

# HOSPICE Management Advisor™

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## Want to improve your retention? Help employees with personal issues

*EAP is cost-effective and demonstrates commitment to staff*

*[Editor's note: This is the first of a two-part series that examines ways to support employees' in their personal lives in order to improve work performance and staff retention. This month we look at the use of Employee Assistance Programs (EAPs) and explore how hospices can choose the right program for their employees. Next month, we learn about a hospice that has set up an in-house wellness program that addresses personal life issues for employees.]*

It is one thing to tell employees that you care about their emotional health and their personal life, but it's important to show employees that you recognize their need for help, says **Pat Holtman**, director of human resources at Covenant Hospice in Pensacola, FL. An Employee Assistance Program (EAP) is one way to demonstrate your hospice's commitment to employees, Holtman says.

Hospice employees help families deal with their issues and grief surrounding the death of the patient, and although most hospices make in-house social workers or chaplains available to talk with employees, the

### EXECUTIVE SUMMARY

Hospice managers know that meeting employee needs is one way to improve retention, but not all employee needs can be met with internal hospice resources. Employee Assistance Programs (EAPs) have proven to be a cost-effective way to help employees deal with personal issues that affect their work.

- Confidential counseling by an outside provider encourages employees to seek help they might not normally seek.
- EAP providers offer access to a wide range of expertise not available within a hospice: financial, credit, and substance abuse counseling.
- Costs of EAP services are not as significant as the cost of hiring and training new employees.

help employees need might not be available within the hospice, says **Sherry Little**, executive director of Home Hospice of Grayson County in Sherman, TX.

“There are times that employees don’t want to share issues from their personal lives with co-workers, and the EAP gives them an outlet,” Little explains.

Although there has not been a formal survey among employees regarding benefits such as the EAP, she receives informal feedback from employees. “They tell me that they appreciate our open attitude about people needing extra support in their lives and they are glad the EAP is available,” Little says.

They have offered an EAP for more than 10 years, she says. “Although it is not a benefit that potential employees use as a reason to choose

one employer over another, I have seen a look of surprise in potential employees’ eyes when I am describing our employee benefits,” Little says. Although many new employees don’t anticipate needing the services of an EAP, all react positively to the news that the hospice makes the benefit available to everyone, she adds.

Holtman estimates that about 30% of Covenant’s 875 employees have used the EAP. “My utilization reports don’t provide names, so I don’t know if the visits are made by employees or family members, so I don’t know an exact number,” she explains.

## Employee access is important

To make the program easily accessible for employees of the agency that has 12 offices in multiple counties in Florida and Alabama, it was important to find an EAP provider with resources that spread throughout the area served by Covenant, she says. “For an EAP to be a real benefit, employees have to be able to use it without disrupting their personal or work life,” she explains. *(See p. 27 for tips on how to choose an employee assistance program.)*

Little considers the benefit an important part of employee retention. Her hospice’s agreement with the EAP provider requires an annual payment of \$1,500 to cover all 65 employees. The flat fee arrangement, as compared to a fee per utilization, works for her hospice because it is easier to budget the expense, she says.

“We have some months when no employees access the service, but we have other months when utilization is high,” Little says. The ability to predict the payments and build a set amount into the budget is an advantage for her agency. “Overall, the EAP is an effective way to offer additional support to employees, which increases retention and decreases the need to replace and train new employees,” Little adds. *(For more about staff retention, see “In this economy you can’t afford to lose good employees,” Hospice Management Advisor, December 2010, p. 133.)*

Covenant and Home Hospice of Grayson County’s EAP benefits extend to immediate family members in addition to the employees. “Employees or their family members each get three free visits to an EAP counselor each year,” says Holtman. The hospice’s health insurance does cover visits to mental health counselors, so she recommends that employees verify that they can continue seeing the same counselor if needed beyond the three EAP visits.

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“We encourage employees to ask the counselor at the first visit if the hospice’s health insurance is accepted in case the employee and counselor decide that more than three visits are required,” Holtman says.

Information about the EAP is given to employees at orientation, in the new employee handbook, and in frequent articles included in the hospice newsletter that regularly spotlights different benefits, she says. If supervisors or managers notice changes in an employee’s behavior that indicate a possible personal problem that might be affecting job performance, they might encourage or recommend that an employee contact the EAP, but the hospice does not mandate use of an EAP, Holtman says.

