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IN THIS ISSUE

- Meeting needs of diverse populations cover
- Beware: Hospice had web site stolen 29
- Safety tips for workers in the home 30
- FDA approves pain drug . . . 31
- When should family be nudged toward comfort care only? 32
- Are kidney disease patients satisfied with medical decisions? 32
- Needlestick injuries increase 33
- Changes to Joint Commission survey agenda 33
- Advice on grieving 34
- **News Briefs:** Fake NHPCO invoices; Medicare fact sheet available; MedPAC recommendation criticized; honorees for end-of-life care 35-36

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Reaching varied cultural groups requires education of staff, community

Understand differences and language to expand services

Only one in five hospice patients in 2009 were non-Caucasian, according to the 2009 *NHPCO Facts and Figures: Hospice Care in America*¹ report issued by the National Hospice and Palliative Care Organization (NHPCO). This compares to U.S. Census data that show almost 25% of the U.S. Population as non-Caucasian.² Hospices are looking for ways to reach diverse cultures and races to increase the number of patients who benefit from hospice at the end of life.

"The major challenge to reaching people of different cultures is that each group has different beliefs regarding end-of-life care," says **Dale Knee**, MHCA, president and CEO of Covenant Hospice in Pensacola, FL. These different beliefs include the use of pain medication, he says. "Even among Caucasians, some religious beliefs do not allow the use of pain medication to the point that the patient is unaware of his or her surroundings," Knee says. One American Indian tribe in Knee's service area believes that the stoic acceptance of pain is part of maintaining

EXECUTIVE SUMMARY

Only 20% of hospice patients in 2009 were non-Caucasian. This represents an opportunity for hospices to expand their services to populations in their communities that don't typically choose hospice care for family members or themselves. The key to increasing acceptance of hospice is a two-pronged educational effort: staff and community.

- Be familiar with the different ways that cultures and religions view death and the role of family members in caring for a loved one.
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- Make sure that language is not a barrier by hiring multilingual staff members and using interpreter services in the community.

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one's dignity while facing death.

Respecting religious and cultural beliefs is a critical part of providing hospice care and requires ongoing staff education, he says. "We train all of our staff, including admissions and outreach education staff members, to be sensitive to different views so we don't unknowingly put up barriers or play on fears," Knee explains.

For example, the largest minority population in his hospice service area is African American. Because some African Americans are concerned about the disparity of health outcomes between their community and others, they often view a referral to hospice as the medical profession giving up on their family member, according to Duke University researchers.³ For this reason, reassure family members and patients of the benefits of hospice care such as better pain control, says Knee. "Explain that no one is giving up on

the patient; it is just a change in the methods of providing care," he says.

Cultural diversity training is required for all staff members, says Knee.

"They must complete the inservice training within 90 days of being hired, and they take refresher courses annually," he explains.

Courses can be taken through computer-based modules offered by the agency or by attending inservices at which speakers are invited, Knee says. "Fifteen years ago, we were bringing in a lot of speakers to talk about different cultural, religious, or ethnic groups, but today we rely more on the modules," he says. "When we hear from staff members that they are seeing patients that practice a religion we don't typically see or a cultural group that is new to the area, we find a member of that community who can present an inservice." **(For resources to reach different cultural groups, see resource box, p. 27.)**

Staff members at New Life Hospice in Elyria, OH, have two in-house experts to provide education related to the Latino community in their service area, says **Joan Hanson, RN, BSN**, director of the agency. A Latino nurse and aide not only serve as staff education experts, but they also conduct community outreach by speaking to Latino groups. **(See p. 28 for more about New Life's outreach efforts.)**

Outreach efforts at Covenant Hospice involve different cultures and are focused, says Knee. "We cover 35 counties that represent several different cultural populations," he says. The agency has developed a computer model that analyzes the number of patients from each zip code, says Knee. "When we see a drop in a zip code that represents a specific cultural group, we increase community education efforts in that area," he says.

The best way to reach out to the community is through organizations that are important to the group you are trying to reach, points out Knee. "Churches are very important in the African American community, so we not only offer presentations at churches, but we try to identify staff members or volunteers who attend the church to be part of the presentation," he says. "Churches and cultural centers are also important in the Vietnamese and Greek communities in our area."

