

HOSPICE Management Advisor™

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Face-to-face encounters with patients now required for recertification

Challenges include timing and physician coverage

Reviewing patient data, finding physician coverage and educating staff are some of the activities undertaken by hospices since the Patient Protection and Affordable Care Act mandated the requirement that hospices have a physician see a patient in a “face-to-face encounter” before their 180-day recertification and for each 60-day recertification. Although there was not enough time to include the final provision in the Hospice Wage Index for Fiscal Year 2011, the final details of the requirement were included in the Home Health Agency Prospective Payment System rules released in early November.

“Medicare hospice certification is now a process that includes several distinct components such as the physician’s face-to-face encounter, attestations, and narratives,” says **Judi Lund Person, MPH**, vice president, compliance and regulatory leadership at the National Hospice and Palliative Care Organization. “Even though the details were not final until November, hospices knew about the regulation and have been prepar-

EXECUTIVE SUMMARY

As of Jan. 1, 2011, a physician who has conducted a face-to-face visit with the patient must certify hospice patients entering their third or subsequent benefit period eligible for hospice care. The new requirement focuses on recertification as a process with several components that include the face-to-face encounter, physician narrative, and attestations to the validity of documentation.

- Rural hospices or hospices with large numbers of long stay patients will face challenges in finding physicians to cover the visits.
- Nurse practitioners employed by the hospice can conduct the face-to-face visit and attest to providing the certifying physician with the information required for recertification.
- The face-to-face encounter can occur no more than 30 days prior to the beginning of the third or subsequent benefit period, and the certification must be dated no earlier than 15 days prior to the beginning of the benefit period.



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ing for the January 2011 implementation,” she explains. (For details on required components, see p. 3.)

Face-to-face encounters for recertification are not new to hospice, but the requirement for physician involvement is a significant change, points out Lund Person. Rather than relying upon nursing notes, results of labs, and review of medical records, physicians now must see and talk with the patient themselves or with the assistance of a nurse practitioner, she says.

“The face-to-face encounter gives physicians a chance to lay eyes on the patient and make sure the patient has a chance to ask questions and indicate wishes,” Lund Person adds. “It’s important that the physician know what the patient does want and doesn’t want for future care.”

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Editorial Questions
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How well hospices can handle the extra burden of physician or nurse practitioner face-to-face encounters for all patients entering their third or subsequent benefit period depends upon a range of factors, says Lund Person. “The physician visit is not reimbursed separately; it is included in the hospice per diem rate,” she says. “However, if during the encounter the physician provides a clinical service such as an assessment of symptoms and a change in the care plan to prescribe different medication to control pain or symptoms, the physician service can be billed to Medicare by the hospice.”

Hospice managers should be careful to make sure that every encounter does not become a symptom management or billable visit, Lund Person warns. “Many providers with whom I’ve talked estimate that only about 10% of the face-to-face encounters will include a billable service,” she adds.

Lund Person believes the face-to-face requirement will be most challenging for:

- small, rural hospices in areas that do not have a large number of physicians to cover hospice patients;
- hospices with large numbers of long-stay patients;
- hospices in areas in which patients move from hospice to hospice for care.

Rural hospices face challenges

Hospice Services in Phillipsburg, KS, is a prime example of a rural hospice. “Our service area covers 12,000 square miles with a population of less than 60,000 people,” says **Sandy Kuhlman**, executive director of the hospice.

Fourteen employees along with temporary help as needed see an average of 28 patients per day, which means a lot of time on the road, Kuhlman points out.

“Even before the face-to-face encounter required a physician, the role of our medical director increased with the Conditions of Participation,” she says. “He has agreed to fulfill the requirements of the face-to-face encounters for recertifications, but our plan is also to hire a nurse practitioner to make the visits that he cannot make. The real concern for rural hospices is that many rural areas are underserved by physician, nurse practitioners, and physician assistants already, and increasing hospice visits for recertification will further reduce the number of hours they are in their offices or clinics.”

SOURCES

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The medical director for hospice services does have two partners in his private practice, so his private patients still can be seen, but it impacts the physicians' practice because one of them can't take call or see patients when he is on the road and out of his office or clinic, she says.

Initial wording for the face-to-face encounter called for encounters and certifications to take place no earlier than 15 days prior to the beginning of the new benefit period, which would have created a scheduling problem for many hospices, says Kuhlman. "Now, the encounter can occur up to 30 days before the start of the next benefit period, with the actual recertification taking place no earlier than 15 days before the start of the next benefit period," she points out. "The extra two weeks helps the physician schedule the visits." (See p. 4 for other steps the hospice has taken to meet new requirements.)