At Home Hospice of Grayson County, there are circumstances in which an employee is required to work with an EAP counselor, says Little. “For example, we had an employee who had a family member with whom she was very close die. Her grief affected her interactions with co-workers and began to affect her ability to do her job when the behavior continued for a long period of time,” she says.

As part of counseling the employee about her job performance, the supervisor included a requirement that the employee see the EAP counselor on a weekly basis for the first month, then as frequently as the counselor and employee thought necessary afterward.

“Although the utilization reports from the EAP identify employees by a number to protect their privacy, when visits are mandated as part of a performance issue, I ask the EAP to verify that the employee did meet with the counselor as mandated,” Little says. Confidentiality of the visits is maintained because Little does not ask for specifics or content of the counseling sessions, just for verification that the employee followed through

on the visit.

Because hospice employees are asked to give so much of themselves to support and help others in their workdays, make sure hospice employees receive the same support, says Little. “An EAP is one benefit that provides an additional level of support that lets our employees know that they are appreciated,” she says. “It is proof that we do care about their wellbeing.” ■

## Evaluate these areas when choosing an EAP

There are many factors to consider when choosing a provider for your Employee Assistance Program (EAP), according to experts interviewed by Hospice Management Advisor. Geographical coverage was most important to Covenant Hospice, a Pensacola, FL-based hospice with almost 900 employees in 12 offices across north Florida and southern Alabama.

If the EAP services are not easy and convenient for employees to use, they won’t view the service as a true benefit and won’t use it, says **Pat Holtman**, director of human resources at Covenant Hospice.

In addition to finding an EAP provider that is geographically compatible with hospice employees, it is also important to find one that can provide a full range of services that address family issues, mental health issues such as depression or anxiety, financial issues, addiction problems, and workplace issues. The EAP program chosen by Covenant Hospice is provided by the mental health division of a large health system in the area.

“They have professionals in all areas in which our employees are located, and if a special service is needed that they don’t provide on staff, they know the areas and can make appropriate referrals,” she says. “The use of licensed professionals who know how to protect our employees’ confidentiality while counseling them was a requirement for us.”

Hospices in urban areas often have a wider range of choices when searching for an EAP. **Sherry Little**, executive director of Home Hospice of Grayson County in Sherman, TX, says, “We really only have one EAP provider in our area, but we’ve been pleased with the service they provide. In fact, we’d probably choose them to provide the service even if there were other options.”

Easy access to the provider, the same people

handling hospice employee calls, and good communication between the provider and hospice management are a few of the reasons the relationship between her hospice and the EAP provider works well, says Little.

## 5 things to consider

Once you are sure that the EAP provider can provide easy access, evaluate the following:

- **Consistent contact person.**

Rainbow Hospice in Parkridge, IL, relies upon Joel Gratch, LCSW, as their EAP provider. Gratch is on the staff of a local adult inpatient psychiatric hospital but serves as a consulting therapist to the hospice for EAP services. “Because I’m a solo practitioner, everyone at Rainbow Hospice contacts me,” Gratch explains. “But even if you are working with a larger EAP provider, be sure to ask for one person to serve as the main point of contact.”

While Covenant Hospice chose a larger organization with multiple offices and contacts in a wide geographic range and Home Hospice of Grayson County relies upon a smaller organization with two licensed psychologists. However, both agencies have a central point of contact so employees make their initial contact with someone who knows the hospice. “Because our employees are located throughout such a wide area, the initial contact person will most likely refer them to a counselor in their area,” explains Holtman.

A central, consistent contact person allows proper follow-up to ensure that all employees receive the services they need, she says.

- **Familiarity with hospice.**

“An EAP provider must understand the structure of the hospice organization and the different types of work each employee might do,” suggests Gratch. “Even if the EAP provider specializes in healthcare, be sure the provider understands the difference between curative treatment and palliative care.”

This distinction is an important one that all counselors might not take into account when working with hospice employees, he explains. “Many hospice employees have difficulty talking with people outside the hospice about their work,” says Gratch. “I’ve had employees tell me that most people think that their work focuses on death, not on the real goal of helping people live their remaining life in the fullest, most comfortable way possible.”

- **Knowledge of other resources.**

“Know the provider’s strengths and limitations and be sure he or she has a referral network to use to get the proper assistance for your employees,” recommends Gratch. “For instance, I’m a generalist who can help people identify the reasons for their personal or work issues.”

