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Growth of hospitalist programs brings confidentiality, continuity concerns

Ethics committees must address unique communication issues

The expansion of hospitalist programs at medical centers nationwide has yielded impressive benefits in terms of reduced costs of care and lowered length of stays, according to recent published studies.

But the use of designated inpatient physicians to assume primary responsibility for admitted patients can have unforeseen consequences for continuity of care, patient privacy, and clinical decision-making, some ethicists are warning.

"There are important ethical issues that people need to understand. And as these ethical issues arise in the hospital, what is best for the patient is for the hospitalist and the primary care provider to work closely together," says **Steven Z. Pantilat**, MD, assistant clinical professor of medicine in the medical ethics program at the University of California-San Francisco (UCSF) School of Medicine.

According to the Philadelphia-based National Association of Inpatient Physicians, there currently are 6,000-7,000 hospitalists practicing in the United States today. But that number is expected to grow to approximately 20,000 physicians over the next 10 years.

Recent studies have indicated hospitalist programs can reduce hospital lengths of stay by 15%-16% and lower hospital costs by an average 13.4%.[1,2]

But ethics committees at centers with hospitalist programs need to be aware of the unique needs and ethical dilemmas these arrangements can provoke, say Pantilat and others.

A particular area of concern is patient confidentiality, he notes.

Whose decision stands?

Pantilat and colleagues at UCSF have published several papers and case studies of ethical issues related to hospitalist systems. A key issue that keeps coming up, he says, is whether the outpatient primary care

provider's decision to keep some information confidential should be respected by the inpatient primary care provider — the hospitalist.

In one case they examined, an HIV-positive patient was admitted to the hospital for treatment. Although the outpatient primary care physician knew the patient's status, the patient did not want the information disclosed — even to his wife and family. However, the hospitalist assuming care for the patient felt duty-bound to inform the patient's spouse.

"One thing we have focused on in our studies is the issue of confidentiality and maintaining confidentiality when another physician enters the care of the patient in the role of the primary doctor responsible for the care of the patient, not simply as a consultant, but really someone who is primarily responsible for the patient in the hospital," Pantilat explains.

The hospital-based physician may have different ideas about his or her obligations to maintain a patient's confidentiality vs. a duty to prevent others from being harmed, he says.

"Because they only see that patient while in the hospital, they may view the value of trust and the implications for patient confidentiality differently than the primary care physician might," he speculates. "Specialists might defer to the primary, because they have ultimate responsibility for the patient. But I feel the hospitalist will feel primarily responsible."

In the cited case, neither physician's position would be wrong, which makes the issue even more complicated.

"HIV is a different situation because in most states, health care providers are permitted to warn [others at risk] but they do not have a duty to warn," he says. "In other cases, like tuberculosis, for example, the physician has a legal duty to notify the health department and warn others at risk."

Rather than attempt to legislate whose position would take precedence, it is more important to have systems in place that foster good communication between the hospitalist and the outpatient physician, he says.

"The closer the hospitalist and the primary care physician can work together, the better for the patient," he says. "If it is an ethical issue, a medical issue, a social issue, in all of those situations — where there are multiple 'right' ways to go — to work together to come up with a solution is what is best."

Maintaining communication

Poorly designed hospitalist systems — those without established protocols for ensuring communication between the hospitalists and primary care providers — can significantly detract from a patient's continuity of care, adds **Ronald Greeno**, MD, chief medical officer and senior vice president of physician services for Irvine, CA-based Cogent Health Care Inc., an inpatient physician management company.

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What is a hospitalist?

The term "hospitalist" can mean a variety of things. But most physicians agree that it is a doctor, based in the hospital, who is there to accept admissions from physicians whose patients require hospital admission and who are not able to, or do not wish to, supervise the patient's inpatient stay, says **Ronald Greeno**, MD, chief medical officer and vice president for physician services for Cogent Health Care Inc., an inpatient physician management company.

"Some people think that if you spend a certain percentage of your time in the hospital, you are a hospitalist, but that's neither here nor there," he states.