The preparation for the face-to-face encounters has required time, along with new financial obligations such as increased amount of contract time for medical director and a new nurse practitioner position for the hospice, Kuhlman says. However, once the process is in place, it will not be overly burdensome for her hospice, she says. "The first thing I did was collect data on our patients to see how many patients represent a need for recertification," she says. "For most hospices, one-third of patients receive care for fewer than seven days, and one-half of hospice patients receive care for less than three weeks."

Even if your hospice has a high number of patients who receive care for more than 180 days, the face-to-face encounter can be a positive, Kuhlman says. "It gives us another chance to take a

close look, from a physician's perspective, at the care we are providing to make sure we are providing the best care possible," she says. ■

Requirements for face-to-face encounter

All components needed for compliance

Effective compliance with the requirements of the face-to-face encounter now in place for certifications of patients receiving the hospice benefit requires attention to proper documentation of the visit.

"Although the physician or nurse practitioner may conduct a physical assessment at the time of the encounter, it is not required," points out **Judi Lund Person**, MPH, vice president of compliance and regulatory leadership at the National Hospice and Palliative Care Organization. In addition to the face-to-face encounter required for recertification after 180 days of care, there are also specific requirements for certification of patients in their first and second benefit periods of care, Lund Person says.

"Although the physician or nurse practitioner may conduct a physical assessment at the time of the encounter, it is not required."

In all instances, a physician must perform the actual certification, even if the encounter is performed by a nurse practitioner who provides information to the physician, she adds.

Medicare Hospice Certification is now to be considered a process consisting of several distinct components, Lund Person points out. The following components may be combined on one page or across several pages as addendums to the actual certification page, but they must be independently present and clearly labeled.

The components for Medicare hospice patients in their first or second benefit period include:

- If a new hospice admission: A signed and dated certification by the attending physician, if there is an attending separate from the hospice physician.
- A physician narrative that provides a brief narrative explanation of the clinical findings that support a life expectancy of six months or less. This section must be composed by the physician and should reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.
- Signed and dated narrative attestation that

states, “By signing by signature, I attest that I composed the above narrative based on my review of the medical record or, if applicable, my examination of the patient.” This attestation should appear above the signature.

- Hospice physician’s signature and date for the certification.

For Medicare hospice patients entering their third or subsequent benefit periods, the previous requirements are needed along with:

- If a new admission to the current hospice: A signed and dated certification by the attending physician, if there is an attending separate from the hospice physician.

- Face-to-face encounter documentation.
- Signed and dated face-to-face encounter attestation that states that the hospice physician or nurse practitioner performed the face-to-face encounter. The attestation should include the date of the encounter. The attestation does not have to be dated the same date as the encounter.

If the face-to-face encounter was performed by a nurse practitioner, he or she must also attest that the information collected during the encounter was provided to the certifying physician.

- Physician narrative similar to narrative required for first two benefit period certifications.

- Signed and dated narrative attestation such as attestation required for first two benefit period certifications.

- Hospice physician’s signature and date for the certification.

Other certification documentation considerations:

- The signing physician should date his or her own signature. If this is forgotten, evidence that the certification occurred on the specific date may be obtained using a notarized statement or other documentation acceptable to CMS or the Medicare administrative contractor.

- Dictated and transcribed encounter notes and narratives are permissible, though evidence may be requested to ensure that the physician composed the narrative himself or herself.

- Electronic or digital signatures and dates are permissible, as long as these comply with other CMS requirements for such signatures.¹

REFERENCE

1. American Academy of Hospice and Palliative Medicine. *AAHPM Guide to Face-to-Face Encounters*. Glenview, IL; 2010. Web: <http://www.aahpm.org/news/default/news6.html>. ■

Notify patients of face-to-face visits

Alleviate concerns with info, familiar face

The most important steps for a hospice manager to take to be sure hospice patients entering their third and subsequent benefit periods is to expand or initiate new contracts with physicians to provide coverage for the face-to-face encounters, says **Sandy Kuhlman**, executive director of Hospice Services in Phillipsburg, KS.

After you’ve made sure you have physician coverage, there are a number of other steps a hospice manager should take to ensure compliance and to prepare patients for the visits, points out Kuhlman.