If the reasons for those problems require financial or credit advice, substance abuse counseling, or other specialized services, Gratch has a network of professionals to whom he can refer the employee. “Your EAP provider’s network needs to be large enough to handle geographic and insurance requirements to improve your employee’s ease of access,” he adds.

- **Accountability.**

Although the primary reason for offering an EAP with an outside firm is to provide complete privacy to employees, the EAP provider should send regular reports to the hospice to keep them informed of utilization, says Little.

By tracking utilization and the types of issues for which employees are seeking help, the hospice manager can evaluate the value of the EAP. Reports that identify employees as numbers maintain confidentiality but still provide important information to the hospice, she adds. If utilization drops for a time, the hospice administrators might want to evaluate communications with employees about the inclusion of EAP as a benefit, or the administrator might need to remind managers and supervisors that the EAP is a resource they can recommend to employees, she adds.

- **Resource for hospice.**

In addition to counseling employees who seek EAP services, some providers also can be resources for inservice education, can facilitate meetings to discuss difficult issues, or can offer advice on personnel issues to managers. “We don’t violate our employees’ privacy, but we will ask our EAP provider for advice on how to handle some situations,” says Little. For example, if hospice managers are trying to determine the best way to handle a tough situation, the EAP provider can suggest different options to address the problem, she says.

Options considered by the hospice might include a change in job responsibilities, additional counseling, or extra training, and the EAP provider can give feedback for what might work best or might offer ideas hospice management did not consider, she explains. Having an outside consultant ensures that all options are considered in difficult situations, she adds. ■

# Dartmouth Atlas Report: No consistency in care

*Care varies markedly across regions, hospitals*

Where they live can determine whether Medicare patients with advanced cancer die in a hospital or while receiving hospice care, according to the findings of a Dartmouth Atlas Project report.

The report, “Quality of End-of-Life Cancer Care for Medicare Beneficiaries: Regional and Hospital-Specific Analyses,” states in its introduction that “[t]his Dartmouth Atlas report examines how elderly patients with poor-prognosis cancer are cared for across regions and hospitals and finds remarkable variation depending on where the patients live and receive care.

“Even among the nation’s leading medical centers, there is no consistent pattern of care or evidence that treatment patterns follow patient preferences,” the report states. The report’s lead author is **David C. Goodman, MD, MS**, co-principal investigator for the Dartmouth Atlas Project and director of the Center for Health Policy Research at the Dartmouth Institute for Health Policy and Clinical Practice in Lebanon, NH.

Good information about the why variability of care exists comes from “a variety of other studies, including two Institute of Medicine reports,” Goodman says. “There are some facts that we know,” as a result of such studies, he explains.

“First, we know that generally, on average, patients receive much more aggressive treatment at the end of life and at the end of life with cancer than they prefer,” he says. There are important individual preference differences that should be respected, Goodman says. “But on average, patients are getting more care than they want, and it really degrades their quality of life,” he says.

“We also know that palliative care is underutilized in the United States — that many patients near the end of life don’t receive adequate pain control or other adequate comfort measures,” Goodman says. “They’re not afforded, oftentimes, the full opportunities to be at home and . . . to be communicating and as close as they would like with their families, because they were in the hospital or intensive care units.”

Hospitals also have leaned toward underinvesting in palliative care services for patients at the facilities, he says. “They are sort of the poor

relation to oncology and intensive care services,” Goodman explains. “In many places, they are seen as an admission of defeat, which mischaracterizes both cancer, its treatment, as well as patient preferences. So, there are problems with inadequate investment in care that patients want, but there [are] also problems in health care providers’ attitudes and understanding of patients’ wants and needs.”

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, issued a news release following the Dartmouth Atlas Project’s report. “The Dartmouth Atlas Project is to be commended for undertaking this thorough examination of end-of-life care for Medicare beneficiaries with advance[d] cancer,” said **J. Donald Schumacher**, president and CEO of the NHPCO, in a released statement. “While the findings of variation in care are not necessarily a surprise, one of the key messages that I take away from this report is the critical need for hospitals and all health care professionals to ensure that all patients are informed earlier about the course of an illness and the range of options available — options that include hospice and palliative care.”

Schumacher said the report should not be construed as a negative comment about patient care in hospitals or academic medical centers. “[R]ather, it’s a much needed reminder that health care professionals must work to help patients and families understand where the course of their illness may take them,” he said. “And, when cure is not possible, it is our duty to offer the robust benefits that the hospice team can provide.”

