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For-profit vs. not-for-profit: Is one better than the other?

Study criticized for conclusions, negative implications

“Cherry picking” was the term used in an Associated Press headline for an article that described the results of a *Journal of the American Medical Association* article comparing diagnoses, length of stay, and patient care between not-for-profit and for-profit hospices.¹ Although the study authors did not use term “cherry picking” in the article, their conclusions that for-profit hospices had a disproportionate number of patients with non-cancer diagnoses and longer lengths of stay implied a for-profit focus on higher revenue-producing patients, according to experts interviewed by *Hospice Management Advisor*.

Members of the hospice industry are concerned that the study and some of the news coverage of the study portrayed hospice as a forced

EXECUTIVE SUMMARY

A study that appeared in the *Journal of the American Medical Association* presented data and conclusions that resulted in headlines portraying for-profit hospices as selecting patients who represented the greatest revenue opportunities. Hospice industry leaders expressed concern that the study would use length of stay, diagnoses, and number of visits to present a picture of care provided in for-profit vs. not-for-profit hospices.

- Available data included number of visits as skilled or non-skilled, but did not include description of types of visits.
- True quality measures of pain control, symptom management, or patient/family satisfaction are not yet available so it is not possible to compare quality.
- Study did not take into account relationships with home health or hospitals that might affect timing of referrals and length of stay.
- Community needs that guide the provision of care to specific diseases or locations of service were not addressed in the study.

choice in an industry loaded with organizations that want to select patients based on potential profit, points out **J. Donald Schumacher**, president and chief executive officer of the National Hospice and Palliative Care Organization in Alexandria, VA. “We are concerned about how hospice is perceived in the community and this study presents problems for both not-for-profit and for-profit hospices,” he says.

“I was shocked at some of the conclusions reached by the study authors and it wasn’t until I looked at the data that I realized the differences reported were small,” says **J. Brad Hunter**, chief executive officer of Legacy Hospice, a for-profit hospice in Charlottesville, VA. “I understand why HHS [Department of Health and Human Services] would fund a study to compare duration of stay

for long length of stay patients, but when the outcome includes such small variation in results, I question why the author would hold these data out as a significant variant between hospices with different tax statuses,” he says.

Another issue that Hunter questions is the data sample used for the study. “While the data are likely statistically valid, I note that approximately 50% of the hospices in America have a for-profit status, and 50% of the hospices in America are considered non-profit,” he points out. “However, her selection of provider data included 78% non-profit hospice agencies and 22% for-profit hospice agencies,” he says. The small variation in data and the small number of for-profit hospices used in the study make Hunter question the results. “I can’t get comfortable with her results based on this sample, much less have any support for the conclusions the author drew,” he adds.

In addition to looking at length of stay and diagnoses, the study also evaluated the number and type of visits made to patients during their hospice stay. Results show that tax status does not affect the number of skilled visits per patient day. However, the study does point out that for-profit agencies provide a greater number of less skilled visits such as home health aides than do not-for-profit hospices.

The study’s use of numbers of visits per day was not meant to be an ideal measurement of quality but with the current Medicare hospice payment model of per diem payments rather than payments based upon specific services provided each day, it was the only measurement available to researchers, says **Melissa W. Wachterman**, MD, MPH, Beth Israel Deaconess Medical Center in Boston, MA, and lead author of the study. “The ‘Holy Grail’ of hospice research is to define and measure quality, but we don’t have the data at this time,” she points out. “As a palliative care physician, I want to know which hospices provide the best pain control, family support, or symptom management, but the type of data available for hospices limits what we know.” One result that is important is that from the perspective of individual patient care, the difference in the number of visits per day was not statistically different, she adds.

“With MedPAC [Medicare Payment Advisory Commission] looking closely at the hospice benefit, the study was designed to look at case mix, length of stay, and visits per day, and see if there were differences based upon the hospice’s profit status,” says Wachterman. MedPAC has recommended that, in 2013, the hospice benefit provide

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Editorial Questions
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relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases, with a higher payment for the costs associated with patient death at the end of the episode. One of Wachterman's conclusions was that for-profit have a higher proportion of patients with non-cancer diagnoses, such as dementia, a long length of stay, and nursing home residence, which represents a financially beneficial opportunity for the hospice because the per diem rate is consistent throughout the episode. She adds, "Patient selection of this nature leaves nonprofit hospice agencies disproportionately caring for the most costly patients."