In addition to cultural beliefs, language also can be a barrier to reaching patients for whom English is not a first language, admits Knee. A combination of staff members who speak different languages, interpreter services from a local university, and educational material printed in different languages

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- ☛ **Dale Knee**, MHCA, President and Chief Executive Officer, Covenant Hospice, 5041 N. 12th Ave., Pensacola, FL 32504. Phone: (850) 433-2155.

- **The Joint Commission offers tools and publications** to help health care organizations identify best practices to meet the needs of diverse patient populations. The publications include *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, a research report that includes a self-assessment tool that hospices can use to evaluate their diversity programs. To download a free copy of the report, go to www.jointcommission.org. On the top navigational bar, select the "patient safety" button, then select "hospitals, language and culture." Scroll down the page to the publication title.
- **The National Hospice and Palliative Care Organization offers to reach patients of different cultures** on its Caring Connections web site. Go to www.caringinfo.org, select "Are you reaching your community" and scroll down to "Diversity outreach." Presentation and publications, including patient education material, specific to African American, Latino, and Chinese communities are available for free download.
- **DiversityRX provides articles, descriptions of models and practices, and resources** such as learning groups and other networking opportunities that can help hospices build a diversity program. Go to www.diversityrx.org.

help the hospice staff communicate with patients, he points out. **(For more tips on how to overcome language barriers, see p. 29.)**

One of the trickiest parts of honoring patient and family cultural beliefs is to balance their beliefs, your staff assignments, and the avoidance of discrimination, Knee says. Some cultures are specific about whether or not a male can care for a female or vice versa, he says. "We identify these requests at admissions and try to accommodate the family's wishes," Knee says. "It is especially important to identify requests that differ due to culture regarding activities after death." **(For more information about post-death activities**

that might differ, see article, below.)

Communicate openly and honestly with staff members, and point out the need to honor the patient's wishes, Knee says. "We have to recognize that a patient's beliefs may not be the same as ours and adapt to the situation," he says. "After all, our primary goal is to provide the best end-of-life care for the patient and family, and that includes honoring their cultural or religious beliefs."

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Understand beliefs about death at admission

Plan to ensure respect for family's customs

When evaluating your hospice's ability to reach different segments of your community's population, don't forget that you must be able to meet their needs prior to and after death.

A key component of serving people of different cultures and religions that is not often discussed is the post-death care, says **Dale Knee**, MHCA, president and chief executive officer of Covenant Hospice in Pensacola, FL. Someone's religious or cultural customs regarding the care of the body following death are just as important as how they believe they should be cared for during life, he says.

"We identify these needs early in the admission process to make sure we are prepared to honor the patient's wishes," Knee reports. Customs that vary might involve care of the body before it is removed from the house, funeral arrangements, type of visitation, and timing of activities.

"Our hospice nurses always stay with the patient after death, until the funeral home arrives, but we make sure that we respect the wishes and beliefs of the family as much as possible," says Knee. Whether or not a nonfamily member can be present, or if the people present have to be a specific gender, is discussed up front, he says.

Sometimes the family's beliefs might exclude a

staff member or volunteer who has cared for the patient, but the staff members understand the family's reasons, says Knee. Because he and his staff know the family's wishes before the time of death, staff members have a chance to discuss the issues and find a way to resolve them to the benefit of the patient's family, he adds. For example, if the family's religious beliefs do not allow a male to help prepare a female patient for transport to the funeral home, the agency can ensure a female nurse is present at death, he explains. ■

Outreach program to Latino community

It takes several presentations to reach some

The staff at New Life Hospice in Elyria, OH, knew that reaching out to the Latino community would be beneficial to the hospice and the Latino population in the area, but the effort did not start out with a bang.

"If I had made the decision about the program's chance of success after my first presentation, it also would have been my last presentation," admits **Joe Ocasio**, RN, one of three Latino employees at the hospice. "The welcoming, smiling faces in the audience as his introduction began, quickly changed to somber faces when he identified himself as a hospice staff member, and there was little participation or questions during the talk," he says. Ocasio did not stop making presentations, and he has seen a slowly growing acceptance of hospice in the community over the past three years.

Although acceptance of the concept of hospice has not resulted in a significant increase in Latino admission to hospice, the program will continue, says **Joan Hanson**, RN, BSN, director of the agency. "We have a large Latino population in our community, and this program is an investment in the future," she reports. "As younger generations learn more about planning for end-of-life care, they will be more likely to choose hospice."