## **Ethical considerations from the report**

There are “fundamental ethical” problems in health care delivery today in the United States, according to Goodman, who is also a practicing physician.

One is that physicians should gather as much information as they can about their patients and provide them with a recommendation that is in their patients’ best interests, Goodman says. “There certainly are situations when the physician uniquely understands both the information and what represents best interest, or when decisions have to be made fantastically quickly, and we [place] trust [in] physicians to make the best call,” he says. However, with many decisions in health care, specially at the end of life or when patients are not doing well with their treatment, it is presumptuous for doctors to say that they uniquely

understand what's in the best interest of patients, he says. "And yet, this is done every day," Goodman says. "It is a failure of ethical communication; it's a failure of providing adequate information to patients and family; and it leads to patients receiving care that is not the sort of care that they want."

## Variation exists

Variation occurs not only across regions, which Goodman indicates reflects "the care provided by physicians and hospitals," but also across hospitals.

"It's interesting," Goodman says. "I think that every place is unique and special. We found just as much variation in the patterns of care across academic medical centers as we did across community hospitals."

Dartmouth Atlas project also found this phenomenon that the when it engaged in studies of other aspects of care, he says. "The notion that academic medical centers practice differently because they are places of teaching and research . . . is not well supported by studies that have been done measuring variation across different types of hospitals," Goodman says. "There are some slight differences that one might see, but they are really overwhelmed by the amount of variation that's seen within hospital type."

The researchers reviewed the records of 235,821 Medicare patients ages 65 or older with aggressive or metastatic cancer who died between 2003 and 2007. According to a news release issued on the project, in at least 50 academic medical centers, "fewer than half of these patients received hospice services. In some hospitals, referral to hospice care occurred so close to the day of death that it was unlikely to have provided much assistance and comfort to patients."

Goodman said, "The well-documented failure in counseling patients about their prognosis and the full range of care options, including early palliative care, leads many patients to acquiesce to more aggressive care without fully understanding its impact on the length and quality of life."

## Regional variation in care

In the United States, about 29% of patients with advanced cancer died in a hospital between 2003 and 2007, according to the report.

"Cancer patients were most likely to die in a hospital in the Manhattan hospital referral region,

where 46.7% experienced death in a hospital," the report states. "The rates were also high in surrounding regions, including Ridgewood, New Jersey (42.8%), East Long Island, New York (42.5%), and Newark, New Jersey (41.1%)."

According to the report, those rates were about six times higher than the rate in the Mason City, IA. In that area, only 7% of cancer patients died in hospital.

"Cancer patients were also much less likely to experience a hospitalized death in Cincinnati (17.8%) and Fort Lauderdale, Florida (19.6%)," according to the report.

The report also sheds light on hospital admissions during the last month of life among hospital referral regions, indicating that "the percent of cancer patients hospitalized at least once during their last month of life varied by a factor of about 1.6" during the same study period. "Nationally, 61.3% of cancer patients were hospitalized at least once during their last month of life," the report indicates. "Cancer patients were mostly likely to be hospitalized during the last month of life in hospital referral regions in Michigan, including Detroit (70.2%), Royal Oak (69.4%), Pontiac (69.4%), and Dearborn (69.1%)," the report states. However, "less than half of cancer patients" were hospitalized during their last month in Mason City, IA, at 44.9%, or San Angelo, TX, at 46.3%, or Cedar Rapids, IA, and La Crosse, WI, at 49%.

The report also indicates hospital days during the last month of life among hospital referral regions, as well as intensive care admissions during the last month of life among hospital referral regions, among other categories examined. In the latter category, for example, the report indicates that 40% of cancer patients who died during the study period were admitted to an ICU in the last month of life in Huntsville, AL, compared to 13% in Madison, WI, 14.3% in Portland, ME, and 14.6% in Minneapolis.

## Variation across academic medical centers

"There is a remarkable amount of variation in the use of hospitals for elderly patients with poor prognosis cancer who are near the end of life," according to the report. "Even after controlling for cancer type, age, sex, and race, there were more than twofold differences in the number of days spent in hospitals and intensive care units in the last month of life."

Such differences should "stimulate teaching

hospitals to further examine clinician practice styles and decision-making processes in relation to the evolving national norms of quality end-of-life care,” the authors write. The report states that “the percent of cancer patients dying in a hospital varied threefold among patients receiving most of their care at academic medical centers.”