Hospice services fit dementia patients' needs

"I am not happy with the implications that dementia patients in nursing homes require a lower skilled level of hospice care than other patients," says **Joan M. Teno**, MD, MS, professor of community health and medicine at the Warren Alpert School of Medicine of Brown University and associate medical director for Home and Hospice Care of Rhode Island, a not-for-profit hospice in Providence, RI. "The assumption is that nursing home patients don't require the same level of care from hospice staff, but that is not true," she says. Once a patient is a hospice patient, the nursing home staff may provide daily care, but skilled care to control symptoms such as shortness of breath or pain must be provided by the hospice staff, she points out. "Patients with dementia can be more difficult than other patients because they are impaired longer, each patient's condition progresses differently, and it is difficult to manage pain in long-term patients," she explains.

"The implication is that for-profit hospices focus on nursing home patients because they are more profitable," Teno says. "I live in a state in which almost one-third of deaths occur in nursing homes," she says. Teno points out that she shared that knowledge with hospice management and suggested they look at enhancing services to nursing home patients. (*See more on specialized services, pg. 40*) "This was not a suggestion made to increase revenue, but to improve end-of-life care for nursing home patients," she adds.

Although the study reports a lower proportion of patients with cancer in for-profit hospices (34.1% vs. 48.4%) and higher proportions of patients with dementia (17.2% vs. 8.4%) and other diagnoses (48.7% vs. 43.2%), Hunter does

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not believe that hospices with either tax status select patients by diagnosis. "I think all hospices want to provide end-of-life care to as many patients and families that qualify for hospice services as possible," he says. Hospices in the area he serves don't turn away patients because they are living with a specific illness that may have a shorter length of stay than other illnesses, he says. "It just doesn't exist or occur in the real world," he adds, "It's unfortunate that some researchers take small variations in data, overlay tax status of an organization, and then conclude that an issue exists due to tax status."

There is nothing wrong with a business model that develops a specialized focus on certain diagnoses or locations of care, says Schumacher. "I spoke with a former CMS [Centers for Medicare and Medicaid Services] administrator who told me that a hospice can market their program as specializing in care for certain diagnoses as long as they accept all patients who are appropriate for hospice care," he says. The Medicare Conditions of Participation apply equally to all hospices, regardless of tax status, so all hospices are bound by the same rules, he adds.

Hospices are required to accept all patients who are hospice-eligible, but referral sources often

influence length of stay with the timing of their referrals, points out **Carole Fisher**, president and chief executive officer of Nathan Adelson Hospice, a not-for-profit hospice in Las Vegas, NV. “We have two inpatient units that most often care for patients who are moved directly from the hospital setting to the hospice setting,” she says. Referrals from hospitals are often late, with just days left in the patients’ lives, she points out. Referrals from home health agencies affiliated with hospices or family physicians familiar with hospice tend to come earlier so patients and family members can benefit from palliative care and counseling. “The study did not define how many of the hospices in the study had inpatient units or were affiliated with hospitals or home health agencies,” she adds.

Handle publicity carefully

Although the *JAMA* article and subsequent news coverage caught the attention of the hospice industry, most hospice leaders did not hear much from their constituencies. “I’ve had a couple of conversations with people, but I pointed out that the study did not paint the full picture,” says Fisher. With a total of 26 hospices in Southern Nevada, most of which are for-profit, Fisher points out that using the study to cast a negative impression of the competition is not the way to go. “We face a tough task to educate people about care at the end of life and we are all working toward the same goal of improving access and care,” she adds. (*For tips on handling negative publicity, see pg. 41.*)

The most important thing for hospice leaders to keep in mind is that the study did not measure quality, points out Teno. Although the data included types of visits such as home health aides compared to nurses or social workers, it was not able to describe the visit, she says. “We don’t know if the visit was a 10-minute interview with a family member or a full assessment or several hours to help with personal needs,” she says. Also, telephone calls were not included in the data as visits, she adds. Many hospices check on patients with telephone calls to follow up on medication changes, symptoms noticed during the visit, or in response to calls from family members, she points out. “Telephone follow up is an important part of care that wasn’t addressed,” she adds.