What became known as the hospitalist movement evolved in the early 1990s during the rapid expansion of managed health care. As primary care physicians (PCPs) began to see more patients, they found it difficult to balance their office practice with supervising the care of their patients who were hospitalized.

"More and more physicians began to realize that it was an inefficient and ineffective use of their time to take care of 30-40 patients a day in the office and then try to run over to the hospital to see one patient who had been hospitalized," he explains.

At first, PCPs mostly made referrals to specialists in the area covering the patient's complaint. If the patient was hospitalized for chest pain, the PCP might ask the cardiologist to go see the patient. Pulmonologists were called for patients with breathing problems, etc.

Eventually, some physician groups decided that it made sense for some physicians to specialize in caring for patients in the hospital, supervising and coordinating care, regardless of their diagnosis.

"When groups of doctors started forming independent practice associations and assuming risk from health plans, the most efficient model for taking care of those hospitalized patients was to have designated doctors admit them when they needed to come to the hospital," Greeno says. "My group and several other groups in California started doing this in the 1990s. This phenomenon was occurring in pockets throughout the country."

At first, hospitalist groups marketed themselves to primary care physicians. The PCPs contracted with the hospitalist group to care for their admitted patients. Increasingly, however, hospitals have started their own hospitalist programs and offered hospitalist services as a benefit for PCPs.

And hospitals found that such programs were more efficient ways to care for patients, Greeno says.

Primary care providers can typically only perform rounds twice a day — in the morning and evening. Because hospitalists are always at the hospital, they are available to interpret test results, make referrals, and make decisions about patient care in a much more efficient manner, some centers have found. ■

"As a hospitalist, you have an obligation to communicate with primary care physicians and to do that in a 100%-reliable way," he notes.

The system must be set up so that patient information, case management, and follow-up cannot slip through the cracks. With two separate physicians assuming primary responsibility for the patient, the potential for such an occurrence is heightened.

"If, as the hospitalist, I am discharging a patient home at 5:15 in the evening on a Friday of a three-day weekend, by the time Tuesday rolls around, I am not going to remember to call the [primary care] doctor about that patient three days later," Greeno says. "Then, even if I call their office, and they are with a patient, by the time they call me back, I am in another part of the hospital, etc."

The physicians can play phone tag, then give each other a verbal update, but, by the time the patient presents for a follow-up visit to the outpatient physician a week later, does the primary care doctor remember all of the information conveyed by the hospitalist?

Cogent's solution to the problem has been to design a standard discharge summary dictated by the hospitalist that is automatically transcribed and faxed to the physician's office immediately upon the patient's discharge. The summary has all of the information about the patient's stay, the medications he or she has been sent home with, and when they will are supposed to present in the office for a follow-up visit.

At the same time, the discharge summary information goes into a central database. A specialized clinical care coordinator is assigned to call the patient 48 hours after discharge to ensure the care plan is in place, that any schedule home health services have occurred, and that patient is in contact with the outpatient physician.

The information in the database also is available to the hospitalist physicians if that patient is readmitted to that hospital or another hospital at a later date, Greeno adds.

"Just that one step, you have to figure out a clear, reliable way to ensure communication and follow-up that provides for good patient care and

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helps the primary care physician with continuity of care," he states.

Another wrinkle in hospitalist programs is the issue of patients who do something to irreparably damage the patient-physician relationship, says Pantilat.

In outpatient physician practices, if a patient is uncooperative or threatening to the physician or staff, the physician can ethically discharge the patient from the practice.

"The reason we can do that is we don't have ongoing care that cannot be handled by somebody else," he explains. "I can give the person numbers of other physicians and help them find doctors, but say, 'Look, I can't have you back here.'"

But what if a patient threatens an inpatient physician and then comes back to the same hospital for treatment? Perhaps the facilities the patient needs are not available at another institution, and the hospitalist group is the only one providing inpatient care at that facility.

"We don't have a good answer for that one yet," Pantilat adds. "On one hand, doctors do have that right. But on the other hand, patients need to get appropriate care."

