice-only, **Linda Rock, MPH**, executive director of Prairie Haven Hospice in Scottsbluff, NE, agrees that a home health agency might not place the same priority on all hospice services that a hospice-only provider does. "We can focus on care that is directly related to end-of-life issues because this is all we do," she explains. "We offer chaplains and volunteers to provide additional support to families, and a mixed agency might not have those resources."

Another area in which nonmixed agencies excel is palliative care, points out Rock. "We have increased our efforts to reach out to home health agencies in our area to offer consultations on pain and symptom management," she says. "By building these relationships, we can educate home health agencies and their patients to the value of hospice while improving the patients' outcomes."

One advantage that a mixed agency has compared to a hospice-only agency is the opportunity to transition a home health patient to hospice care, points out Rock. "The difficulty is that patients don't want to give up their home health nurse, but most home health staff members are not comfortable discussing end-of-life issues," she says. **(For more information about transitioning between home health and hospice, see p. 52.)**

Education key to successful transition

Even in a mixed agency, it is a challenge to get home health nurses to understand when to refer patients to hospice, admits **Kim Kranz, RN, MS**, vice president of operations for Home Nursing Agency, an Altoona, PA-based agency that offers home health and hospice services.

"We provide a lot of cross-education sessions for both sides of the agency so that staff members understand the differences in the two services and recognize opportunities to transition patients from one service to another," she reports. "OASIS [Outcome and Assessment Information Set] has made us look at how we do business by asking home health clinicians about the anticipated life expectancy of the patient when we start care." However, even with this question to prompt consideration of hospice, the biggest challenge is the mindset of the home health nurse compared to the hospice nurse, she says. "Death is not an anticipated goal in home health, so nurses don't want to consider that as an outcome for the patient," Kranz explains.

Although education has improved home health referrals to hospice, Kranz' agency is also

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Editorial Questions

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using software tools to analyze patient information collected in OASIS to identify potential hospice patients, she says. "We have just started using this tool to analyze a patient's activities of daily life and life expectancy to identify patients who might be better served in hospice," Kranz says. (See resource box, right.) The patient's physician is contacted before any discussions with the family, she adds.

Mixed agencies might cross-educate staff members, but it is rare to find a home health nurse who wants to learn to care for hospice patients as well, says Kranz. "There are different regulations for each service, different documentation requirements, and a different focus of care, so it is not practical to expect one staff member to see both types of patients," she says. The exception at Home Nursing Agency is the nurses who work on the night teams in smaller counties, Kranz says. "If there are not enough patients in a county to justify a home health night team and a hospice night team, nurses are hired and trained to provide care for both," she says.

Documentation and regulations don't cause problems for night team nurses because they are handling one crisis event, not developing a plan of care or following the patient through the entire episode, explains Kranz. "Because learning to care for both home health and hospice patients is part of the job description, nurses know when they apply for the position that they will see both," she adds.

While the hospice segment of a mixed agency might be described as a home health agency-based hospice, **Mark Murray**, president and CEO of The Center for Hospice and Palliative Care in South Bend, IN, describes his agency as a hospice-based home health agency. "Less than 10% of our patients are home health patients, but we keep our home health license current to be able to offer palliative care to patients who might not qualify for hospice," Murray explains. "We have a narrow focus in our home health service. We only accept patients who have a life-limiting illness with a life expectancy of up to one year."

Because his agency focuses on patients who are dealing with end-of-life issues, he offers all of the traditional hospice services, including bereavement and pastoral support to all family members, even if the patient is still a home health patient, says Murray. "This higher level of hospice service is better for patients and their families," he says.

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

List of services considered hospice

In a comparison of hospice services offered by mixed and nonmixed agencies, authors **Shayna E. Rich**, MA, an MD/PhD candidate, and **Ann L. Gruber-Baldini**, PhD, an associate professor at Maryland School of Medicine in Baltimore, asked directors of hospices that are a part of a home health agency and directors of hospice-only agencies to identify hospice-related services offered by their agencies.¹

Typically, mixed agencies provided fewer of the hospice services than nonmixed agencies,

Need More Information?