Schumacher agrees that the study should not be used by anyone to evaluate quality of care. He is concerned that people looking at this study may overlook the critical importance of quality mea-

asures when discussing the provision of hospice care. He points out, “It’s important for people to know that quality of care is not based on tax status, it is based upon leadership within the hospice.” ■

REFERENCE

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Disease-specific programs enhance care

Focus on community to reach new patients needs

Developing a business model or marketing strategy that includes services focused on specific patient populations does not necessarily mean that a hospice is targeting higher revenue patients as implied in a study recently published in the *Journal of the American Medical Association*,¹ but it often represents a response to a community need, says **Carole Fisher**, president and chief executive officer of Nathan Adelson Hospice, a not-for-profit hospice in Las Vegas, NV. One way to improve care is to improve care by addressing specific patient needs,” she says.

Although hospices accept all appropriate hospice patients according to Medicare’s Conditions of Participation, some hospices are developing disease-specific programs to provide more focused care for some conditions. “We developed a program to address the needs of patients with pulmonary diseases such as chronic obstructive pulmonary disease (COPD),” says Fisher. “COPD patients are an underserved population in our area and offering services that are specific to their needs was the right thing to do,” she adds.

“My hospice has specific programs for Alzheimer’s, congestive heart failure, and COPD,” says **Mark M. Murray**, president and chief executive officer of The Center for Hospice Care, a not-for-profit hospice in Mishawaka, IN. These are non-cancer diagnoses for which it is more difficult to predict length of service, and which typically result in longer lengths of service, he says. “It is a good business model that results in our hospice providing service to a variety of patients who benefit from hospice care,” he adds.

Murray was surprised that the *JAMA* article used the care of dementia patients as an indicator that for-profit hospices were selecting patients who required less expensive care. “Dementia-related deaths increased by 46% from 2000 to 2006, which means this is a population that hospices should be serving in increasing numbers,” he says.

The key to providing good hospice care is to look at the needs of your community, he suggests. “This study did not look at local needs that drive the programs you develop or the patients you serve,” he adds. “We developed our COPD program because a high percentage of our community members smoke and develop lung diseases,” he explains.

Programs that provide care to patients in nursing homes are also important regardless of the hospice’s tax status, says **Joan M. Teno, MD, MS**, professor of community health and medicine at the Warren Alpert School of Medicine of Brown University and associate medical director for Home and Hospice Care of Rhode Island, a not-for-profit hospice in Providence, RI. Hospices and nursing homes can work together to provide the best care possible at the end of life, she says.

“Not only can hospice staff and volunteers provide the hospice services directly to nursing home patients, but they can also serve as consultants and educators to support the nursing home staff,” says Teno. “The nursing home will have patients who don’t qualify for hospice care, but may need palliative care and a partnership with a hospice can benefit those patients as well,” she says. In order for all areas of health care to provide the best care possible, it is necessary to look for innovative ways to partner with each other, she suggests. (*For more about hospice-nursing home partnerships, see “Are you taking advantage of nursing home opportunities?” Hospice Management Advisor, February 2010, pg. 13.*)

While hospice was originally focused on care of cancer patients, the increase in the number of non-cancer diagnoses has changed the needs of hospice patients, says Fisher. She adds, “At one time, hospices tried to be everything to everybody but now we see patients with a wide range of diseases that increase the need to offer some disease-specific programs. ■

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Focus on quality, not tax status

Outcomes mean more to patients

Headlines comparing the level of care provided by not-for-profit vs. for-profit hospices did not produce a flood of calls to local hospices questioning their quality of care, but it did create some conversations.