QI efforts strengthened

Though the dual-doctor system may present ethical challenges, there are many ways hospitalist programs improve patient care as well as save money, Pantilat and Greeno note.

Because hospitalists are always at the hospital, it is much easier for facilities to implement and monitor quality improvement efforts.

Cogent's system monitors the discharge summaries to ensure that patients with specific diagnoses receive the recommended treatments, Greeno says.

For example, the monitoring ensures that patients with heart disease are instructed to take aspirin and that patients who have experienced heart failure are given ACE inhibitors on discharge.

"QI efforts and changes in policy may be easier to implement because you have a smaller group of doctors caring for these patients — and educating them about procedures and policies and ethical issues is simplified," says Pantilat.

Discussions about code status and helping patients with serious illnesses consider implementing advance directives also is an area where hospitalists may fare better than their outpatient counterparts.

Cogent requires its physicians to ask about code status with any patient admitted for a certain diagnosis.

"It is one of the things we look at in our audits of discharge summaries," Greeno says. "For 11 different diagnostic groupings, we look for evidence there was a discussion of the patient's code status and the result of that discussion. For patients with certain serious illnesses, patients admitted with ischemic stroke or chronic liver disease, etc., we ask the physician to inquire about code status."

Inpatient physicians may fare better during these discussions than the outpatient primary care providers, speculates Pantilat.

"I completely agree that hospitalists, in some way, have a responsibility to bring it up, and, in some ways, not having known the patient or have a long history with the patient may make it easier," he notes. "The hospitalist can explain that questions about code status are a standard part of what he or she does. But if it is a patient's primary care doctor, the patient may wonder, 'Why are they bringing this up now?'"

For more information

• The web site of the National Association for Inpatient Physicians (NAIP) contains information about ethical issues related to hospitalist practice and background information on hospitalist programs across the country. www.naiponline.org.

• A supplement publication of the *American Journal of Medicine* covered the proceedings of a symposium on the hospitalist movement: Pantilat SZ, Wachter RM. The patient-provider relationship and the hospitalist movement. *Am J Med* 2001; 111(9B). ISSN:0002-9343. Full text available to subscribers at: www.AJMSelect.com.

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Is the time right for a single-payer system?

Health experts and the public are calling for reform

In November, Oregon voters were asked to consider a once unthinkable measure: abolish private health insurance in favor of a taxpayer-funded, single-payer health system that would cover everyone.

Although the proposal was defeated, many observers were surprised at how much public support the effort received. As it turns out, the Oregon campaign foreshadowed the emergence of renewed debate about overhauling the U.S. health care system.

Following the 1994 defeat of the Clinton administration's proposal to offer Americans universal health insurance, reforming the nation's health system largely fell out of favor with political leaders in Washington. But with health care costs continuing to skyrocket, an estimated 1.4 million Americans losing their health insurance last year — joining the 41 million who already had no coverage — many experts feel the time is ripe for reform.

In addition to the Oregon initiative, potential presidential candidate Al Gore told the *Los Angeles Times* in November 2002 that he has concluded that a government-sponsored single-payer system is the solution to the crisis, and he would make universal health coverage a central part of his next campaign.

In December, the American Medical Association (AMA) announced its own reform proposal for expanding health insurance coverage. And Bruce G. Bodaken, chief executive of Blue Cross Blue Shield of California, proposed a plan combining mandated employer coverage and state subsidies in order to cover all of California's 6 million uninsured residents.

"I think the environment now is very similar to 1992," notes **Kenneth Thorpe**, PhD, a member of the Clinton administration's Health Care Reform Task Force, and currently chair of the department of health policy and management at the Rollins School of Public Health at Emory University in Atlanta. "If you go back to the genesis of the interest in broad-based reform — universal coverage and some national effort to control the growth of spending — those conditions are back once again, and they are accentuated by a lot of things that the Institute of Medicine has pointed out with respect to the quality of care."