“We developed a notification process that includes a letter hand-delivered by the patient’s nurse to the patient and family that explains the physician’s upcoming visit,” says Kuhlman.

Information about cuts in services during the healthcare reform debate might cause some patients and families to view the visit as an effort to end services, she points out. “These families are already in crisis, so we need to reassure them that the physician visit is part of our effort to provide excellent care and to evaluate the care we’re providing,” Kuhlman says.

At her hospice, the physician or nurse practitioner will be accompanied by a staff member who regularly cares for the patient so there is a familiar face for the patient and family, Kuhlman adds.

The trickiest part of meeting the requirements will be setting the schedule so no one is missed, says **Judi Lund Person**, MPH, vice president of compliance and regulatory leadership at the National Hospice and Palliative Care Organization. Patients who have been with one hospice since their start of care should not pose great problems to track, but in areas with multiple hospices and patients who move from hospice to hospice, there is the additional challenge of determining how many days the patient has already received hospice care, Lund Person says. “The face-to-face encounter must occur prior to the start of the third or subsequent 60-day benefit period, regardless of which hospice provided the care,” she says. This requirement means a patient who received hospice care for the first 90-day benefit period from one hospice, then switched to a second hospice for the second 90-day benefit period, must be recertified with a face-to-face encounter prior to the start of

the next benefit period, Lund Person says.

“You cannot count 180 days from the start of care within your hospice; it is 180 days from the start of care for any hospice,” she explains. “Hospices will have to be diligent when they admit new patients. Although the Medicare Common Working File (CWF) contains all of the beneficiaries’ information about past care, the nine databases that contain information do not “talk” to each other, points out Lund Person. “This means that up to nine different databases may need to be checked to ensure that the patient has not received hospice care somewhere else prior to admission to your hospice,” she says. “This could extend the admission process for some hospices that experience a high number of admissions at one time without the staff to handle researching prior admissions.”

Kuhlman says, “We would typically conduct database searches about four days a week, but to do a thorough search and quickly identify whether or not a patient has received previous hospice care, we will probably conduct the searches every day.”

More importantly, an additional staff person has been trained to conduct the searches of the CWF to make sure no time is lost if the primary staff person is on vacation or out sick, she adds.

Once a patient is admitted and the clock starts ticking toward the recertification period, be sure you have a system to alert you to the need to schedule a face-to-face encounter, suggests Kuhlman. “We use an electronic records system that will generate a report showing when recertifications are due,” she says. “One staff person is designated as the monitor of these reports to start the process early.”

Although the face-to-face encounter cannot occur more than 30 days prior to the start of the next benefit period, the patient’s record can be flagged and a visit can be scheduled for the correct timeframe, she says. ■

Education, recognition, support boost retention

Programs increase job satisfaction

[Editor’s note: This is the second of a two-part series that examines strategies for employee retention. Last month we looked at the importance of patient satisfaction surveys and exit interviews. This month, we look at specific programs that enhance retention.]

Being named one of Modern Healthcare’s Best Places to Work in 2010 was quite an honor for Rainbow Hospice and Palliative Care in Park Ridge, IL, but the most incredible part of the story is that the employee surveys that resulted in the honor were completed during a year that included a reduction in force, frozen salaries, and increased workloads.

“I was amazed that 87% of our employees responded to the survey and responded positively,” says Pat Ahern, chief executive officer of the hospice. “We are in a very competitive market, with 32 hospices in our county, and we don’t pay the highest salaries in the area.”

The high level of employee satisfaction can be attributed to several initiatives put into place at the hospice, she says.

The first step is to hire well by making sure people not only have the experience and skills necessary for the job, but that they also have the emotional and social strength to handle the job, Ahern says. This strength is especially necessary for non-professional staff who might have to answer a call from a crying woman whose husband just died, for example, she points out. After ensuring that you’ve hired the best people possible, the hospice offers the following suggested programs:

- **Employee Assistance Program (EAP).**

“We contract with a psychologist to provide counseling and support to our employees who may need help dealing with grief, stress, and concerns about their job,” says Ahern.

Although hospice social workers and managers or supervisors are available and willing to talk with employees about these issues, the “outside” person provides a safe environment for people who may be unwilling to discuss some issues with people at work, she explains.

- **Leadership development programs.**

In addition to typical inservice programs that enhance skills needed for specific jobs, the hospice also provides programs to help supervisors, service leaders, and managers enhance the skills they need to manage employees, says Ahern. “The initial class for people in any type of leadership position provides guidance on how to lead during times of change and other general management skills,” she says. “We also provide information on to conduct a performance appraisal including how to work with employees so the appraisal does not contain any negative surprises for the employee.”