The best way to respond to questions from board members or community members who raise questions about quality and tax status is to point out that quality is measured by outcomes, not tax status, says **Joan M. Teno, MD, MS**, professor of community health and medicine at the Warren Alpert School of Medicine of Brown University and associate medical director for Home and Hospice Care of Rhode Island, a not-for-profit hospice in Providence, RI. Hospices are measuring outcomes now in preparation for public reporting of quality so a more accurate comparison of all hospices can be made, she says. “I don’t have a crystal ball but I image we’ll see opportunities for improvement in outcomes for not-for-profit and for-profit hospices once we have the ability to see those results.”

“We discussed the study and its implications in our administrative staff meeting,” says **Mark M. Murray**, president and chief executive officer of The Center for Hospice Care, a not-for-profit hospice in Mishawaka, IN. “The story wasn’t picked up in the local media so we talked about how to handle the conversation if someone brought it up, but we did not take proactive steps to address it in the media or with our staff,” he says. “Why create an issue where there is none?”

“I’m not sure the public cares about tax status if your hospice provides the care a patient and family need,” says Murray. One of the questions asked of focus groups conducted by Murray’s hospice in preparation of a marketing program was “Does it matter to you if the hospice is not-for-profit or for-profit?” “Forty-five percent of the focus group participants said it did not matter or they didn’t know if it would matter.”

Although the general public may not care, the real concern is that the study will be read by the Medicare Advisory Payment Committee, says **J. Brad Hunter**, chief executive officer of Legacy Hospice, a for-profit hospice in Charlottesville, VA. “For those of us who are for-profit hospices to select only specific patients based on revenue,

we'd have to ignore physician referrals as well as the Medicare Conditions of Participation (COPs)," he says. "If we ignore referrals and COPs we won't continue getting referrals or reimbursement from Medicare!" ■

CMs guide seniors through EOL processes

They provide education, support

Seniors covered by BlueCross BlueShield of Tennessee's Medicare Advantage plan are guided through the end-of-life processes by case managers (CMs) who empower the members with the education, resources, and assistance they need to make their own decisions about what kind of care they want to receive at the end of life.

The Chattanooga-based health plan end-of-life planning program received a bronze award from URAC at the Best Practices in Health Care Consumer Protection and Empowerment awards ceremony last fall.

The program began in 2009 after the health plan started its Medicare Advantage program in 2006, says Alice Greer, RN, BSN, CPHQ, quality research analyst in quality management, who was a case manager at the time.

"As we worked with the Medicare population, we realized that end-of-life concerns are a big issue. We found that even though some of the members knew they were facing a potentially terminal illness, they hadn't thought about end-of-life plans, or if they had, they didn't have a legally appropriate form or had not shared their wishes with their family or their physician," Greer says.

At the same time, the insurer determined that many staff members were uncomfortable initiating a conversation about end-of-life considerations and needed education to learn how to approach members about their choices.

"We looked for ways to assess our Medicare population to identify people who needed the program and to aid the CMs in bringing up the subject with members and leading them through the process," she says.

The CMs who work with the Medicare Advantage members have been trained on how to approach the subject and have information at their fingertips to help educate the members, she adds.

The health plan also collaborated with the non-profit Tennessee End-of-Life Partnership and sponsored a day-long educational program for CMs and the health plan's community of providers.

When seniors sign up for Medicare Advantage, the health plan sends them the health needs assessment. They can return it by mail and have it scanned into the computer program, or they can call and complete the assessment over the telephone.

Referrals come from the health needs assessment, the utilization management department, claims data that show members with multiple hospital admissions, and the health plan's predictive modeling.

"CMS requires Medicare Advantage to conduct an initial health needs assessment. We tweaked our assessment and configured our computer system so it would automatically send out a referral when someone had a condition that indicated they might benefit from an end-of-life discussion," Greer says.

Any Medicare Advantage member who is referred to case management is asked if they have end-of-life plans, and if they would like to discuss the subject. Those who meet the criteria for needing immediate end-of-life support are offered a more intensive care plan, Greer says.

Criteria for the intensive care plan include debility, failure to thrive, cancer patients with a terminal diagnosis or uncontrolled symptoms, advanced heart disease patients, advanced pulmonary diseases, dementia, end-stage liver or renal disease, and neurological disorders such as stroke, Parkinson's disease, and amyotrophic lateral sclerosis.