There is a difference in the way various generations of Latinos view end-of-life care, Ocasio says. "There is a great respect for older members of the family throughout all generations, and the belief is that you show your respect by caring for older, sick members of the family," he explains. "When we go into the home as outsiders, we have to be careful to involve family members in the care and emphasize

a group approach to care." By making sure the family knows that hospice staff members are there to assist them in the care of their loved one, letting them make decisions, and respecting their role as primary caregiver, hospice is seen as a valuable service, Ocasio says.

When the caregiving family members are single parents or two-career couples, they are more apt to seek the services of hospice to help care for their older family members, Ocasio points out. "The baby-boomers' values and traditions are more modern and they are more likely to use home health, hospice, and nursing homes to make sure family members get the best care," he says.

Ocasio admits that the smiles on everyone's face when he steps up to do his presentation still disappear when he says, "My name is Joe Ocasio, and I'm from New Life Hospice." He continues his talk by focusing on how hospice care can make their family members' days more comfortable. "I talk about relieving pain, treating shortness of breath, and alleviating constipation," Ocasio says. Because Latinos are family-centered, he talks about how hospice can keep the family members at home and out of hospitals.

The types of questions Ocasio hears during his presentation range from, "How do you control pain?" to "Whom do we call in the middle of the night?" The most often-asked question is, "How do doctors or hospice staff know when a patient has six months or less to live?" says Ocasio. "Their concern is that only God knows when someone will die," he explains. Because Latinos are often religious and Roman Catholic, Ocasio doesn't want to offend their beliefs. He often says, "I agree. No one is God." Ocasio then says doctors and nurses will see trends in the health of the patient that make them come to this decision, but they are wrong sometimes.

"We also make sure that our social workers and nurses educate family members about the signs once we are caring for the patient," Ocasio adds.

Presentations are made at churches and community group meetings in the Latino community, says Ocasio. Some attend because they have been told that a family member might be ready for hospice, but others simply might want to learn more about hospice, he says. "I see some of the same faces at different presentations, but they may not be ready to hear what I'm saying until the third or fourth time," he says. It is for this reason that Ocasio says he'll "continue doing the presentations, even if he doesn't get a positive response from the audience at each one." ■

Don't let language discourage use of hospice

Multilingual staff, interpreters bridge the gap

One of the most important parts of a hospice staff member's or volunteer's job is to make sure that patients and family members understand what is being done to provide comfort and how they can be part of the process. It is not an easy process, but when the family and patient speak a different language, it can be a significant challenge.

"We do have access to interpreter services in our community, but we are fortunate to have Spanish-speaking staff members as well," says **Joan Hanson, RN, BSN**, director of New Life Hospice in Elyria, OH. "When we admit a Spanish-speaking patient, we try to assign a nurse and aide that speak Spanish," Hanson says.

There also is a group of six to eight volunteers at New Life Hospice who speak Spanish, she says. The agency's volunteer coordinator speaks Spanish as a second language, and she has made presentations to Latino groups to recruit volunteers.

Dale Knee, MHCA, president and chief executive officer of Covenant Hospice in Pensacola, FL, says, "We try to hire bilingual staff members, but 60% to 70% of our patients live in very rural areas, and it is hard to find bilingual staff in those areas." Covenant Hospice keeps a computerized list of all staff members and community interpreters who can interpret over the phone and makes that list accessible to all staff members. "We are fortunate that a local university has a Japanese program with professors willing to interpret for us," he says. Professors in other language programs also are interpreters for the hospice.

In addition to finding someone who can speak with patients and family members, provide written patient education material in different languages, says Hanson. "We have all of our patient education material in Spanish as well as English," she says.

It might be impossible to develop print materials for every language you may encounter, so choose the populations you most often serve, suggests Knee. "We have a large Vietnamese population due to the fishing industry, and our Spanish-speaking population is growing, so we offer materials in those two languages." ■

Is your web site being used in a fraud scheme?

Potential victim alerts hospice

A hospice's web site is a valuable tool to inform the public, encourage referrals, and attract job seekers. But, what happens when your web site content has been used to create a fraudulent site to steal personal financial information from potential job seekers?

"We knew nothing about the web site until we got a call from someone who saw an ad on Craig's List for a job with our agency," says **Marykay Morelli**, community relations director for Community Home Health and Hospice in Longview, WA. "She called and asked if our agency was for real," she says with a laugh.