Another program is geared toward potential future leaders, says Ahern. “This is our version

of succession planning,” she says. “We want to identify these people early and let them know that we see potential advancement for them within our hospice.”

Although the purpose of this program is to keep good, potential leaders in the agency, it doesn't always work, Ahern admits. “Sometimes we can't keep them because other opportunities open up for them in other hospices before we have something, but it does improve morale among all employees because the program is proof that we want our employees to succeed,” she says.

- **Tuition reimbursement.**

In addition to offering in-house educational programs, the hospice reimburses tuition for full-time employees who are working toward an academic degree that is relevant to their position within the hospice, says Ahern. “For example, we have a nursing aide who is attending nursing school and a vice president who is pursuing an MBA,” she says.

Providing educational opportunities is an important part of making employees feel valued and appreciated, points out **John Edson, RN, MS**, director of the hospice program at MetroWest HomeCare & Hospice in Framingham, MA. “Whenever there is a conference that offers educational opportunity for an employee, the hospice will make money available for registration,” Edson says. When there is a local healthcare conference, schedules are arranged so that all hospice employees can go to one or two days of the conference, he adds.

“We also set up inservices anytime we get a new piece of equipment, pain pump, or other clinical item,” says Edson. With a small staff of six RNs, two chaplains, one social worker, and a volunteer coordinator, it is easy to get everyone together, but the real value is the continuing education, he adds.

MetroWest's management team also focuses on employee engagement and recognition, says **Jane Pike Benton**, executive director of the agency. Not only are new employees greeted with a red carpet and a welcome sign with their photograph on their first day, but Pike Benton meets with employees during their third week to touch base and ask how everything is going. “Everyone has a voice in the organization, and I think it's important for him or her to hear that from me as well as his or her own supervisors or managers,” she says.

Recognition programs include “Bright Ideas,” which give all employees a chance to submit ideas for changes within the agency. The sugges-

tions are submitted to a team of employees who oversee the agency's service excellence activities. “If the idea is reviewed and implemented, the employee gets a “High Five” card along with a gift card to Dunkin' Donuts,” Pike Benton says. “If the idea is not implemented, the employee receives the ‘High Five’ card along with our thanks for being creative and thinking of ways for the agency to improve.”

Ideas that have been implemented include providing field staff with double laptop batteries so their computers last longer when visiting patients and ending all phone calls with “is there anything more I can do for you?” ■

Do doctors, consumers agree about hospice?

Physicians say that hospice is great, but there's too little service, and it's offered too late. That's one of the top findings of a new national survey conducted to compare attitudes and perceptions about hospice care among consumers and physicians.

Consumers agree with physicians on the quality of hospice and the amount of service that should be provided. But when it comes to the right time to discuss hospice, it's an individual preference.

Quality of hospice in the United States is good to excellent say both groups. Respondents were asked to rate the quality of care received by their loved ones; 64% of consumers and 61% of physicians said the care was excellent.

As for length of service, physicians and consumers agree that patients should be receiving hospice care for at least 90 days, with most of the general public (54%) and physicians (52%) identifying six months or longer as the appropriate length of time. But half of hospice patients today receive care for less than three weeks, according to the National Hospice and Palliative Care Organization.

Though nearly everyone says they want more time in hospice, there are key differences between physicians and consumers when it comes to initiating the service. Sixty-two percent of doctors said that hospice in America is offered to patients too late. In contrast, 77% the general public said it was offered at the right time.

When asked about their own loved ones, one out of three consumers and physicians said they would like to start the hospice conversation at the time of diagnosis or the start of treatment. Yet

only one out of five physicians actually starts the conversation then.

“Being ready to discuss hospice is clearly a very personal matter,” says **Perry Farmer**, president of Crossroads Hospice, which commissioned the survey. “Sadly, many physicians and patients wait until all treatment options have been exhausted to even bring up the subject. Hospice care helps the terminally ill live the remainder of their lives with comfort and confidence. It’s a godsend to many families.”

Porter Storey, MD, FAAHPM, executive vice president of the American Academy of Hospice and Palliative Medicine, said he hopes the survey results will encourage doctors to make sure their patients know the benefits of this special type of medical care. “We’ve always known that patients start receiving hospice care late, missing out on months of symptom relief and the many other ways hospice care can improve quality of life for them and their families, but it’s good to see that patients and doctors do appreciate its value and want to talk about it.” he said.