For more information about hospice services in a mixed or nonmixed agency, contact:

- ☛ **Kim Kranz**, RN, MS, Vice President of Operations, Home Nursing Agency, 201 Chestnut Ave., Altoona, PA 16603-0352. Phone: (814) 946-5411. Fax: (814) 941-1648. E-mail: kkranz@homenursingagency.com.
- ☛ **Mark Murray**, President and CEO, The Center for Hospice and Palliative Care, 111 Sunnybrook CT, South Bend, IN 46637. Telephone: (574) 243-3100. E-mail: Mmurray@centerforhospice.org.
- ☛ **Linda Rock**, MPH, Executive Director, Prairie Haven Hospice, Two W. 42nd St., Suite 2300, Scottsbluff, NE 69361. Telephone: (308) 630-1149. E-mail: rockl@rwmc.net.

For more information about data software to identify potential hospice patients, contact:

- ☛ **Strategic Healthcare Programs**, 121 E. Mason St., Suite B, Santa Barbara, CA 93101. Telephone: (805) 963-9446. Fax: (805) 963-2102. Web: www.shpdata.com. The company offers software tools designed for specific types of home care agencies such as home health, hospice, and durable medical equipment. Costs vary according to type of software application and size of organization.

with hospice-only agencies routinely providing volunteers, physician services, spiritual care, bereavement care, counseling, and medications more frequently. Mixed agencies did more often provide services such as skilled nursing, physical therapy, and occupational therapy on a more frequent basis. Social services were offered at a comparable level by both agencies.

- **Services defined as core hospice services in study:** volunteers, physician services, spiritual care, bereavement care, counseling, dietary and nutritional services, social services, and skilled nursing services.

- **Services described as noncore hospice services:** medications, durable medical equipment and supplies, continuous home care, respite care, personal care, homemaker/household services, intravenous therapy, speech therapy/audiology, occupational therapy, and physical therapy.

- **Other services:** pastoral care, transportation, respiratory therapy, psychological services, enterostomal therapy, referral services, companion services, and meals.

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. ■

Smooth transition from home health to hospice

Use team approach to address concerns

On paper, transitioning a patient's care from the home health side of an agency to the hospice service of the same agency should be a smooth, easy to accomplish task. The difficulty is that home health patients form attachments to their nurses and don't want to sever the relationship, says **Kim Kranz**, RN, MS, vice president of operations for Home Nursing Agency, an Altoona, PA-based agency that offers home health and hospice services.

"Unfortunately, while we can cross-educate staff about the benefits of each service, it is more difficult to cross-train an entire home health staff to care for hospice patients," she says. The main difficulty is that home health staff members chose home health and don't want to work with patients who are dying, Kranz adds.

The transition in her agency is handled by a joint visit from the home health nurse and the hospice nurse, she explains. "The home health nurse introduces the hospice nurse in a way that shows confidence in the hospice nurse's abilities," Kranz says. "We pass the baton carefully so that the patient and family members are comfortable with the transition." Whenever possible, they include the physician in the conversation to increase the patient and family's confidence in their decision, she adds.

"I've found that nine times out of 10, the patient knows that it is time to seek hospice care, so our focus is showing the family how hospice can support them," says Kranz. "Hospice's specialty is symptom and pain management; that is often what convinces family members to support the patient's decision for hospice. They don't want to see the patient in pain."

Because Prairie Haven Hospice in Scottsbluff, NE, is offering palliative care consults to local home health agencies, it makes sense that the staff also offers to make joint visits to conduct the end-of-life discussions that make home health nurses uncomfortable, says **Linda Rock**, MPH, executive director of Prairie Haven. "We can explain hospice services and give the patient and family information that they can use when making their decision," she explains.

Transition and continuity of staff are not an issue for patients of The Center for Hospice and Palliative Care in South Bend, IN, a hospice that also maintains a home health license to care for palliative care patients with a life expectancy of up to one year. "We discharge easily from home health to hospice when appropriate, and the change is transparent to the patient," explains **Mark Murray**, president and CEO of the agency. Because the type of care provided to the home health and the hospice patients is similar, there is no difference in the staff's focus, he points out. "The same staff care for home health and hospice patients, so there is usually no change of staff members," Murray says. ■

Music offers relief from anxiety and pain

Therapy program reconnects patients, family

The woman was young for dementia. In her late 50s and suffering from end-stage dementia, she was lethargic and uncommunicative.