Concerns about the rate of medical and medication errors, the rising unemployment rates, and the rising cost of health insurance are swamping the U.S. health system. And there is nothing currently on the horizon that might slow those trends down, he states.

"There has not been a lot of interest in broad-based reform until now," he says. "The conventional wisdom was that the only way you could proceed was through incremental small reforms — basically, targeting certain populations but leaving everyone else alone."

The legislation creating the state Children's Health Insurance Program was the last national effort to address specific populations that lacked health coverage and that occurred in 1997, he adds.

Now, people are looking at the underlying problems in quality, coverage and cost and coming to the conclusion that a broad-based national approach is required.

Single payer?

However, broad-based does not necessarily mean a government takeover of the entire health system, say Thorpe and others. There is plenty of room for fixing problems without a such a complete change.

The American Medical Association's proposal calls for employers to create defined-contribution plans that set aside funds for employees' health care costs. The plan also calls on Congress to pass legislation that would allow such accounts to rollover funds from year to year.

Such a proposal is similar to the consumer-driven model proposed and piloted by CareGain, a Monroe Township, NJ-based health care asset management company, says **Amit Gupta**, MD, CareGain's president and chief executive officer.

Under their model, employers fund individual health care reimbursement accounts at a set amount and then provide a health insurance plan that kicks in and pays for health care costs that exceed that.

Such a plan allows employers to reduce their high insurance premium burdens by only contracting with insurers for catastrophic medical coverage. At the same time, employees have the freedom to choose the health care provider and services they want.

"Let's say an employer gives everyone a $2,000

account with an insurance policy behind that, and tell the employee that, based on how they spend that $2,000 over the course of the year, [the company] will distribute any funds left in the account at the end of the year in the employee's own personal, portable health care IRA," Gupta explains.

If the employee needs health care immediately, the funds are available. But if like the majority of people they do not need major services that year, they can roll over the funds to save for when they do need it.

"They can use the rollover to purchase long-term care insurance or similar products if they choose," he says.

Ninety percent of third-party payer transaction volume is in the outpatient setting, Gupta notes. The administrative costs of processing all of the $10-$15 copay claims drive up the employer premiums.

If the company only contracts with the insurer for the relatively few claims that rise above the $2,000 in the reimbursement accounts, they save a great deal of money, he claims.

"It lowers administrative costs while giving people incentives to save their resources for when they need it," he notes.

CareGain is working with different third-party payers to develop products to market to companies. They have worked with several different small companies serving as pilot programs for their model.

"Our smallest company was a five-person company, and the largest was a 100-person company," he notes. "We took small companies because we wanted to enroll 100% of the work force."

All of the pilot companies have reported satisfaction with the model program.

Shifting decision making

The current managed-care dominated health system has not been able to control costs and provide the care consumers want because the decision-making power is left mostly to the insurers, who negotiate contracts with preset fees for products and services.

As a result, consumers feel restricted in their health care choices yet at the same time are unaware of the true costs of the care they receive, says Gupta.

"For example, Claritin is the big allergy drug — people know about it because of all of the advertising," Gupta says. "To the consumer in an HMO plan, it was just a $10 copay. They would go to their physician and say, 'I need Claritin.'"

The reality, says Gupta, is that the real cost of Claritin to the insurance company was around $300. Comparable competitor's drugs are up to $90 cheaper, and the generic versions are only about $30 for a month's supply.

"Consumers have no idea what the real costs are," he says. "They need to be educated so they can make the choices they need to make."

Under the CareGain model, consumers could still get the high-end allergy drugs, but they would have to decide whether it was worth $300 out of their $2,000 account, instead of just a $10 copay.

For major medical services and procedures, the insurance coverage still is there. But on the smaller items, the consumer bears more of the burden.

"You decide whether you need the $300 drug or the $30 version, you and not the insurer and not the physician," he notes.

Any future health care cost-containment efforts that do not come from the patient and physician are doomed to fail just like past efforts, agrees Thorpe.

"Previous efforts have been concocted by the employers and the health plans and providers were left out of the discussion," he notes. "We know that doesn't work.