After talking with the caller, it became apparent that the web site content had been copied into a web site for a "dummy" agency. "Our name, address, and phone number were not used, but everything else, including staff member names and photos, were on the other site," says Morelli. The caller was able to locate Community Home

Health and Hospice by performing a search using some of the staff members' names, she explains.

"After the initial call, we found the web site, contacted the web site host, and requested that the site be taken down and that we be given documentation that the site no longer existed," says Morelli. (See resource box on procedure to find web site host, p. 30.) Morelli also filed a report with the Internet Crime Complaint Center (www.ic3.gov), as well as state and local authorities. Although state and local authorities took the report, they admitted that they receive thousands of complaints each year and can't do much about them, says Morelli. Even so, you still should file a report to protect the agency from any potential liability, she adds.

A second call from another potential job applicant came after the first site was taken down, says Morelli. "A second web site had appeared, with all of our information," she says. The same process to take down the site and file reports was followed for the second reported site, she says.

The agency also has placed information in local and surrounding media to make sure that people know about the fraud, says Morelli. "We make it clear that we never ask for financial information such as credit card account numbers on

Need More Information?

For more information about fraudulent web sites, contact:

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- **Whois.Net** is a domain-based research service that can give you the registration information for web sites. Go to www.whois.net and type in the domain name to identify the site registrar.

our job applications or through our web site," she says.

Now, Morelli and her staff have a new job: monitoring the Internet for more sites using their information. "On a weekly basis we do an Internet search," she explains. "One of our staff members has an unusual name, so we use it to search for our web site material," Morelli says.

"Unfortunately, this is something that can easily happen to anyone," she says. It just takes a few minutes to copy a company's web site, make minor changes, and go into business, Morelli says. "You can encrypt your web site content, but that limits access, and we don't want to limit access to our community members," she says. "We'll just continue monitoring the Internet and taking down the sites when we find them." ■

'Safety comes first' should be more than slogan

Protect workers, boost retention and patient care

Imagine showing up at your workplace and having to run full speed back to your car to escape being mauled by a dog, or arriving at work only to be greeted at the door by a gun pointed at your face.

Two clients of attorney **Robert Markette**, JD, did not have to imagine either of these hazardous situations because they experienced them. "Luckily, the nurse was able to outrun the dog, and the home health aide was able to back away from the patient's door and get to her car," says Markette, with Gilliland & Markette in Indianapolis. "But

both of these situations demonstrate the unique employee safety challenges faced by home health agencies."

Needlesticks, falls on slippery floors, and injuries from lifting patients are hazards faced by health care workers in all settings. Hospitals, nursing homes, and other health care facilities control the safety of the workplace with processes and resources that employees can easily access.

Take the hazards faced by facility-based nurses and aides and add family violence, working in isolation, traveling in high-crime areas at night, aggressive pets, and unsanitary environments, and you have a good picture of the challenges faced by home health managers who want to ensure a safe workplace.

Workplace safety for home health differs from workplace safety in other health care settings, admits **Robyn R.M. Gershon**, MSN, DrPH, associate dean of research resources and professor at the Mailman School of Public Health at Columbia University in New York City. "The workplace for home health nurses and aides is the patient's household, which is not regulated by anyone," she says. This location puts home care staff members at higher risk for hazards than other health care workers, Gershon notes.

Unsafe household conditions reported by 738 registered nurses who participated in a 2008 survey included animal hair (74% of respondents), cigarette smoke (72%), excessive dust (58%), vermin (44%), and unsanitary conditions (43%). The threat of violence also was reported frequently, says Gershon, one of the study authors.¹ When home health aides are surveyed, their concerns focus more on violence in the house and neighborhood, drug use in the home, guns in the home, or aggressive pets. "Aides are also in the homes for longer periods of time, up to 12 hours at a time, so they are exposed to more interaction with family, neighbors, and friends," she says. "Aides in urban areas are frequently using mass transit late at night and walking through areas that might not be safe."

Although ensuring employees' safety is a challenge in home health, take every step possible to do so, says Gershon. "Studies have shown that employee safety is directly correlated to employee injuries, adverse medical events, and to employee job satisfaction and retention," she says. "Other studies have also shown a correlation between the safety of the home health employee and the quality of patient care."

It's not surprising to learn that patient care can suffer if an employee does not feel safe, Gershon

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says. "A nurse or aide who feels threatened in a home might cut a visit short, skip a visit, or choose not to perform some tasks that agitate a patient or family member," she explains.