Also, the authors write that “the likelihood of being admitted to the hospital during the last month of life among cancer patients varied from less than 50% to more than 75% across academic medical centers.” ■

## Oncology group issues new policy, patient guide

The American Society of Clinical Oncology (ASCO) has called on physicians, medical schools, insurers, and others to help improve quality of life for people with advanced cancer. In a new policy statement, ASCO recommends steps to ensure that physicians initiate candid discussions about the full range of palliative care and treatment options soon after patients’ diagnosis with advanced cancer (defined as incurable disease).

“While improving survival is the oncologist’s primary goal, helping individuals live their final days in comfort and dignity is one of the most important responsibilities of our profession,” said ASCO President **George W. Sledge Jr., MD**. “Patients have a right to make informed choices about their care. Oncologists must lead the way in discussing the full range of curative and palliative therapies to ensure that patients’ choices are honored.”

Because doctor/patient communication is critical to optimal patient care, ASCO also released a guide to help patients with advanced cancer broach difficult conversations about their prognosis, treatment, and palliative care options with their physicians. Later this year, ASCO will issue its first clinical guidance to help oncologists initiate these conversations and better integrate palliative therapy into oncology practice.

“Studies show that palliative therapies not only improve patient quality of life, but can even extend life,” said Sledge. “Yet for many with advanced cancer, conversations about palliative and hospice options do not occur until the patients’ final weeks or days of life, if they happen at all. This not only hurts patients, but their caregivers as well. ASCO’s new patient booklet and upcoming clinical guid-

ance will help patients and physicians broach these topics early in the course of care.”

A randomized trial sponsored by The ASCO Cancer Foundation recently found that patients with advanced lung cancer who received chemotherapy and palliative care immediately after their diagnosis lived almost three months longer than those who received chemotherapy alone. Another study published in the *Journal of Clinical Oncology* showed that caregivers of terminally ill patients who receive palliative therapy suffer less emotional stress. ICU and hospital deaths were associated with more psychiatric illness among bereaved caregivers compared with home hospice deaths.

In addition, a new, preliminary analysis of 5,500 patient records from ASCO’s Quality Oncology Practice Initiative (QOPI), a quality improvement program involving about 600 oncology practices nationwide, indicates that less than half (45%) of cancer patients are enrolled in hospice care before death. Of those enrolled, one-third were enrolled in the last week of life. The analysis also found that a significant number of patients did not receive appropriate management of their pain (one-in-five patients) or shortness of breath (two-in-three patients) in their last two medical visits.

ASCO’s policy statement was published online ahead of print in ASCO’s *Journal of Clinical Oncology*. To access, go to <http://jco.ascopubs.org>. Click on early release. Under “January 24, 2011,” select “American Society of Clinical Oncology Statement: Toward Individualized Care for Patients With Advanced Cancer.” It outlines essential elements of care for patients with advanced cancer and identifies barriers that prevent advanced cancer care planning conversations between physicians and patients. The statement enumerates critical steps to ensure that care is individualized to address each patient’s needs, goals and preferences throughout the course of their illness. The key elements identified by ASCO to individualize advanced cancer care include:

- Physicians should initiate candid discussions about prognosis with their patients soon after an advanced cancer diagnosis. Such conversations occur with less than 40% of patients with advanced cancer.
- Quality of life should be an explicit priority throughout the course of advanced cancer care. Physicians must help their patients fully understand their prognosis, the potential risks and benefits of available cancer treatments, and quality-of-life considerations. In cases in which active treatment is unlikely to extend survival, palliative care should be

discussed as a concurrent or alternate therapy.

- Clinical trial opportunities should be increased. Few patients with advanced cancer participate in trials due to strict eligibility criteria, a dearth of trials that address quality-of-life issues, and other barriers. Increasing opportunities for these patients to potentially benefit from trials and to contribute to improving cancer care should be a high priority.

ASCO CEO **Allen S. Lichter, MD**, said many barriers prevent physicians and patients from engaging in optimal advanced cancer care planning. “Oncologists recognize the importance of palliative therapy and other quality-of-life measures in advanced cancer, but physician education and training programs historically have provided little guidance in this area,” Lichter said. “Although patients are entitled to make informed choices about their palliative care and treatment options, our nation’s health care system currently places no value on conversations that can guide these decisions.”