National leadership needed

It is not as though no one knows what is wrong with the health system and what to do to fix it, Thorpe says. But there is no national dialogue or impetus behind changing the status quo.

"We have to get this back on the public agenda," he states.

Large-scale efforts need to be made in the efforts of steamlining administrative processes, such as billing and record keeping that consume so many resources, as well as addressing the problems of medical errors and the low quality

SOURCES

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and the high cost of care.

"There are also opportunities for both the public and private sector to step up to the plate on the quality side," he says. "We have technologies and interventions to fix the problems of medical errors, and hospitals are willing to initiate these measures, but somebody has to come up with the initial capital to pay for it."

Coverage for the uninsured

Once the nation focuses its attention on resolving the crisis, the government should support coverage of those unable to obtain employer-sponsored insurance by funding demonstration projects at the state level, Thorpe says.

"The IOM's approach was that you basically kick in some money and have the states put together three model approaches to do it," he explains. "The problem now is we give states some discretion in how they provide coverage, but we don't give them any more money to do it."

CareGain's Gupta says his company is proposing to host and manage individual health care reimbursement accounts and health care IRAs for the uninsured, funded by donations from those with employer-sponsored accounts willing to give a small amount of their rollover amounts to another person.

"We think, if it is marketed correctly, many people would be willing to do this," he says.

Government subsidies could also fund these accounts, and the taxpayers would see the same cost savings available to the employers choosing this model, Gupta says.

There are a number of coverage models that could work to offer a safety net to the uninsured, Thorpe says. The problem with the last effort at legislating universal coverage was that different stakeholders were too attached to their preferred plan and unwilling to compromise, he states.

"We have to think about compromising from everybody's favorite approach," he explains. "Right now, we have a third who like Option A, a third who like Option B, and a third who like Option C. And the alternative is the status quo. So we have to figure out a way to build coalitions so that everybody's second choice isn't to just do nothing."

Whatever proposals are ultimately chosen, universal coverage has to be the cornerstone of any new reform effort, he adds.

"To me, having universal coverage is a precursor for having broad-based cost control as well," he concludes. ■

Hefty outlier payments may border on fraud

Some charging structures gouge government

The federal investigation into alleged billing fraud and unnecessary surgeries at a Redding, CA, hospital also has shed new light on potential abuses of a unusual Medicare reimbursement mechanism designed to help hospitals who perform difficult procedures or care for very sick patients.

In addition to charges that two of its heart surgeons performed unnecessary procedures, federal officials allege that Redding Medical Center inappropriately charged more for services in certain diagnostic-related groups (DRGs) in order to take advantage of higher Medicare outlier payments. These are payments given in addition to standard reimbursement, when charges for specific cases are significantly higher than the amount paid for that DRG.

An analysis performed by the California Nurses Association and the Oakland, CA-based Institute for Health and Socio-Economic Policy found that California hospitals owned by Tenet Healthcare Corp., including the Redding facility, collected outlier payments as up to 10% of their total Medicare inpatient reimbursement, while national averages for outlier payments run around 3% to 4% of total Medicare reimbursement.

Federal regulators allege Tenet hospitals have charged inappropriately high fees for certain DRGs in order to game the system and trigger the outlier calculation for higher payments.

Outlier payments not unusual

Despite all the negative press outlier payments have received in the national media, it's important to remember that they are not illegal or unusual, says **Renee Leary**, MPH, a hospital billing expert and president and chief operating officer of HHS Inc. a medical billing software company in Hamden, CT.

"Sometimes, there is no DRG that appropriately describes a patient's condition," she notes. "The patient may have something that is relatively rare and Medicare doesn't have a classification for it. The hospital can report the nearest DRG, but the reimbursement is not really accurate. So the outlier payment would take care of that."

Also, the set DRG reimbursement amounts are

based on averages of what care for typical cases in that grouping costs. Very ill patients or patients who have complications may end up costing the facility a great deal more than the average amount.