EXECUTIVE SUMMARY

Music therapy is a well-defined, recognized discipline that hospices are incorporating into their service offerings.

- Music can be used to relieve anxiety, shortness of breath, and pain.
- Board-certified therapists identify methods to use music to achieve the goals of the patient's plan of care.
- A music therapy program can be used to increase exposure for the hospice in the community.
- The program can be supported by community donations.

After talking with the husband, the music therapist learned that the couple had enjoyed karaoke throughout their marriage. On her next visit, she brought a karaoke machine. It did not take long for the patient to sing along with the songs she and her husband always had enjoyed.

Although the patient responded only to music, finding this method of communication improved the husband's ability to communicate, says **Diane Tomasi**, director of community relations for Big Bend Hospice in Tallahassee, FL. "The husband wrote love songs for his wife so he could convey his feelings for her in a way that she heard," she adds. "Music brought them back together at the end of her life."

Music therapy is an integral part of the services offered by Big Bend Hospice. "We offer music therapy to all patients upon their admission," says **Jennifer L. Haskins**, MT-BC, manager of music therapy at the hospice. "We use guitars, keyboards, and other instruments, as well as singing, to improve the patient's quality of life," she says. "About 60% of our patients choose to receive music therapy," Haskins adds. Even if a patient declines music therapy at first, nurses and social workers can offer it to the patient later, she notes.

Music can relieve anxiety, regulate breathing when a patient has trouble with shortness of breath, and decrease pain, points out Haskins. "There is also a social aspect to music, so it can be used to increase bonding between family members and patients," she says. Because family members might not know how to interact with the patient, music can give them a way to participate during therapy by singing along or just by listening while the patient talks with the therapist, Haskins adds.

True music therapy is more than playing a CD or listening to an audiotape, explains Haskins. Music therapy is a recognized discipline with an educational component and a board-certification process, she says. "Music therapists have practicums and internships that are required for licensure," Haskins says. In fact, one way a hospice can build a music therapy program is to use interns as a way to enhance the size of the staff, she suggests.

There is no typical therapy plan for a patient, says Haskins. "It is a very individualized plan with a specific goal," she says. Depending on the patient, music chosen for therapy might range from classical to country-western, and instruments can be guitars or portable keyboards, Haskins points out. "The key is to keep the goal in mind, such as pain reduction or relief from anxiety," she says.

Therapist part of team

The key to a successful music therapy program is involvement of the therapist in the multidisciplinary team, says Haskins.

Even when the patient initially chooses not to see a music therapist, there have been instances when the team is discussing a patient's progress, and the music therapist identifies an issue that music might solve, she says. "The therapist asks the nurse or other members of the team if they think the patient might agree to a visit, and the nurse introduces the idea to the patient or family," she explains.

Introducing music therapy to other staff members requires education because it is a misunderstood field, admits Haskins. "It doesn't take long for other clinicians to see the positive benefit of the therapy," she adds.

Music therapists continue through the bereavement support with the family, often playing favorite songs at the patient's funeral, says Tomasi. "We see this as a continuation of therapy," she explains.

At Big Bend, music therapy also is an important part of the agency's fundraising and community outreach efforts, says Tomasi. "We use music as part of all of our community events, and we have songs written by our therapists for specific events," she says. The hospice's foundation solicits funds specifically for the music therapy program, Tomasi adds. "We often have family members designating gifts to the program because the music meant so much to them and the patient," she says.

Music therapists also will perform "living room" concerts as part of fundraising efforts for

Need More Information?

For more information about music therapy, contact:

☛ **Jennifer L. Haskins**, MT-BC, Manager, Music Therapy, Big Bend Hospice, 1723 Mahan Center Blvd., Tallahassee, FL 32308-5428. Telephone: (800) 772-5862 or (850) 878-5310. E-mail: jennifere@bigbendhospice.org.

To post a job opening, contact:

☛ **American Music Therapy Association**, 8455 Colesville Road, Suite 1000, Silver Spring, MD 20910. Telephone: (301) 589-3300. Fax: (301) 589-5175. Web: www.musictherapy.org.