The first step to take to ensure employee safety is to develop clear policies regarding employee safety and make sure all employees are aware of the importance management places on employee safety, Markette suggests.

"Employees should know whom they should contact about unsafe conditions at a patient's home," he says. Be sure employees understand that they don't have to wait until there is violence or an accident or injury. "In every case in which an employee or patient is harmed, there were warning signs," Markette adds. This means that any concern expressed by an employee must be taken seriously, he points out. "Have a process in place to receive the complaint, investigate the complaint, and communicate your decision regarding action needed to address the complaint," he says. "It is important that every concern expressed by an employee be investigated, even if the supervisor doesn't see it as an issue."

Once you have a policy and process in place, educate staff, suggests **Norma R. Anderson**, RN, MSN, CNL, DNP(c), nurse educator, University of San Francisco School of Nursing and author of "Safe in the City," a study of workplace danger in home health.² "Preventing injuries to workers through yearly safety training and daily reminders about safety is important," she says. "Employees

need to feel valued and know that safety is of utmost importance."

Ongoing education and incorporation of safety discussions into team meetings and conversations between supervisors and employees is one way to create a culture of safety, Anderson adds.

Part of the education about employee safety is to emphasize the need for employees to stay alert and tuned into their instincts about different situations. "Clinicians who feel 'invincible' or blind to the potential risks can be a danger to themselves," Anderson points out.

RNs are more likely to report concerns about safety, Gershon says. "A nurse will not hesitate to tell a supervisor that she needs a sharps container in the home or that she wants a safety needle to use," she says. "Aides are less likely to report concerns, because they may believe the complaint will put their job at risk." Also, because aides spend longer periods of time with the patient and family, the aide might become so accustomed to the environment that he or she doesn't recognize risk, Gershon says. "It's important that aides maintain their awareness of potential dangers, so they don't find themselves in a hazardous situation," she says.

Part of safety training should include discussions of the importance of being aware and tools that can help in dangerous situations, says Gershon. Escape plans, lists of agency personnel who can be contacted for assistance, and cell phones are a few tools nurses and aides should have. "I'm a big believer in making sure that all aides have cell phones, even if the agency has to provide prepaid phones for them to use in an emergency."

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Morphine sulfate solution receives FDA approval

Manufacturer ensures product availability

The U.S. Food and Drug Administration (FDA) approved morphine sulfate oral solution for the relief of moderate to severe, acute, and

chronic pain in opioid-tolerant patients. This medicine will be available in 100 mg per 5 mL or 20 mg per 1 mL.

Oral morphine is commonly used in hospice care for patients who are unable to swallow tablets. In early 2009, the FDA issued a ban on the use of many pain control drugs that were being used for nonapproved purposes. Oral morphine initially was banned from use as a pain control medication for hospice patients and then excluded it from the ban in March 2009. At that time the FDA allowed continued use of the oral solution until at least one manufacturer filed the necessary documentation to request FDA approval for use of the drug to relieve moderate to severe, acute, and chronic pain. (See “Action from FDA results in some drug shortages,” *Hospice Management Advisor*, August 2009, p. 85.)

This morphine sulfate oral solution is the only FDA-approved one available at this concentration. As part of the unapproved drugs initiative, the FDA has worked with the manufacturer of the now-approved product, Roxane Laboratories (Columbus, OH) to ensure that there is enough drug available for patients. ■

Discussion of rationing end-of-life care

Acknowledging that the idea of rationing health care, particularly at the end of life, might incite too much anger to gather much rational consideration, a Johns Hopkins emeritus professor of neurology called for the start of a discussion anyway, with an opinion piece featured in January issue of the *Journal of Medical Ethics*.

In the article, **John Freeman, MD**, Lederer professor emeritus of pediatric neurology and a faculty member of the Johns Hopkins Berman Institute of Bioethics, asks the Obama administration to consider rationing end-of-life care as an initial step toward health care reform.

The piece, “Rights, Respect for Dignity and End-Of-Life Care: Time for a Change in the Concept of Informed Consent,” starts with the premise that futile and expensive care at the end of life is widespread. It also starts with the premise that it has been a major contributor to the increasingly unaffordable cost of health care and that the nation is

unable to provide it equitably to all.