So the outlier mechanism was set up to handle that.

"Hospitals pay a fixed amount for each DRG," explains **Dean Farley**, MS, PhD, HHS vice president for health policy and analysis. "What goes beyond that — the outlier calculation — starts with the charge reported on the patient's bill, the total charge."

The total charge is then multiplied by a set cost-to-charge ratio, a figure preset by the regional Medicare fiscal intermediary and which is based on the hospital's prior reporting of costs in previous years. That calculation reveals the cost for that case.

The intermediary then has a set threshold amount above that cost before any other calculation takes effect, he adds.

"If the calculated cost exceeds the base DRG payment plus the threshold amount — which this fiscal year is about $20,000 — the government steps in and pays the hospital the difference," Farley explains. "Before a hospital can receive additional payment, they must incur costs well in access of the normal DRG payment."

Gaming the system

However, it is true that the outlier payments are directly tied to a hospital's reported charges for each case. Conceivably, hospitals could just hike charges for certain expensive procedures to the point that it would trigger the intermediary's outlier calculation.

Although it is illegal for hospitals to charge Medicare higher rates than it does private insurers, it is unlikely that hospital's have one set charge for a specific service or procedure.

"It is a gray area," Farley notes. "You can have different payment arrangements for different payers. One payer might insist on paying for operating room [OR] services in 15-minute increments, the price for that payer is for 15 minutes of OR time. Another payer might go along with that but negotiate different prices for inpatient and outpatient surgery. Another payer might want to carve out specific types of surgery. There are different ways of putting the pieces together."

If a hospital knows that its Medicare population uses more inpatient surgery than outpatient surgery, rather than set up a single price for surgical services, they may set up inpatient surgery a little higher, he adds. "All payers pay the same price, but because more of your inpatient surgeries are Medicare beneficiaries, this price differential may disproportionately affect them."

Regulators may take a dim view of pricing structures that appear to disproportionately impact Medicare patients.

Boosting charges

Because the cost-to-charge ratio set by intermediaries typically lags behind current cost data, some hospitals justify charging higher rates until the ratio catches up to current levels.

However, because charges are always reported to the intermediary for consideration in the overall cost calculations, over time the ratio can skew high.

"The problem with that is the cost-to-charge ratio is going to catch up and then you start pushing charges to stay ahead of yourself," Farley says.

A simple example is the skyrocketing costs of hospital outpatient services before ambulatory payment classifications (APCs) were established.

"Beneficiaries were paying a flat 20% of the charge," Farley notes. "Hospitals kept pushing charges up and up, getting more money from copayments. Medicare wasn't paying more, but the beneficiaries were."

The government eventually nosed out this practice and cracked down with the set APC payments.

Monitoring your facility

Given the attention that the federal Department of Health and Human Services' Office of the Inspector General is paying to the "outlier" payment issue, it is both ethical and practical for hospitals to monitor their reimbursement strategies to insure they are fair, say Farley and Leary.

"Medicare has a set average for what percentage of its reimbursement typically goes through the outlier program," Farley says. "The average now is about 3.5%, and that is a number that a hospital ought to be watching."

If a facility notices that 5% to 6% of its inpatient Medicare reimbursement is in the form of outlier payments, then they ought to look at which DRGs are receiving the additional amounts.

"Look at the DRGs. Where are your outliers?" asks Leary. "You would expect to see the outliers group in a few DRGs. Hospitals may specialize in providing certain difficult procedures that naturally will mean more complications. Are the outliers in a

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- **Renee Leary** and **Dean Farley**, HHS Inc., 2321 Whitney Ave., Fourth Floor, Hamden, CT 06518.

couple of those DRGs or are they in all of them? If you start seeing outliers in low-cost DRGs, that would be a much bigger alarm."

Once you notice the DRGs, it might be helpful to go in and pull out some specific cases to determine whether the documentation exists to support the additional payment.

"The worst thing that can happen to you is that the charges were appropriate, but you don't have the documentation support it," she notes.