JOURNAL REVIEWS

Ped hospice expenditures affected by ethnicity

Little research has been conducted about the use of pediatric hospice care, but a study published in the *Journal of Palliative Medicine* takes a look at who is using pediatric hospice and what factors affect the costs of pediatric hospice.¹

The authors conducted an analysis of Medicaid administrative data and death certificates for 1,527 children who received coverage through the Florida Medicaid program. Only 11% of children used hospice, even though the home was the location of death for 55% of the children in the study. Children who eventually entered hospice care showed higher outpatient, inpatient, emergency, and pharmacy expenditures than children who did not use hospice.

Results suggest that black non-Hispanic, Hispanic, and children of other races had \$730 to \$880 fewer hospice expenditures than whites. Higher hospice expenditures (\$970) were associated with longer enrollment spans.

The authors suggest that information in the study be used to develop interventions that will raise awareness of the hospice and palliative care services available to pediatric patients to improve the child and family's quality of life at the end of life.

Reference

1. Knapp CA, Shenkman EA, Marcu MI, et al. Pediatric palliative care: Describing hospice users and identifying factors that affect hospice expenditures. *J Palliat Med* 2009; 12:223-229. ▼

Hospice cost fluctuates during length of service

Hospice care can improve symptom management and quality of life for patients, but intensity and cost of care varies from patient to patient, depending on the length of service, according to a study in *Inquiry*.¹

the music therapy program, but their performance always is educational, says Tomasi. "We do get requests for our therapists to perform at luncheons or other events because all of our therapists are talented musicians and singers, but we have to be careful to focus on the educational aspect of the performance," she says.

If a hospice manager is evaluating the addition of music therapy to the hospice's services, Haskins suggests starting with one board-certified therapist. "After the therapist has been at the hospice for a year, the program can offer internships," she says. A therapist can increase the size of the program by another two full-time equivalents without the cost of hiring another board-certified therapist, Haskins explains. "Interns don't receive salaries, but they are often offered a stipend and expense reimbursement," she adds.

Finding qualified music therapists is not a problem for Haskins. "We do have Florida State University in our community, and the school has a well-established, well-known music therapy program," she says. But even if a hospice doesn't have a nearby university with a program, it is easy to post job openings with the American Music Therapy Association, Haskins says. "Don't use local papers to advertise the position," she warns. Qualified, certified therapists use the association web site to find positions, so the local papers are a waste of time and money, Haskins says.

Although establishing a music therapy program takes time, planning, and fundraising, it is worth the effort, says Tomasi. "Music therapy is a true value-added service for our hospice patients," she says. ■

Costs are higher at the beginning of service due to staff time needed to set up the admission and plan of care, and time needed to arrange for medical equipment, supplies, and medications. However, costs drop after the initial three days of care. Nursing visits, equipment or medication changes, and assessments continue throughout the length of service, but it is not until the patient nears the end of life that costs rise again. This increase is due to intense, round-the-clock care needed to provide symptom and pain management, as well as family support.

The study does point out that hospice costs are lower for nursing home patients due to the overlap of nursing home and hospice services. The authors recommend a downward adjustment of the hospice per diem for patients in a nursing home.

Reference

1. Huskamp HA, Newhouse JP, Norcini JC, et al. Variation in hospice patients' costs. *Inquiry* 2008; 45:232-244. ▼

Studies probe health care costs at the end of life

Patients with advanced cancer who discuss end-of-life care with their physicians appear to have lower health care costs in the final week of life than those who do not, according to a report in the March 9, 2009, issue of *Archives of Internal Medicine*.

A second report in the same issue finds that black and Hispanic patients tend to have higher health care costs at the end of life than white patients, despite dying of similar causes.

A disproportionate share of medical costs occur at the end of life, according to the first article. Almost one-third of Medicare expenditures are attributable to the 5% of beneficiaries who die each year, and about one-third of expenses in the last year of life are spent in the final month. Previous studies suggest that most of those costs result from life-sustaining care, including resuscitation and mechanical ventilation.

Baohui Zhang, MS, center statistician at the Dana-Farber Cancer Institute, Boston, and colleagues studied 603 patients who were part of the Coping With Cancer study, funded by the National Institute of Mental Health and the National Cancer Institute. At the beginning of the study, between 2002 and 2007, 188 (31.2%) reported discussing

their wishes about end-of-life care with their physicians. They then were followed up through death.