The utilization management department has a trigger list of criteria. If someone calls to get approval for a procedure and the patient falls into one of the diagnosis categories, those nurses are trained to send a referral to a CM, she says.

The CMs make outreach calls to all members who are eligible for the intensive care planning program.

They start by explaining the services the health plan offers, what the role of the case manager is in end-of-life planning, and what they can do to empower the member to make their own decisions.

If members consent to participate in the program, the CM completes a thorough assessment that includes their current health status, their present functional status, what resources they have, who their caregivers are, their understanding of their current level of health, diagnosis and prognosis, information on their socioeconomic status, and any educational or language barriers they may face.

“The case managers can mail materials to the member or provide Internet resources. We go so far as to help them prepare their forms if they know what they want and don’t know how to get the Tennessee state-approved forms,” she says.

The Medicare Advantage staff include two social workers who help people complete the forms over the telephone or, if the member prefers, will meet with them at the health plan’s Silver Life Center.

The CMs get consent to notify the member’s primary care provider and collaborate with the physician as well as the caregiver so everyone is on the same page about the member’s end-of-life choices.

When the CM conducts the assessment, the software system automatically triggers an appropriate end-of-life plan based on the answers the member gives to questions. The care plan includes automated talking points that pop up on the screen.

For instance, if the member says he hasn’t made end-of-life plans and doesn’t know what is available, the CM can click on a list of advanced directions with a concise explanation of each.

The assessment and care plan is available in the health plan’s software for CMs in other areas of the company and other lines of business to use. The specific assessment is geared to the senior population, but the care plan is appropriate for any age, Greer says.

When developing the care plan, the CM helps members make choices from all the options available, such as where they want to receive care, symptom management, bladder control, and issues such as mobility, safety, comfort, and pain. They discuss caregiver needs and stresses, and services needed at home if the member chooses to stay at home.

The case management team spends a lot of time educating members about hospice and palliative care and the difference between the two, she says.

One of the goals of the end-of-life program is to overcome the negative impression many older people have of hospice care by educating them. Some members aren’t aware of the hospice benefits they have. Others don’t take advantage of them because of their perception of what hospice means, Greer says.

“Length of stay in hospice is incredibly short with our Medicare population. If somebody doesn’t get into hospice until the last two days of their life, they’ve lost the opportunity to increase the quality of life, have gone through unnecessary procedures, and increase the stress on the family. Knowing about hospice and what it means saves people a lot of panic-mode trips to the emergency

room for interventions and makes them feel more in control,” she says.

As they work with the members, the CMs stress the importance of collaborating with their health care providers so the treatment team will be aware of the patients’ wishes.

If patients agree to participate in the program, the CM follows them and contacts them at least every 30 days. The patient and family members have a telephone number they can call to talk to the case manager at any time.

Patients who enroll stay in the program until they decide to drop out or they pass away.

Before the program began, CMs documented a discussion with members on end-of-life issues only 58% of the time. After the training, the figure went up to 99%.

“It’s hard to measure outcomes in a program like this, but we know we are making a difference because we get a lot of letters from family members after the death of a loved one, thanking us for the case manager’s support. They tell us how grateful they were that the case manager support alleviated their hesitancy to accept hospice care and that their loved one was able to die at home where they wanted to be.

“We also get positive feedback from the members themselves who really appreciated being educated and empowered to make their own choices and to make sure their wishes are followed. Some are chronically ill but may still have years left, and it makes them feel good to know they have taken care of business, so to speak.” Greer says. ■

Ethics committee debates end-of-life treatment

Palliative sedation policies reviewed

As hospitals add more palliative care services, ethical issues arise that sometimes cannot be handled solely by a hospital ethics board because a broader community perspective is necessary.

For instance, what is the hospital’s policy regarding cardiopulmonary resuscitation (CPR) when all attending clinicians agree the patient cannot be resuscitated? Or should physicians provide palliative sedation, and how should this be

described to patients and families?