The Hospice Care study is a comprehensive survey of adults and physicians across America. Respondents included 700 consumers age 35 and older and 300 physicians: 200 specialists and 100 primary care physicians. All respondents had some familiarity with hospice. ■

Surrogate decision-makers want full authority

Speaking out on withdrawing life support

The decision to stop life-support for incapacitated and critically ill patients is, for surrogate decision-makers, often fraught with moral and ethical uncertainty, and long-term emotional consequences. But as difficult as these decisions are, more than half of surrogate decision-makers prefer to have full authority over the choice than to share or cede that power to physicians, according to a recent study out of the University of Pittsburgh School of Medicine.

“This report suggests that many surrogates may prefer more decisional control for value-laden decisions in ICUs than previously thought,” said **Douglas B. White, MD, MAS**, associate professor and director of the Program on Ethics and Decision Making in Critical Illness at the University of Pittsburgh.

The study, a prospective cohort study that included 230 surrogate decision-makers, was published online in advance of the print publication of the American Thoracic Society’s *American Journal of Respiratory and Critical Care Medicine*.

The researchers identified surrogate decision-makers for incapacitated adult patients who require mechanical ventilation and had APACHE II scores of 25 or more, indicating that they were very ill and had about a 50% chance of dying during this hospitalization. The surrogates completed two hypothetical vignettes regarding treatment choices to be made for their loved ones. In one scenario, the question was whether to withdraw life support in the case that the patient had “no hope for recovery”; in the other scenario, the question was about a decision to use one antibiotic or another in treating the patient and asked to select their preferred degree of control over the decision.

The researchers found that more than half (55%) of surrogate decision-makers preferred to retain control over “value-laden” decisions such as whether and when to withdraw life support. Surrogate overwhelmingly wanted more control over the value-laden decisions that the technical decision regarding antibiotic choice. However, a significant portion (40%) of surrogates wanted to share even value-laden decisions with physicians, and 5% wanted to cede that authority to the physician entirely. A significant factor in determining the extent to which surrogates wished to retain control over life-support decisions was their trust in the physician overseeing care. Men and Catholics were less likely to want to give up their decision-making power.

“We found substantial variability in the role surrogates prefer in making value-sensitive life support decisions for incapacitated, critically ill patients,” said White, who is also a critical care physician at University of Pittsburgh Medical Center. “Surrogates with low levels of trust in the treating physicians were more likely to prefer to retain final authority over value-laden life support decisions. These results indicate the need for a conceptual distinction between physicians sharing their opinion with surrogates and physicians having final authority over those decisions.”

For even among those who wished to retain authority, 90% wanted the physician’s opinion on whether to forego life-sustaining treatment.

This critical research highlights that family members have varied positions about their role to make decisions about life support, says **J. Randall**

Curtis, MD, MPH, immediate past-president of the American Thoracic Society. “This variability runs the full spectrum from wanting responsibility for these decisions to wanting physicians to take this responsibility,” Curtis says. The physician should match his or her approach to the individual family member that they are speaking with, he says. “Unfortunately, we have not trained physicians in how to elicit this information from family members,” Curtis says. “We need to learn how best to elicit this information and to teach ICU clinicians this important skill.”

White did note that in certain cases, physicians’ obligations to act for the good of their patients might supersede the desires of the surrogate decision-makers to retain authority. “However,” he noted, “this step shouldn’t be taken without justification because of the ethical and practical complexities it raises.”

While more research is needed to understand and elucidate the nuances that go into informing the decisional authority desired by surrogate decision-makers, this study does point out that 95% of all surrogates wish to have some, if not all, authority over value-laden decisions.

“This research makes clear that the vast majority of surrogates in ICUs want to be active participants in these difficult decisions,” said White. “The challenge for physicians is to tailor their approach to give the family the information and support they need.” ■

Nationwide recall of Triton infusion pump

WalkMed Infusion of Englewood, CO, is initiating a nationwide recall of a total of 2,018 Triton Pole Mount Infusion Pumps. The pumps have been found to possibly have a problem with the pump door open alarm, which potentially could result in over infusion of medication.

The recall includes the serial numbers 001 through 500 and serial numbers TR1401 through TR 2559 manufactured and sold before June 2010. Consumers who have Triton Pole Mount Infusion Pumps that are being recalled should return the pump to the manufacturer. The Food and Drug Administration (FDA) has been apprised of this action.