In the final week of life, patients who reported having end-of-life discussions with their physicians had average aggregate health care costs of \$1,876, compared with \$2,917 for patients who did not. Formal and informal caregivers who were interviewed after patients' deaths reported that those with higher costs also had a worse quality of death in their final week.

In the second article about end-of-life costs, **Amresh Hanchate**, PhD, of Boston University School of Medicine, and colleagues report on an analysis of data from 158,780 Medicare beneficiaries who died in 2001. In the last six months of life, costs varied significantly by racial and ethnic background. Costs for whites averaged \$20,166, compared with \$26,704 for blacks and \$31,702 for Hispanics.

Between 40% and 60% of these excess differences are associated with geography, such as living in high medical expenditure areas. However, substantial differences remain, even after adjustment for many patient characteristics in addition to geographic variables, the authors wrote.

"Strikingly higher rates of use of intensive end-of-life treatments, such as ICU and ventilators, account for most of these residual differences," they wrote. "Therefore, at life's end, minorities often receive more expensive but not necessarily life-enhancing care. It is unclear how much of this was actively sought, or the extent to which racial and ethnic differences is principally driven by how choices are presented or how they are 'heard.'" The authors suggest additional research. ▼

Is fear the motivation for physician aid in dying?

Individuals exploring physician aid in dying in Oregon appear to be motivated by worries about future pain and loss of autonomy rather than current symptoms, according to a report in the March 9, 2009, issue of *Archives of Internal Medicine*.

Researchers surveyed 56 individuals who requested physician aid in dying or contacted a related advocacy organization. Participants were asked to rate the importance of 29 reasons for seeking this option on a scale of 1 (least important) to 5 (most important), according to researcher **Linda Ganzini**, MD, MPH, professor of psychiatry and

medicine senior scholar, Center for Ethics in Health Care, Oregon Health and Science University (OHSU), Portland. Ganzini conducted the research with colleagues at OHSU and at Portland Veterans' Affairs Medical Center.

The most important reasons, with median (midpoint) scores of 5, were wanting to die at home and control the surrounding circumstances of death; loss of independence; and concerns about future pain, poor quality of life, and inability to care for one's self. All current physical symptoms were rated as unimportant.¹

The data suggest that when patients first request physician aid in dying, they do so in anticipation of future suffering that they perceive as intolerable, not because of physical symptoms or quality of life at the time of the request, the authors write. "Their desire to die is not strong, and they do not believe that their life is poor in quality, meaningless, or worthless. Rather, they appear to be protecting against the risk of future experience they do not believe they can endure," they wrote. "When confronted with a request for physician aid in dying, health care providers should first work to bolster the patient's sense of control and to educate and reassure the patient regarding management of future symptoms." ▼

Do feeding tubes help in advanced dementia?

Family members grappling with the decision to allow a feeding tube for a relative with advanced dementia will find little comfort from a new review of evidence.

Poor food intake is common in individuals with dementia for a variety of reasons. In advanced dementia, health care providers might intervene by feeding patients artificially, usually by inserting a feeding tube through the stomach. This decision is emotional, controversial, and influenced by complex ethical issues.

But do feeding tubes actually help people with degenerative dementia? In a new Cochrane review from London, doctors searched for evidence that this intervention was beneficial.¹

"We found that there is no research evidence that tube feeding prolongs survival or improves the quality of life for people with advanced dementia," said lead author **Elizabeth Sampson**, MD, a senior lecturer at the Marie Curie Palliative Care Research

Unit in London. "In fact, some studies suggest that tube feeding may have an effect opposite to the desired and actually increase mortality, morbidity, and reduce quality of life," said Sampson, who also is affiliated with Royal Free Hospital and University College Medical School, also both in London.

At first glance, it appears counterintuitive that individuals fail to benefit from tube feeding, but the way that the body utilizes food is complex, she said. With some forms of dementia, the body might be unable to metabolize food properly. Especially worrisome for families is the pain typically associated with prolonged hunger and thirst.