Freeman goes on to say that while administering such care — as ordered through a living will, next of kin, or parent — should be respected, he advocates that the ethical imperatives of “patient autonomy” and “surrogate autonomy” (passing responsibility for decision making to next of kin when a patient no longer is competent to make his own decisions) should be weighed against the societal impact and costs of such care in futile circumstances. “Perhaps when surrogate autonomy and the ethical principles of beneficence” — the duty to do more good than harm — “compete with the utilitarian principle of doing the greatest good for society, the family be given a ‘nudge’ towards comfort care only,” he suggests in the piece.

“There must be few situations more undignified, more dehumanizing or more humiliating than lying in bed, incontinent, tube fed, with or without a respirator, unable to speak or to relate to individuals or the environment,” Freeman says. These are factors that more surrogates might want to give more weight, he says.

Rationing and providing only comfort care should be considered not just at the end of life for adults, Freeman maintains, but also in instances of extremely premature births. He cites studies showing that intensive care for infants born at 22-23 weeks resulted in more than 1,700 extra days in intensive care, with less than 20% surviving. Of those 20%, less than 3% survived without profound impairment that required expensive interventions. ■

End-of-life care falls short for kidney disease patients

Patients with advanced chronic kidney disease (CKD) often don’t receive adequate end-of-life care and are unhappy with the medical decisions made as their conditions worsen, according to a study appearing in the *Clinical Journal of the American Society Nephrology (CJASN)*. The findings indicate that end-of-life care should be improved to meet the needs of CKD patients.

Although many CKD patients die prematurely, surprisingly little research has been done to study CKD patients’ preferences for end-of-life care and how those preferences align with the care they receive. **Sara Davison, MD, FRCP(C)**, assistant professor, Division of Nephrology at the

University of Alberta, Canada, surveyed 584 late-stage CKD patients as they came to dialysis, transplant, or pre-dialysis clinics in a Canadian, university-based kidney program between January and April 2008.

Patients reported that they would like their kidney care team to help them plan for the future in case they become incompetent to make decisions. If seriously ill, patients indicated interest in receiving help with managing pain and other symptoms and psychosocial and spiritual support. These services were not routinely integrated into their kidney-related care. Patients often were unaware of palliative care options and of the status and progression of their illness. Of the patients studied, 61% regretted starting dialysis and noted that the decision to start the treatment reflected physicians' and family members' preferences rather than their own personal choice.

While the vast majority of dialysis patients die in hospitals, more patients in this survey wanted to die at home (36.1%) or in a hospice facility (28.8%) than in a hospital (27.4%). Less than 10% of patients reported having discussed end-of-life care issues with their kidney specialists in the past year.

"This study helps us identify gaps between current end-of-life care practice and patients' preferences and will hopefully help prioritize and guide future innovation in renal end-of-life care policy," wrote Davison.

Davison noted that study limitations included the study being single-centered with predominantly white patients and that the answers were provided in response to a questionnaire, which made it difficult to interpret patients' understanding of the questions.

An editorial was published in the same issue of *CJASN* by **Daniel Cukor**, PhD, The State University of New York, and **Paul Kimmel**, MD, FACP, senior scientific officer, National Institute of Diabetes Digestive and Kidney Diseases. Cukor and Kimmel noted that while more detailed studies are needed to provide clearer pictures of CKD patients' needs regarding end-of-life care, Davison's findings serve as a call to kidney care teams to inquire more about patients' preferences. "While we labor to increase the quantity of life for our patients, we must be cognizant of its quality as well," they wrote. Within the editorial, the doctors also emphasized the role of patient and provider education regarding these issues in the future.

The article, titled "End-of-life care preferences and needs: perceptions of patients with chronic kidney disease" (doi 10.2215/CJN.05960809) and

the editorial, titled "Education and end-of-life in chronic kidney disease: disparities in black and white" (doi 10.2215/CJN.09271209) are online at cjasn.asnjournals.org. ■

Needlesticks increase with stressful environment

As sicker, more complex patients are increasingly cared for by home health nurses, the risk for needlestick injuries also increases. In a recent study, researchers identified the rate of needlestick-type injuries to be 7.6 per 100 nurses. At this rate, researchers estimate that there are nearly 10,000 needlestick injuries each year in home care.¹

More than 700 home health nurses in the state of New York participated in the study that looked at needlestick injuries that occurred in the previous three years. Fourteen percent of the RNs reported one or more needlestick injuries, but 45.8% of these injuries were not formally reported. Factors contributing to the injuries include a lack of compliance with standard precautions, recapping of needles, exposure to household stressors, exposure to violence, mandatory overtime, and safety climate.