No injuries have been reported to date, and no reports of this issue have been received from field use. The issue was found internally by WalkMed

Infusion. The condition has been found on some, but not all pumps in these serial number ranges and results from variability in the door open sensor mechanism. If the pump door is not closed and latched per the instructions on the side of the pump and in the operator manual, the pump door open alarm might not alert the user to this condition. It is then possible for the pump mechanism not to be engaged and a gravity feed flow condition to exist if the pump operator has not checked tube set for flow prior to starting the pump. If the instructions for use on the side of the pump and in the operator manual for set up and tube set placement are followed, gravity feed flow will not occur from this condition.

WalkMed Infusion has notified its distributors and customers by phone and e-mail and has begun the upgrade of all recalled products. Five of the eight distributors/customers have had their pumps upgraded.

Adverse reactions or quality problems experienced with the use of this product may be reported to the FDA’s MedWatch Adverse Event Reporting program online, by regular mail, or by fax. Online: www.fda.gov/medwatch/report.htm. Regular mail: use postage-paid FDA form 3500 available at www.fda.gov/MedWatch/getforms.htm. Mail to MedWatch 5600 Fishers Lane Rockville, MD 20857. Fax: (800) FDA-0178. ■

ED program targets end-of-life patients

Offering ‘comfort, control and choices’

An emergency department (ED) program designed to serve the terminally ill? It makes perfect sense to **Mark Rosenberg, DO, MBA, FACEP**, chairman of emergency medicine at St. Joseph’s Regional Medical Center in Paterson, NJ. So much so, in fact, that his department recently introduced Life-Sustaining Management and Alternative (LSMA) services. The program is designed to provide comfort, control, and choices for chronic and terminally ill patients and their loved ones.

“St. Joseph’s has a large peds ED and a very active ED in downtown Paterson with a fairly large geriatric population that had been continuing to grow,” Rosenberg says. “We decided to develop full-circle care in the ED.”

Rosenberg says his ED had been seeing 40-60 geriatric patients a day, but it had not really met its goal

of providing complete care because it did not have a program to help most of them who had a life-limiting disease. “In January [2010] we decided to start the program and take care not just of geriatric patients but anyone who had life-limiting illness,” says Rosenberg. “We felt management of these patients could be better if it was initiated in the ED and then followed through to the community or the hospital.”

The ED leadership was particularly qualified to develop such a program because both Rosenberg and ED nurse coordinator **Ramazan Bahar**, RN-BC, had been involved in palliative care over the years. “When a patient has a terminal illness they know they are dying, but often no one wants to discuss it with them,” notes Bahar. This approach takes control away from the patient, she says.

Bahar recalls the case of an elderly Dominican woman with metastatic brain cancer. “The children were told she had three weeks to live, but they had not wanted to tell her,” she says. “I said, ‘I’ll tell you something: She knows. Let’s let her decide how she wants to spend that time.’”

The daughters gave their permission, and the ED physician in charge of the case told her. Her response? “I knew.” The provider team and the family asked her what she wanted to do. “She wanted to go back to the Dominican Republic,” says Bahar, “And we made arrangements for hospice and palliative care.” (*Rosenberg takes a non-traditional approach to one specific type of palliative care. See the story on p. 10.*)

A different approach

A program such as this one runs counter to the traditional ED approach to care, says Rosenberg.

“We are usually focused on curing, and sometimes you need to focus on caring,” he explains. “We have now created that model in the ED,

EXECUTIVE SUMMARY

The new Life-Sustaining Management and Alternative (LSMA) services program in the emergency department at St. Joseph’s Regional Medical Center in Paterson, NJ, is designed to offer patients with life-limiting disease greater control over their care choices and also help them contact services such as hospice if they are needed.

- Two ED physicians and one nurse are on call 24/7 for consulting referrals from ED physicians.
- The consultants meet with the patient and their family to review the case and present alternatives.
- The program shifts the traditional ED focus of curing to one of caring.

where you can provide care without curing and give control back to the patient.”

A “treat, stabilize, cure, and discharge” approach might work for most patients, Bahar says, “but there is a different type of treatment for these patients. We are here to advocate for them and make sure their wishes are translated to the next level of care.”

Rosenberg and Bahar provide a consulting service and are available 24/7 along with another ED physician. Rosenberg says, “Any time a patient is in need of palliative care or has to deal with end-of-life issues, rather than them having to deal with it, they call us. We take the burden away from the emergency physician.”