"In a study with patients terminally ill with advanced cancer and unable to eat, however, few experienced painful feelings of hunger and thirst," Sampson said. "If they did, this pain was alleviated by simple measures, such as pain relief or small sips of water. Compassionate nursing and medical care, similar to that which underlies the philosophy of the hospice movement, can alleviate a great deal of suffering and should be available to people with dementia, too."

This research encompassed a review of 452 studies in seven health care databases, with five from the United States. Overall, the studies included 1,821 people; 409 of whom received some form of tube feeding and 1,467 who did not. The researchers found no randomized controlled studies, considered the gold standard of studies. "Just because we found insufficient evidence of benefit does not mean that for some individuals with advanced dementia, tube feeding is the wrong decision," Sampson said. "Each case needs to be considered individually. We would hope that family members will feel better informed about the pros and cons of tube feeding in persons with advanced dementia because of this paper."

Artificially feeding individuals with dementia is a relatively new phenomenon that evolved after development of the percutaneous endoscopic gastrostomy tube (feeding PEG) in the early 1980s, said **Stephen Post**, PhD, a professor of preventive medicine at Stony Brook (NY) University. Their intent was to nourish seriously ill children until they got well; but by 1985, PEGs became widely used as a cost-saving measure in nursing homes, which lacked sufficient staff to do assisted oral feedings.

"As Dr. Sampson found, there is no evidence that the feeding tube benefits patients with advanced dementia," Post said. "Indeed, as she details in this paper, there are all sorts of considerations for not using feeding PEGs. The most

serious reason, perhaps, is physical restraint, which is terrible. One study shows, in fact, that 71% of persons with advanced dementia, who receive feeding tubes, are physically restrained.”

It is important to realize, he adds, that the gastrointestinal system of patients close to death often shuts down, and a feeding tube can cause considerable suffering.

The choice is not either a feeding PEG or nothing, said Post, who also is president of the Institute for Research on Unlimited Love, and the author of a book on moral issues in Alzheimer’s disease. He said there is a third option that people have been using since the beginning of time: assisted oral feeding. “My grandmother had Alzheimer’s disease in the 1970s, and I regularly helped feed her soft foods like applesauce and gave her something to drink,” Post recalls.

Post said the most important thing a loved one can do is to routinely stop by the nursing home on the way to or from work, and spend a half-hour doing assisted oral feeding. There is also an emotional connectedness that goes on, he believes, and countless benefits of giving for the giver. “The most humane thing is assisted oral feeding,” he said. “There is almost a sacred quality to it in my mind.”

Reference

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Sensitivity training helps staff understand

Participants simulate vision and hearing loss

Before they start their job managing the care of senior members, case managers at Senior Care Action Network (SCAN) Health Plan try to sort pills while wearing heavy gloves, strain to understand a speaker whose voice is muffled, and fill out a medical information form while wearing special glasses that simulate vision loss.

It’s all a part of the Medicare Advantage Plan’s Senior Sensitivity program to help employees feel, see, and hear what common physical and cognitive changes that occur with aging actually feels like and understand how much loss seniors experience as they age. The health plan requires the Senior

Sensitivity training for all of its employees, including board members, says **Sherry Stanislaw**, senior vice president at the health plan in Long Beach, CA.

“The training is a good complement to the clinical training of the nurses and social workers, because they literally get to be in the shoes of the seniors. It helps our staff understand the challenges that their clients face in their everyday life and in adhering to their treatment plan,” says **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring.

For example, during the training, Roth had to walk around with popcorn in her shoes to experience the pain of neuropathy or arthritis in a senior’s feet. “This class helps our case managers understand the problems that members face so they can work with them on strategies that keep them safe at home and out of the hospital. If the senior’s eyesight or hearing is limited, the case managers know how to overcome the barriers,” she says.

The health plan started its Senior Sensitivity training about five years ago, and the program is based on experiential learning.

“We use tools to accelerate aging and help the participants understand how seniors may struggle with everyday activities, as well as the challenges they face as they maneuver through the health care system,” Stanislaw says.

Tools include vision loss glasses that simulate glaucoma, cataracts, and other eye diseases. In one exercise, the participants are asked to put on the glasses and a pair of bulky gloves and try to open a pill bottle filled with small candies, and then sort the candies according to color. “This exercise helps the participants understand how seniors struggle when they have arthritis or have lost dexterity in their hands and, at the same time, have impaired vision,” Stanislaw says.