The Harvard Community Ethics Committee is a potential model for how these issues might best be handled. The committee is comprised of 16 men and women who are diverse by age, profession, language, ethnicity, religion, and in other ways.

“The Harvard Community Ethics Committee was set up within the division of medical ethics as a resource for faculty and fellows of the Harvard-affiliated community to have access to a diverse group of lay people when they wanted to ask for a public response to things,” says **Christine Mitchell**, MTS, MS, associate director of clinical ethics in the department of global health and social medicine at Harvard Medical School in Boston, MA.

A recent example of how the committee fulfills its role occurred when a couple of physicians from the Harvard Medical School community asked the committee how the public understood and felt about palliative sedation.

The committee met with experts in palliative sedation, reviewed various policies on the subject, and eventually wrote a report that answers a list of questions, such as these:

- What does the community understand when asked about palliative sedation?
- What sorts of patients would be appropriate for this treatment option?
- How sick or close to death do you think someone ought to be before this person is considered for palliative sedation?
- How do members of the committee feel about the distinction between palliative sedation, euthanasia, and physician-assisted suicide?

During the committee’s discussions, members expressed discomfort with the terminology, Mitchell recalls.

“People asked, ‘Why don’t we call it what it is?’” she says. “So we ended up deciding to call it ‘continuous deep sedation as comfort care until death.’”

The ethics committee defined a whole set of terms used in the report, including addressing the issue of what it meant to say someone was imminently terminal, Mitchell says.

“They noted that these were patients for whom other ways of treating their pain have not been successful, she says.

The committee looked at how palliative sedation might be linked to euthanasia or physician-assisted suicide, beginning at first with some member confusion over the various terms and their meanings. They ended up being convinced that there is no legitimate link between palliative

sedation and the intent to end a sick patient’s life, Mitchell says.

“It’s not close to the illegal or controversial methods of dying, the committee said,” she adds. “This is something that should be considered as a reasonable treatment option for patients dying of pain and who couldn’t be treated in other ways.”

The aim of euthanasia and physician-assisted suicide is to end a patient’s life; the primary goal of palliative sedation is to relieve a patient’s pain, the committee decided.

“We had people lined up in opposing camps at the beginning, saying, ‘You can’t do it,’ and others saying, ‘Of course you want to treat someone’s pain if they’re dying — even if they’re asleep,’” Mitchell says.

After conversations with nurses and physicians in palliative care, the committee members’ views evolved.

The Harvard committee handles its broad diversity in opinion and experience by drafting a survey of questions for each member to consider and answer. The questions include those with just “yes” and “no” responses and those that require a more detailed description of the member’s thoughts. This ensures each member’s thoughts and concerns are taken into account, Mitchell explains.

Committee members are seeking input on these ethical issues from friends, as well.

“We have a second step that gets the issue beyond this committee that has thought about it and out to people who don’t think about it,” Mitchell says. “Everybody completes the survey and gives their reasons on paper for their thoughts.”

The palliative sedation discussion lasted nearly a year, with some interruptions for other ethical considerations. Each part of the report’s wording needed full committee agreement and review.

The final report is not the same as policy, but it’s sent to members of the Harvard Ethics Leadership Group, the division of medical ethics at Harvard, and to ethics committees at Harvard teaching

SOURCE

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hospitals and health care facilities.

Each institutional ethics group could use and adopt the report as policy, if desired.

Sometimes a hospital will use the report to inform and assist with policies, Mitchell says.

“I know within the Children’s Hospital at Harvard, they were working on a policy about social media, and our committee’s report on the topic influenced their policy,” she adds. ■

Educating hospital staff about palliative care

Hospitals increasingly recognize need for it

Palliative care once was a rare treatment option in the hospital setting, but in recent years it has grown in popularity to the point that most major hospitals and many small-to-mid-sized hospitals have palliative care programs available for patients, an expert says.

Hospital administrators and providers have come to realize that palliative care is not the same as hospice or end-of-life care. It’s a way to provide patients with more comfortable care than they’d receive while in the hospital or nursing home, which is where many patients spend their last days. With palliative care, patients often transition more smoothly from the hospital to home care or nursing home care, often receiving better quality and more cost-effective care, according to the Center to Advance Palliative Care in New York, NY.