To address barriers to advanced cancer care planning, ASCO recommends:

- Advanced cancer care planning should be emphasized in physician education and training programs.
- Communication skills for discussing prognosis and care options should be emphasized in oncologists’ initial training and in continuing medical education (CME).
- For oncologists in practice, advanced cancer care planning should be a key part of ongoing quality improvement programs.
- Palliative care should be incorporated into American Board of Internal Medicine oncology training and certification, and into oncology fellowship programs.
- Provide insurance coverage for advanced cancer care planning discussions. Most public and private insurance plans provide little or no compensation for discussions with patients about palliative care options, despite their demonstrated value. To address these issues, ASCO’s statement calls for:
  - public and private insurers to provide direct reimbursement for advanced cancer care planning discussions;
  - private insurers to expand pilot programs that maximize palliative care (e.g., hospice) without requiring patients to abandon cancer-focused treatment. By requiring patients to end their cancer treatment in order to receive palliative care, many plans currently reinforce the false choice between fighting the cancer and maximizing quality of life;
  - increase opportunities for advanced cancer

patients to participate in clinical research. ASCO calls for researchers and research sponsors to prioritize studies that:

- evaluate strategies to maximize quality of life for patients with advanced cancer;
- examine potential ways to improve communication between oncologists and patients to ensure patients’ care reflects their individual goals and preferences;
- assess which patients with advanced cancer are most likely to benefit from novel treatments, and study how to overcome biological mechanisms that make their cancer resistant to available treatments;
- increase educational resources for patients with advanced cancer. To help guide patients through difficult yet important doctor-patient discussions, ASCO has a free comprehensive educational booklet for patients with advanced cancer. For copies of the booklet, go to [www.Cancer.Net](http://www.Cancer.Net). Select “order cancer.net materials” and then “Advanced Cancer Care Planning.” ■

## Home case management reduces hospital visits

### *Hospital focuses on frail elderly patients*

In three months following participation in a program that provides care management and outpatient services to the frail elderly in their homes after discharge, patients in Dartmouth Hitchcock Regional Medical Center’s Bridge Program experienced a 41% decrease in emergency department visits and a 27% decrease in inpatient admissions compared to the three months before the program began.

“Our data show a continued trend toward the same kind of outcomes. We feel like our program has made a difference in a lot of our patients’ lives. Their feedback shows that they are very satisfied with the care they are receiving,” says **Ellen F. Thompson, MS, RN**, interim director of care management at the 396-bed tertiary care hospital located in Lebanon, NH.

The purpose of the program is to bridge the gap between the hospital and the community and reduce the chances of patients being rehospitalized by working as a team with the patient, family, the primary care physician, and community organizations that provide support. The majority of patients in the Bridge Program are between 75 and 84 with multiple health care and psychosocial

needs. The program coordinates care for about 35 to 40 patients at a time and follows the patients for four to six weeks following discharge.

The Bridge Program is staffed by a nurse practitioner certified in geriatric medicine, two part-time physicians (one of whom is a board-certified geriatrician), a master's-prepared social worker continuing care manager, and an RN continuing care manager. Using the information gained in a complete medical and functional assessment, the team provides education to the patients and their families about their disease process and discusses additional resources available to support their often complex needs.

The team strives to help patients settle back into living at home by offering medical visits and arranging for community resources, Thompson adds. Each patient receives a visit from one of the physicians or the nurse practitioner. These visits typically focus on clinical issues, such as complicated medical plans of care, new diagnoses, or multiple medical changes. The continuing care managers support patient, family, and provider team coordinator, Thompson adds.

"They provide information and support to help patient access community resources and systems, complete functional health status and risk assessments, identify health promotion and risk avoidance strategies, advocate and negotiate for needed health and social services, facilitate transitions with and across care settings, identify system issues, and initiate improvement efforts," she says. "We try to have the same clinician follow the patients to create continuity in care and try to limit the number of team members who see a patient. However, if patients have an emergent need, we send out any clinician who is available."

Patients who are eligible for the program are identified while they are in the hospital, usually by discharge planning nurses working with the hospital's hospitalist staff. To be eligible for the program, patients must live within a 30-mile radius of the hospital and live alone or with an elderly spouse. Elderly patients who have experienced acute changes in functional status, multiple hospital admissions, who take four or more medications for a chronic illness, or who have terminal illnesses or severe symptoms but are not ready for hospice, are also eligible. Other criteria include frailty, dementia, and a high risk for readmission.

"We also offer the program to any patient the discharge team feels needs more education, additional supervision, or multiple changes in the plan of care," says Licia Berry-Berard, MWS, LCSW,

continuing care manager for the Bridge Program and manager of patient- and family-centered care.