It’s a real “ah-ha” moment for many case managers, who often suggest that members who are on multiple medications fill the compartments in a pill box with their medications for each day of the week, says **Kelly Giardina**, MS, manager of geriatric health management and monitoring. “It was hard to fill the box while we had gloves on,” she says. Another challenge was attempting to separate pills by color while wearing glasses to simulate vision loss. Such tasks help the case managers consider if they are being realistic to expect seniors to fill their pill box. “From our perspective, it’s easy to think they could use a pill box; but if they have a deficit, it could prevent them from implementing the plan,” Giardina says. “Typically, they need to

have someone set up the pill box for them.”

The participants have to fill out a standard medical information form, similar to the kind used in physician offices, and fill it out with their left hands (to simulate impairments caused by a stroke) and while wearing the vision-altering glasses. They must write down what they hear on a tape when the speaker’s voice is muffled.

During the classes, participants talk about common hearing loss problems, which are common in the senior population, Giardina says. “Many seniors can hear vowels but lose their ability to hear consonants, particularly on the end of words,” she says. “When we play the tape, the participants are straining to hear and understand, and most of them get most of the words wrong.”

Addressing psychological losses

The program also deals with psychological losses that occur as people age. The participants have to write down the three most treasured things they have: family members, jobs, etc. The facilitator walks through the room and starts snatching things away from the participants.

“It’s amazing how people react when the facilitator takes away the things that are important to them,” she says.

A memory loss exercise gives participants a list of items that they have to remember. “At the same time we are doing these exercises, we also remind participants that you can never stereotype seniors. Not every older adult experiences all these losses. A lot of it is individual,” she says.

The trainers give the class tips on how to compensate for the disabilities during their interaction with members.

The case managers at SCAN range in age from the very young to those who are almost seniors themselves. Some have experience working with patients face to face, but others have only telephonic case management experience, Roth says. “Without the experience of a deficit yourself, it’s hard to understand what seniors face in the real world and to come up with unique ways to help members be adherent,” she says. “The classes give them the feel of having a deficit and serve as a good reminder to put ourselves in the situation of the seniors.”

Part of the initial case management assessment is to gather information that helps the case manager understand any challenges the member may face, Roth says. “We ask about their vision, their hearing, and other functional aspects to assess

Need More Information?

For more information about the Senior Sensitivity program, contact:

☎ **Lisa Roth**, MS, Director, Independent Living Power and Geriatric Health Management and Monitoring, Senior Care Action Network (SCAN) Health Plan.
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some of the potential challenges the member has, so we don’t assume that the member can do things or understand things when they can’t,” she adds.

The case managers learn to adjust their pace and their volume as they interact with members, Giardina says. “They stop and confirm that the member understands what they are saying and can repeat it back,” she says. “It is a matter of adjusting interactions to compensate for whatever deficits the member may have.”

The case managers are trained to look for signs of deficits and vary the services they provide based on the different needs of their clients, Roth says. For example, if someone is visually impaired, the case managers might send them information in large print or provide an audio resource for the information. “As a result of the program, the case managers work with the physicians to get the members a large-print copy of the medical questionnaire and send it to the members ahead of time,” she says. “The case managers in our geriatric health management program always work on preparing the members for their doctors visits, helping them gather the information the doctor needs, and empowering them to make their doctor visits successful.”

As a backup to help overcome hearing and memory deficits, after the case managers talk to members, they send out a letter recapping what they have gone over during the telephone call, Giardina says. “We do this because many of our members have trouble hearing, and it gives them the information in writing that they can take to their doctors,” she adds.

SCAN has given classes to elementary school children to help them learn to better understand their grandparents. Stanislaw says, “We talk to the kids about communicating with their grandparents and teach them techniques, like being face to face when they talk, so the seniors can hear them and pick up on both visual and audio cues. It’s all a matter of understanding the other person’s challenges.” ■

Book reports strategies for end-of-life care

Waiting for Rick: A Caregiver's Dilemma, by Rick Duffy, uses the author's personal experience to reveal strategies and resources for better end-of-life caregiving.