“It’s a simultaneous care model that should be administered at the point of diagnosis of serious illness, cognitive impairment, or multiple illnesses,” says **Diane E. Meier**, MD, director of the Center to Advance Palliative Care at Mt. Sinai School of Medicine in New York, NY.

“Palliative care is what we do to prolong life, improve the quality of life, mood, depression, family caregiver well-being, and reduce the likelihood of someone ending up in the hospital or intensive care unit (ICU),” she adds.

There are more than 1,500 hospitals in the United States with palliative care programs, and 80% of the largest hospitals have palliative care programs, Meier says.

“Palliative care serves the sickest 5% to 10% of patients, the group that tends to have long and costly hospital stays that don’t benefit the patient and are paid by DRGs,” she explains. “The longer

these patients stay in the hospital, the less money the hospital makes, so hospitals lose money on these very sick patients.”

Also, there are various ethical considerations: First, these very sick patients would have a better quality of life in a palliative care program, where it was presented at home or in another care setting; and, two, other patients who need the hospital beds occupied by the very sick patients are prevented from getting the care they need, Meier says.

“This small group of patients blocks up the intensive care unit (ICU) and emergency department and increases the rate of ED diversion — which is a huge financial hit for hospitals,” she adds. “They reduce efficient throughput, and that’s why so many hospital CEOs have not only invested in palliative care programs, but have recruited leadership to lead these programs.”

In these poor economic times, hospitals are under incredible financial stress, so anything they can do to provide better patient care while strengthening their financial reserves is important, she says.

Hospital ethics boards might address palliative care, looking at whether their own facilities properly identify and refer patients to these services, and they might help educate staff and providers about palliative care, Meier suggests.

“They might take the lead in educating physicians and the nurse community within the hospital about how palliative care is not end-of-life care,” she says. “They should show data on the impact of palliative care on quality, survival, family well-being, and patients getting the kind of care they need in a setting they want, while avoiding risk.”

Hospital stays are in themselves a risk factor for higher morbidity and mortality, she notes.

People who are very ill often are at the greatest risk of infection or having complications while in the hospital, Meier says.

“There’s the risk of medical error and the risk of hospital-acquired infection,” she adds. “So when you have serious and advanced chronic disease, an infection acquired in a hospital can be life-threatening.”

SOURCE

For more information about educating staff, contact:
• **Diane E. Meier**, MD, Director of Center to Advance Palliative Care, Mt. Sinai School of Medicine, New York, NY.
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Research has shown that hospice care can prolong life in congestive heart failure patients and among people with some types of cancer, Meier says.

Hospice care can positively impact patients' psychosocial well-being, social support, and mood/depression. Since palliative care provides some of the same pain relief and psychosocial support that hospice provides, it's likely this type of service also would have a positive emotional impact on patients.

"You can't separate the body and the mind," Meier says. "When people are incredibly stressed, anxious, and not sleeping, they die sooner."

These are all potential reasons for the beneficial outcomes of palliative care.

"I think it's important for ethics committees to not see palliative care as a means for people we've given up on," Meier says. "Palliative care helps people live longer, and ethics committees should be at the forefront of promoting early and widespread integration of fundamental palliative care principles."

Hospital ethics committees also might look at their health care institutions' policies and procedures to identify what's in place to promote the timely application of palliative care.

"Ethics boards should ensure the fundamental competencies of palliative care for front-line staff, including care managers, critical care doctors, oncologists, and other groups who take care of this 5% to 10% of the hospital population," Meier advises. "The staff should be encouraged to get additional training, skills, and expertise in palliative care."

Hospital staff can obtain checklists, policy templates, and other materials about palliative care from the website of the Center to Advance Palliative Care at www.capc.org.

There are referral checklist tools available for a free download, as well as a tool that offers suggested communication phrases in palliative care and guidance on how to respond to emotion.

"Ethics committees could see that hospitals have the checklist integrated into required care," she says.