A critical finding of this study was the statistical correlation between needlesticks and exposure to stressful conditions in the patients' household. Nurses reporting household stressors, such as cigarette smoke, unsanitary conditions, air pollution, and vermin, were nearly twice as likely to report needlestick injuries. Most significant was the fact that home health care nurses exposed to violence in their patients' households were nearly 3½ times more likely to also report needlestick injuries, according to the study.

Reference

1. Gershon RRM, Pearson JM, Sherman MF, et al. The prevalence and risk factors for percutaneous injuries in registered nurses in the home health care sector. *Am J Inf Control* 2009; 37:525-533. ■

Joint Commission changes survey agenda process

The Joint Commission has implemented a more collaborative process for developing the

survey agenda. The Joint Commission will inform providers before their survey about the on-site survey length and number of surveyors. Also, the organization can work with surveyors during the survey to determine the best timing for various survey activities.

The new process will be more sensitive to the time demands of health care organizations and their staffs during the on-site survey. All accreditation customers due for survey this year will experience this revised agenda process. The new process does not affect certification reviews.

The Joint Commission will send an e-mail to the organization to confirm the programs to be surveyed and to direct the organization to its Joint Commission Connect extranet page for a list of survey activities for each accreditation program. The list is a planning tool that can be used with the *2010 Survey Activity Guide for Health Care Organizations*. The Joint Commission also will provide a program-specific document list that identifies initial materials surveyors will request at the onset of the survey.

Shortly after an organization receives its e-mail, it will receive a phone call from its

account executive to confirm that it has reviewed and understands the information on its extranet site. At this time, the account executive will provide the anticipated number of days and number of surveyors that will be assigned to the survey.

On the first day of the survey, surveyors will work with the organization to confirm that the schedule considers the organization's operations and needs. During the survey, organizations will work with surveyors to determine the best time for scheduling survey activities so they coincide more effectively with patient care and administrative operations. The Joint Commission notes that survey activities are *not* changing.

The *2010 Survey Activity Guide for Health Care* is available on The Joint Commission web site (www.jointcommission.org). The guide provides information for all accreditation programs about how to prepare for the on-site survey, including:

- ways to facilitate the on-site survey process;
- logistical needs for the on-site survey;
- materials that surveyors will need while on-site;
- on-site survey activities. ■

Working through grief differs for every person

A death of a loved one, a job loss, the end of a marriage, an illness or disability. Everyone faces losses and grief, but the toll that grief can take on the mind and body can catch many people by surprise.

In years past, grief often was described as following a certain pattern or orderly progression from one feeling to another, according to a recent issue of the *Mayo Clinic Women's HealthSource*.¹ But there is no one way to grieve. People who are grieving experience many different emotions in any number of combinations. They might include denial, sadness, anger, confusion, despair, and even guilt. Physical reactions can include sleeping problems, changes in appetite, a drop in energy level, body aches and pain, or the development or worsening of an illness.

Time spent grieving varies, too. Some people take months to fully accept or adapt to a loss. For others, the process may take years. To help cope with grief, people can:

- **Express feelings.**

Suppressing thoughts and emotions might prevent working through grief. Friends, family, or

members of the religious community often can be a source of support and comfort. Other options are support groups or grief counselors.

- **Delay any major decisions or changes.**

Decisions that affect life and lifestyle, such as housing changes or new ways of handling finances, should wait a while. Advice from a trusted family member or friend, financial adviser, or attorney might be helpful.

- **Take care of personal health.**

Eating right, getting adequate sleep, and limiting alcohol are important. Regular exercise can relieve stress and anxiety.

- **Be patient.**

Expecting to simply "get over" grief is unrealistic. Ups and downs might last for weeks or months following a loss. Though some feelings of loss might never fully go away, the most intense signs and symptoms of grief typically diminish over time, within six months or so. Grief that is prolonged and debilitating might be a sign of depression or post-traumatic stress disorder. A doctor should be consulted for treatment options.