Three days after Duffy lost his mother, Alberta, to a grueling battle with cancer, he sat down at his computer and began to compose her story. The result is a book intended to serve as a tribute to her life and a how-to manual for families experiencing the challenges of saying goodbye to an elderly loved one in failing health.

With some 70 million baby boomers reaching an elderly age, an increasing number of families are charged with the care of their parents, Duffy said. "I want readers to reflect on the quality of life of their aging loved ones and to show appreciation for those dedicated and compassionate professionals working every day in the health care system," he said.

Waiting for Rick is organized into two sections, beginning with a detailed account of Duffy's experiences with his mother's dementia, cancer, and eventual death. The second section offers commentary on the phases of Alberta Duffy's decline, and it provides reference information regarding health care options and final planning. Selected portions also feature artwork by Duffy's daughter, Heather, that symbolize fading and receding memories.

Waiting for Rick: A Caregiver's Dilemma is available for sale online at Amazon.com, BookSurge.com, and through additional retail channels. For more information, go to www.waitingforrick.com. ■

Know requirements for consolidated billing

Providers might find the rules confusing with regards to consolidated billing (CB) under the

Balanced Budget Act (BBA) of 1997. This might be particularly true when patients are discharged to skilled nursing facilities (SNFs) and home health services.

The Centers for Medicare & Medicaid Services (CMS) has provided descriptions and clarifications about how CB works for these post-acute services at these web sites: www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp and www.cms.hhs.gov/HomeHealthPPS. Here is a summary of what CMS says:

• **Excluded services are billed separately to Part B.** Services excluded from SNF CB are billed separately to Medicare Part B, but the bills still must contain the SNF's Medicare provider number. The services that are excluded include:

- Hospice care, an ambulance trip that conveys a beneficiary to the SNF for the initial admission, and physician "incident to" services;
- Physicians' services that include furnished to SNF residents, although the technical component of physician services is subject to CB and must be billed to and reimbursed by the SNF;
- Physician assistants, nurse practitioners, and clinical nurse specialists working in collaboration with a physician or under a physician's supervision;
- Certified nurse-midwives, qualified psychologists, and certified registered nurse anesthetists;
- Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Part B coverage of epoetin alfa (Epogen) for certain dialysis patients.

Some specific outpatient hospital services also are excluded: Some hospital services are so intensive and costly that CMS has excluded them from SNF CB. Also, durable medical equipment is excluded from CB.

• **Changes were made to original CB legislation.** The original CB legislation in the BBA was modified over the years. Now the provision regarding SNFs applies only to services that a skilled nursing facility resident receives during a covered Medicare Part A stay. The only exceptions include physical, occupational, and speech

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language therapy, which remain subject to CB regardless of whether the resident receiving the services is in a covered Part A stay. ■

FDA reverses decision on liquid morphine

In a surprising move, the Food and Drug Administration (FDA) amended a March 30, 2009, action warning manufacturers to stop producing and distributing certain unapproved prescription opioids, including 20 mg/ml morphine sulfate oral solution.

This form of highly concentrated liquid morphine is a common medication used for hospice patients with pain that cannot be controlled with other medications. Concerns raised by hospice and palliative care organizations resulted in the amendment to the list of unapproved medications.

“While the FDA remains committed to ensuring that all prescription drugs on the market are FDA-approved, we have to balance that goal with flexibility and compassion for patients who have few alternatives for the alleviation of pain,” says **Douglas Throckmorton**, MD, deputy director of the FDA’s Center for Drug Evaluation and Research.

Other meds aren’t affected

Other medications included in the initial warning to cease production are not affected by this amendment. The other pain control products that will no longer be available after July 1 include immediate release tablets containing morphine sulfate, hydro-morphine, and oxycodone. There is a concern about potential shortages of opioid painkillers with the sudden withdrawal of all unapproved versions of the medication, says **Porter Storey**, MD, executive vice president of the American Academy of Hospice and Palliative Medicine. Storey suggests that the FDA consider a slower withdrawal of medications to enable manufacturers to provide a better supply of alternative medications.

For a copy of the warning letters to companies and the products affected go to: www.fda.gov/cder. Select the March 31 news item “FDA acts to halt marketing of unapproved narcotic medications,” then click on the link within the copy to go to the letters. ■

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