At admission, nurses could find out whether patients have appointed surrogate decision-makers in the case of loss of capacity and ask whether the patient or family have any questions about what to expect regarding the illness, she adds.

"The screening list would be done by admitting nurses with a daily checklist done during work rounds by whoever is responsible for the patient," she says. "There would be continuous assessing for these issues." ■

ED focuses on caring for end-of-life patients

Program offers 'comfort, control, and choices'

An 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."

SOURCE

For more information about treating terminally ill patients in the ED, contact:

• **Ramazan Bahar**, RN-BC, ED Nurse Coordinator, and **Mark Rosenberg**, DO, MBA, FACEP, Chairman of Emergency Medicine, St. Joseph's Regional Medical Center, Paterson, NJ. Phone: (973) 754-2000.

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, 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. ■

Walking competitions keep staff happy

Program addresses mental and physical health

[Editor's note: This is the second of a two-part series that examines ways to support employees in their personal lives in order to improve work performance and staff retention. Last month we looked at the use of Employee Assistance Programs (EAPs) and offered suggestions for choosing the right provider for your hospice. This month, we learn about a hospice that has set up an in-house wellness program that addresses personal life issues for employees.]

Designing a program that appeals to the interests of all employees is not an easy task, but the managers and employees of Home Hospice of Grayson County in Sherman, TX, have developed an employee wellness program that offers something for everyone.

"We have to take care of our employees just as we ask them to take care of our patients," says **Sherry Little**, executive director of the hospice. While her hospice has had an Employee Assistance Program (see "Want to improve your retention? Help employees with personal issues" Hospice Management Advisor, March 2011, pg. 25) for 16 years, the agency offers other in-house programs that also address the personal needs of employees, she points out. In 2010 the hospice offered an employee wellness program that addresses emotional, spiritual, financial, and physical needs of employees, she says. Although participation in the different facets of the program is not required, 100% of employees have participated in at least one seminar or activity, she says.

A series of seminars and activities throughout the year address topics that help employees find support in each of the four areas addressed by the wellness program, Little explains. Topics of seminars have included team building, how to identify what makes you happy, and how to save money. "We also have a monthly meeting led by our chaplains to address spiritual needs," she adds.

Helping employees stay physically healthy is also important, points out Little. "In addition to nutrition seminars and health screenings for high blood sugar or cholesterol, we also developed a competitive walking program," she says. Employees who participate in the walking program join teams and each person wears a pedometer to measure the distance walked. Results are tracked to see which teams walk the furthest. "We set goals for the mileage by choosing destinations," she says. "For instance, the teams are now walking from Sherman, TX, to Pikes Peak." Employees who choose to work out at local health clubs enjoy the

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hospice's offer to pay one-half of the health club membership fee, she adds.

One activity that about one-third of employees attends regularly is a breakfast meeting that started about six years ago and occurs every two weeks, says Little. Entitled "Our time together," the meeting is organized and led by employees, she says. Leadership for the meeting rotates among employees who regularly attend the get-together. The meeting's leader asks four people who plan to attend to bring breakfast and decides the topic of the morning.

Topics range from dealing with the grief and stress that is part of a hospice employee's job to sharing personal stories that might inspire others, says Little. "The bi-weekly breakfast gives newer employees a chance to get to know long-time employees on a personal level," she says. "You hear things you don't hear in a team meeting to discuss patient care; you hear stories that explain why we do what we do," she adds. The breakfast meetings not only serve to encourage employees, but also to let them see that other people do understand what they are feeling, she says.

Employees are paid for their time to attend "Our time together" as well as other seminars that occur during their normal workday, points out Little. "We are planning evening workshops this year so spouses can accompany employees for some of the seminars," she says. "We are also going to invite our board members and their spouses."

Hospice employees are asked to help patients and families face the most stressful and emotional times in their lives and that responsibility increases the need for hospice managers to make sure their employees get the help they may need for themselves, points out Little. She adds, "A recent employee survey conducted to evaluate the wellness program showed that 100% of employees liked the program and want the hospice to continue offering it." ■

SOURCE

For more information about employee wellness programs, contact:

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