The Bridge Program team also makes sure that patients have advance directives in place and discusses end-of-life issues with the patients and family members when appropriate. "We have found that a fair number of patients who aren't ready for hospice yet may need some support in transitioning to that level of care. As a social worker, I can provide counseling and support and educate patients and family members about palliative care and hospice," Berry-Berard says.

Many people are not aware of their options when they near end of life and have a preconceived notion about what hospice means, Thompson points out. "It really helps to have someone who can talk with them about how to proceed and what support they need to stay in their home. If the family can't provide the support, they can talk about other options. The continuing care managers can take more time with these issues than physicians can provide during an office visit," Thompson says.

If the patients don't already have a primary care physician, the Bridge team helps them identify one. They work with the patient's primary care physician on ensuring that the patients can safely remain in their homes. "A big focus of the program is building relationships with primary care physicians and letting them know that what we want to do is to provide a safe transition from the hospital to home. Physicians recognize that patients are leaving the hospital much sicker than in the past and that they still need a lot of care when they go home," Thompson says.

The physicians see the Bridge Program as an extension of hospitalization. The Bridge team visits patients in the home, helps them get stabilized, then turns them back over to the primary care physician. "We are the physicians' eyes in the patient's home. It's not often that physicians have the opportunity to know how their patients function when they are at home. With complex patients, they appreciate having another pair of eyes do a home assessment and look at the treatment plan," she adds.

The team members typically make between five and 10 visits with a patient, depending on the patients' needs. On rare occasions, on the initial visit, the team member might determine that the patient understands his or her medication, has all the needed support in place, and has a follow-up appointment with the primary care physician. In that case, the Bridge team provides the primary care physician with an assessment of the patient

and the home situation and closes the case.

“Sometimes patients are ready to move into hospice shortly after discharge from the hospital. We bring in someone from hospice to talk to the patient and arrange care,” Berry-Berard says. ■



## MedPAC recommends increase for hospice

The Medicare Payment Advisory Commission (MedPAC) has recommended a 1% increase in hospice payment rates for FY 2012 along with payment reforms that reflect increased costs at end of life.

MedPAC staff predicted hospice profit margins in 2011 of 4.2%, taking into account the increased expense of implementing the face-to-face-encounter and the ongoing implementation of the Budget Neutrality Adjustment Factor.

In addition to the 1% update in the payment rates, MedPAC commissioners also recommended the following:

- Reform the hospice payment system to:
  - increase payments per day at the beginning of the episode and reduce payments per day as the length of the episode increases;
  - provide an additional end-of-episode payment to reflect hospices' higher level of effort at the end of life.
- Implement a budget-neutral payment change that will redistribute revenues.
  - Overall, revenues will increase for provider-based, nonprofit, and rural hospices and will decrease for other providers.
- The secretary of Health and Human Services should direct the Office of Inspector General to investigate:
  - the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that might represent a conflict of interest and influence admissions to hospice;
  - differences in patterns of nursing home referrals to hospice;
  - the appropriateness of enrollment practices

for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices);

— the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

At press time, these recommendations were scheduled to be presented to Congress this month. ■

## Rule would expand notification to hospices

The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would require most Medicare-participating providers and suppliers to give Medicare beneficiaries written notice of their right to contact a Medicare quality improvement organization (QIO) with concerns about the quality of care they receive under the Medicare program, according to the American Hospital Association (AHA).

Currently, only beneficiaries admitted to hospitals as inpatients are required to receive information about contacting their state QIO regarding quality of care issues, the AHA says. The proposed rule would pertain to all Medicare patients at hospices; home health agencies; hospitals and critical access hospitals; ambulatory surgical centers; rehabilitation agencies and public health agencies that provide outpatient physical therapy and speech-language-pathology services; comprehensive outpatient rehabilitation facilities; long-term care facilities; portable x-ray services; rural health clinics; clinics and federally qualified health centers.

CMS will accept comments on the proposed rule through April 3. The proposed rule can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-2275.pdf>. You may submit electronic comments on this regulation at <http://www.regulations.gov>. ■

## Joint Commission deletes element of performance

The Joint Commission has approved the deletion of element of performance (EP) 10 at MM.05.01.01 for the home care, behavioral health

care, critical access hospital, hospital, and long term care accreditation program. The deleted element of performance requires that “all medication orders are reviewed for the following: Variation from the hospital’s indication for use.”