Reference

1. Mayo Clinic. Coping with loss — a look at grief and the grieving process. *Mayo Clinic Wom HealthSource* 2009; 13:1-2. ■



NHPCO members receive fraudulent invoices

The National Hospice and Palliative Care Organization (NHPCO), Alexandria, VA, has issued an alert warning members that fraudulent NHPCO membership dues invoices have been faxed to some members.

The faxed dues invoice was from an organization called the National Home Care and Hospice Palliative Care Association for 2010 annual dues of \$475. The payment address has a Massachusetts address. These faxed invoices are similar to ones sent to hospice providers in fall 2009.

NHPCO's alert states that the organization does not fax renewal notices. The NHPCO renewal notices were mailed to members in fall 2009. NHPCO is investigating the source of the faxes. Any NHPCO member with questions about an invoice should contact NHPCO by phone at (800) 646-6460 or e-mail MemberService@nhpco.org. ▼

Payment fact sheet available from CMS

The revised *Hospice Payment System Fact Sheet* is available in print format from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network.

The free fact sheet provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and additional reporting required

on hospice claims.

To place your order, login and visit www.cms.hhs.gov/MLNGenInfo, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." Scroll down to "Medicare Payment Policy" and select "Hospice Payment System Fact Sheet (ICN# 6817)(Nov 2009) (Fact Sheet)." ▼

NHPCO objects to MedPAC projections

The National Hospice and Palliative Care Organization (NHPCO) urged the Medicare Payment Advisory Commission (MedPAC) to adjust the community's 2010 projected profit margins from 4.6% to 2.6% to more accurately reflect hospice's unique, mandatory program costs of volunteer and bereavement services.

The hospice benefit includes all care related to the terminal illness and requires programs to provide up to 13 months of bereavement services to the families and loved ones of the beneficiary after he or she dies. In addition, the Medicare hospice benefit requires that trained volunteers provide at least 5% of the patient care hours. These services are mandatory as detailed in the hospice conditions of participation, and these requirements are unique to the hospice benefit.

"While other providers also may establish volunteer programs, and perhaps the cost of those programs are considered nonreimbursable costs on the Medicare cost report, we know of no other provider that is federally required to establish and maintain a volunteer program and to track and document the cost savings achieved," says NHPCO vice president of public policy **Jonathan Keyserling, JD**. "The costs of both volunteer and bereavement services must be included in the margin computation. Any other approach would ignore the financial reality of hospice programs bearing these mandatory costs."

MedPAC staff projected hospice margins of 4.6% for 2010. NHPCO contends this figure

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overstates the actual margin being experienced by most hospice programs. "The MedPAC staff previously noted that they estimated bereavement costs to be about 1.5%. Another cost for every hospice program is the cost of administering and tracking volunteer services, but these also are not considered in margin calculations. We estimate that the cost of volunteer services would be 0.5%. Therefore, the "true" margins of hospice programs, providing the range of required services under Medicare, would then be 4.6% minus 1.5% minus 0.5%, yielding a real margin of 2.6%," says Keyserling.

The 2008 MedPAC projection for hospice margins was 3.4%. NHPACO argues that a 4.6% projection for 2010 indicates, mistakenly, that hospice margins are growing, adds Keyserling. ▼

Physicians honored for end-of-life care

A surgeon and a pediatrician are among the four American physicians who have been named recipients of the first Hastings Center Cunniff-Dixon Physician Awards.

The awards were given by the Cunniff-Dixon Foundation, whose mission is to enrich the doctor-patient relationship at the end of life, in partnership with The Hastings Center in Garrison, NY.

Robert A. Milch, MD, FACS, of The Center for Hospice and Palliative Care, near Buffalo, NY, will receive the established physician award of \$50,000. He has been involved with hospice and palliative care for more than 30 years, most of it at Hospice Buffalo, where he initially served as a volunteer medical director.

Early career physician awards of \$15,000 each will be given to Jeffrey N. Stoneberg, DO, of San Diego Hospice and The Institute for Palliative Medicine; Elisabeth Potts Dellon, MD, MPH, of the University of North Carolina; and Eytan Szmuiłowicz, MD, of Northwestern Medical Center in Chicago.

The Cunniff-Dixon Foundation was founded in 2005 by Matthew A. Baxter in memory of his wife, Carley Cunniff, who died of breast cancer, and her attending physician, Peter S. Dixon, MD, who has a private practice in Essex, CT. "He was the guiding light who enabled her to die a peaceful death at home with her family and loved ones," said Baxter in a statement. ■

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