The ED physicians simply have to call his or Bahar’s extension. If they’re out, it goes to their cell phones, notes Rosenberg. “We’ve created a whole new level of care for these individuals,” he says. (*For an example of a recent case, see the story below.*) ■

Case shows hospital met patient’s request

A recent case in the ED at St. Joseph’s Regional Medical Center in Paterson, NJ, shows the value of its new Life-Sustaining Management and Alternative (LSMA) services, says **Mark Rosenberg**, DO, MBA, FACEP, chairman of emergency medicine and co-creator of the program.

The patient was 56-year-old male with stage IV lung cancer who was having difficulty breathing. He had been through chemotherapy, but it was no longer efficacious. His oncologist had told the family there was nothing more he could do.

Rosenberg met with the patient and his wife and reviewed his history. He also presented them with alternatives. “The hospitalist was going to admit him, probably drain the malignant effusion in his chest, and put him in the ICU, where he may have died,” he said. When Rosenberg explained the circumstances to the patient, “he was excited ... happy. He knew he was dying and just wanted somebody to say it and know what was in store for him,” he says.

The patient decided he would rather go home. Rosenberg arranged for hospice care. “We also got him to tape record messages for his nieces, who were 1 and 3, and for others, so he could leave a legacy for them,” he notes. “We also had family meeting, and to this day the family couldn’t be

more thankful that we let him have a choice and reach his goals.”

The patient died at home three weeks later without medical support. ■

Clinical Tips

Some EOL care is not adequate

Shortness of breath in terminally ill patients is often managed poorly, says **Mark Rosenberg**, DO, MBA, FACEP, chairman of emergency medicine at St. Joseph’s Regional Medical Center in Paterson, NJ, and co-creator of its new Life-Sustaining Management and Alternative (LSMA) program.

“The tendency is to put a breathing tube in, but a very good treatment is giving morphine,” Rosenberg says. “A lot of people think this will shorten life, but studies show it will actually lengthen life.

Rosenberg adds that ED managers and their staffs have a lot to learn about treating these patients. “My feeling is there is great opportunity for emergency doctors to provide better care by better understanding EOL [end of life] initiatives,” he says. “From a clinical point of view, it’s a better opportunity to learn how to manage acute chronic pain, narcotics like morphine, methadone, and dilaudid in particular. You can get very skilled.”

There are several recommended drugs for EOL care that can help mask symptoms such as dizziness, nausea, vomiting, constipation, and diarrhea, Rosenberg adds. ■

Impact of human factors on home health quality

A new report funded by the Agency for Healthcare Research and Quality (AHRQ) examines the impact of human factors on home health care quality and safety. The report includes seven commissioned papers on topics that include matching care to people in their home care environment; the prevalence, characteristics, and care provision ability of informal caregivers; medical devices and information technology and systems in home care; impact of social, cultural, and community environments on home care; and the

effects of policy, reimbursement, and regulation on home health care.

Based on proceedings from an October 2009 workshop, the report, *The Role of Human Factors in Home Healthcare: Workshop Summary and Papers*, also features summaries of the discussion at the workshop on how home care quality and safety are impacted by the capabilities and limitations of patients and providers in the use of technologies. The workshop summary report, which is published by the National Academy of Sciences’ National Research Council under contract to AHRQ, is available for free download from their web site (http://www.nap.edu/catalog.php?record_id=12927).

A final consensus report and designers’ guide for home-based consumer health IT developers, which build on the workshop proceedings, are under development and will include recommendations related to the safety and quality of home health care. The report and designers’ guide are expected to be released in spring 2011. ■



JOURNAL REVIEWS

Study shows hospice accessible

Proximity to service not a barrier to use

Researchers at Mount Sinai School of Medicine have found that 98% of the U.S. population lives in communities within 60 minutes of a hospice provider, which suggests that disparities in use of hospice are not likely due to a lack of access to a hospice provider.¹

The research team studied data from the 2008 Medicare Provider of Services data, U.S. Census data, and geographic mapping software. Census tract characteristics evaluated included population per mile, population over the age of 65, median household per capita income, percentage over the age of 18 with less than a high school education, black population percentage, and census region. The team determined that 98% of the U.S. population lives within 60 minutes of a hospice, and 88% live within 30 minutes from one.