The Joint Commission believes this requirement is redundant because standard MM.04.01.01, EP 9 requires every medication that is ordered to include an indication for use. In addition, standard MM.05.01.01 contains other requirements that meet the intent of EP 10. These EPs state that “all medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.” These EPs also state that “[a]fter the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.” ■



## Steps recommended for communications

*EOL talks happen less than 40% of the time*

A new policy statement issued by the American Society of Clinical Oncology (ASCO) offers guidance to physicians to initiate discussions about the full range of palliative care and treatment options soon after a patient is diagnosed with advanced cancer.<sup>1</sup>

ASCO’s policy statement outlines essential elements of care for patients with advanced cancer and identifies barriers that currently prevent advanced cancer care planning conversations between physicians and patients. The key elements identified by ASCO are:

- Physicians should initiate candid discussions about prognosis with patients soon after an advanced cancer diagnosis. These conversations currently occur with less than 40% of patients with advanced cancer.
- Quality of life should be an explicit priority throughout the course of advanced cancer care. Physicians must help patients understand their prognosis, potential risk and benefits of available treatments, and quality-of-life considerations. In cases in which active treatment is unlikely to

extend survival, palliative care should be discussed as a concurrent or alternative therapy.

- Clinical trial opportunities should be increased. Currently, very few patients with advanced cancer participate in trials due to strict eligibility criteria. Few trials address quality-of-life issues and other barriers. Increasing opportunities for these patients to potentially benefit from trials and to contribute to improving cancer care should be a high priority.

To address barriers to advanced care planning, ASCO recommends the following:

- Emphasize advanced care planning in physician education and training programs.
  - Communication skills for discussing prognosis and care options should be emphasized both in oncologists’ initial training and in continuing medical education.
  - For oncologists in practice, advanced cancer care planning should be a key part of ongoing quality improvement programs.
  - Palliative care should be incorporated into American Board of Internal Medicine oncology training and certification, and into oncology fellowship programs.
- Increase opportunities for advanced cancer patients to participate in clinical research. Prioritize studies that do the following:
  - evaluate strategies to maximize quality of life for patients with advanced cancer;
  - examine potential ways to improve communication between oncologists and patients to ensure patients’ care reflects individual goals and preferences;
  - assess which patients with advanced cancer are most likely to benefit from novel treatments and study how to overcome biological mechanisms that make their cancer resistant to available treatments.
- Increase educational resources for patients with advanced cancer. To help guide patients through difficult patient-doctor discussions, ASCO has published a free booklet for patients with advanced cancer. To access a copy of the book-

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let, go to [www.cancer.net](http://www.cancer.net), select “Coping” from the left navigational bar and scroll down to select “Advanced Cancer Care Planning.”

## REFERENCE

1. Peppercorn JM, Smith TJ, Heift PR, et al. Individualized care for patients with advanced cancer. *J Clin Onc*. Online before print. Accessed online Jan. 31, 2011. Web: <http://jco.ascopubs.org/cgi/doi/10.1200/JCO.2010.33.1744>. ■

# Legal restrictions deter advanced directives

Although all states and the District of Columbia have laws providing for the use of advanced directives, those same legal statutes might hinder the effective use of advanced directives, according to researchers at the University of California, San Francisco.<sup>1</sup>

In a review of 51 statutes addressing advanced directives as well as articles and legal proceedings, researchers discovered several unintended barriers to effective clinical use. Barriers included poor readability because all of the laws were written above a 12th-grade reading level. Another barrier was health care agent or surrogate restrictions. Forty states did not include same-sex or domestic partners as default surrogates. Execution requirements needed to make forms legally valid also can pose problems. Thirty-five states did not allow oral advance directives, and 48 states required witness signatures, a notary public, or both.

The researchers suggest doing away with mandatory legal language; relaxing health care agent and surrogate limitations, including non-medical professionals who might be close to unbefriended adults; promoting universal acceptance of oral advance directives; and eliminating witness and notary requirements.

They recommend that all states adopt nonrestrictive reciprocity laws for directives from other states, regardless of the location or type of advance care planning tool used, and urge that patients be allowed to document their religious, social, and cultural values and preferences for end-of-life care.

## REFERENCE

1. Castillo LS, Williams BA, Hooper SM, et al. Lost in translation: The unintended consequences of advance directive law on clinical care. *Ann Intern Med* 2011;154:121-128. ■

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