The average number of minutes between a community center and a hospice was 15 minutes. The number of minutes to the nearest hospice was

lower in communities with several characteristics, including: higher population per square mile, higher median household income, lower percentage with less than a high school education, and a higher black population percentage. Communities with higher percentages of the population who are black are more likely to have geographic access to hospice, but previous research has shown that people who are black are less likely to use hospice compared with people who are white.

Authors suggest that the growth in the number of hospices since 2000 has improved access to hospice care as the closest hospice for about one-third of the population, in both rural and urban areas, is a relatively new hospice, certified by Medicare since 2000. However, the authors point out that more research is needed to determine why more patients and their families are not under the care of a hospice at the end of life, including hospice admission criteria and patient financial and cultural factors that might present barriers to hospice use.

REFERENCE

1. Carlson MD, Bradley EH, Du Q, et al. Geographic access to hospice in the United States. *J Palliat Med* 2010; 13:1331-1338. ■

Acupuncture helps cancer treatment

Recent studies have shown that acupuncture can help control several symptoms and side effects — such as pain, fatigue, dry mouth, nausea, and vomiting — associated with a variety of cancers and their treatments.

Experts from Memorial Sloan-Kettering Cancer Center's Integrative Medicine Service, who have conducted or reviewed many of these studies, recommend that cancer patients interested in acupuncture seek a certified or licensed acupuncturist who has training or past experience working with individuals with cancer. Acupuncture's use for the treatment of symptoms and side effects of a variety of cancers has been investigated in several studies:

- **Head and neck cancer.**

A study conducted by Memorial Sloan-Kettering investigators and published in the April 2010 issue of the *Journal of Clinical Oncology* sought to determine if acupuncture could reduce pain and dysfunction in individuals with cancer of the head or neck who had received a surgical dissection of

lymph nodes in their neck. The study evaluated 58 patients who were suffering from chronic pain or dysfunction as a result of neck dissection. For four weeks, study participants were randomly assigned into one of two groups: those receiving weekly acupuncture sessions and those receiving standard care, which included physical therapy, as well as pain and anti-inflammatory medication.

The study found that individuals in the group receiving acupuncture experienced significant reductions in pain and dysfunction when compared with individuals receiving standard care. Individuals in the acupuncture group also reported significant improvement in xerostomia, a condition in which patients receiving adjuvant radiation therapy experience extreme dry mouth.

- **Leukemia.**

Many people with leukemia try additional treatments outside their standard care because they hope to manage symptoms and, in some cases, to improve their treatment outcome. In a commentary in the September 2009 issue of *Expert Reviews Anticancer Therapies*, investigators from Memorial Sloan-Kettering examined the results from available studies testing the effectiveness of such approaches. They report that among the complementary therapies used to decrease symptoms and side effects, acupuncture is significantly beneficial for symptom management.

For some leukemia patients, cancer chemotherapy drugs can damage the peripheral nervous system (peripheral neuropathy), causing pain, numbness, tingling, swelling, and muscle weakness in various parts of the body, especially in the hands and feet. In some cases, doctors must reduce the chemotherapy dose in order to prevent the neuropathy from progressing further. Acupuncture has been found to decrease these difficult neuropathy symptoms, which allows the maximum amount of chemotherapy to be used and, thereby increases the patient's chance for a successful outcome.

COMING IN FUTURE MONTHS

- Update on pain management

- Tips for growing your hospice

- How to prepare patients and family for death

- Quality improvement studies that produce results

Acupuncture also is known to reduce the effects of nausea caused by chemotherapy agents used to treat leukemia. Research has shown that timing the acupuncture sessions 1-2 days before chemotherapy infusion and continued weekly throughout the chemotherapy regimen produces the best results. In addition, the authors note that acupuncture has been proven safe for patients receiving the anticoagulation drugs Coumadin or heparin during their leukemia treatment. ■



New benchmark tool available for hospices

A new tool from the National Hospice and Palliative Care Organization gives hospice decision-makers the information they need to compare their program against like-sized hospices.

The National Summary of Hospice Care — Peer Reports provides reports that include information on referral sources, length of service, payer mix, staffing characteristics, patient visits, and volunteer services. Reports are available by agency-size and type and can be purchased by sending a request to nds@nhpco.org. Providers who submitted data to the 2009 National Data Set can purchase the Peer Reports set for \$150. Non-participants can purchase the Peer Reports set for \$300. ■

Publication targets hospice payments

The revised Medicare Learning Network publication titled “Hospice Payment System” (September 2010) is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf.

This publication provides information about the coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees. ■

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