Dangerous incentives

Hospitals must make sure the message they send to physicians is only to thoroughly document the procedures and services rendered, and that such services and procedures and needed and appropriate, advises **Paul Risner**, JD, a health care attorney with the firm Akerman Senterfitt in Orlando, FL.

"There is a very low tolerance for practitioners or institutions who are pushing the envelope and have no reasonable basis for what they are doing," he states. "They want to punish people for taking liberties with billing or overcharging or overcoding their cases."

A few years ago, physicians routinely attended seminars coaching them on what elements of documentation would enable them to report a higher level of service. This is a no-no, Risner reports.

"If a hospital changes its coding or charging practices suddenly that's the first red flag," he adds. "[Centers for Medicare & Medicaid Services] may come in and ask, 'Who's been to a seminar lately?' If you just got back from the ABC School of Coding in Las Vegas, that tends to be a signal that you just learned how to code better, not that you've changed the way you practice."

Hospitals may indeed see large percentages of cases that justify the outlier payments, but they key is, they must have the documentation that supports the higher level, he emphasizes.

"That is the underlying principle that will save anyone we are reading about in the newspaper today," he notes. "Do they have their charts in order, and can they justify what they charge?" ■

Report card gives states low grades on EOL care

Programs increase but improvement scarce

Though the number of programs to improve care for patients at the end of life have increased, little real progress has been made, claims a new report from Washington, DC-based Last Acts, the Robert Wood Johnson Foundation-sponsored coalition to improve care for the dying.

On Nov. 18, 2002, Last Acts released a report card grading all 50 states on key end-of-life care criteria. The report, *"Means to a Better End: A Report on Dying in America Today,"* gave most states grades of Cs, Ds, and Es (with E being the lowest rating that could be received) in most of the areas studied.

"Changing the way America cares for the dying amounts to no less than a major social change," **Steven Shroeder**, president of the Robert Wood Johnson Foundation, said in a statement accompanying the release of the report. "Although we have begun making progress on many fronts, today we find ourselves at a crossroads. We need the dedicated support of policymakers and health care leaders to put us on the path to establishing end-of-life care, once and for all, as an integral part of American medicine."

In the report, each state receives letter grades on eight key elements of palliative care: state advance directive policies; location of death; rate of hospice use; hospital end-of-life care services; care in intensive care units at the end of life; persistent pain among nursing home residents; statement pain management policies; and the numbers of physicians and nurses certified in palliative care.

Advance directive laws are insufficient

According to the report, some state laws governing advance directives include confusing language or create bureaucratic hurdles that make it difficult for citizens to express their preferences or to designate the desired surrogate decision-makers.

Only seven states got an 'A' for their state advance directive measures: Delaware, Florida, Hawaii, Maine, Maryland, Michigan, and New Mexico.

Those states most closely followed the recommendations for state policies contained in the

Uniform Health Care Decisions Act, the report stated. Those recommendations are:

• Recommend a single, comprehensive advance directive, which reduces confusion (1 point).

• Avoid mandatory forms or language for medical powers of attorney or combined living wills / medical powers of attorney, giving residents the freedom to express their wishes in their own way (1 point).

• Give precedence to the agent's authority or most recent directive over the living will, recognizing that an agent has the advantage of being able to weigh all the facts and medical opinions in light of the patient's wishes at the time a decision needs to be made (½ point).

• Authorize default surrogates (typically next of kin) to make health care decisions, including decisions about life support if the patient has not named someone (1 point).

• Include "close friend" in the list of permissible default surrogates, recognizing that family in today's world often extends beyond the nuclear family (½ point).

• Have a statewide *(nonhospital)* DNR (do-not-resuscitate) order protocol for emergency medical service personnel (EMS) to ensure that the wishes of terminally ill patients in the community can be followed by EMS personnel (1 point).

States receiving an "A" scored 4.5 to 5.0 on the above criteria, while states earning an E (Alaska, Kansas, Pennsylvania, and Vermont) scored 0.5 to 1.0.

Only 25% die at home

Although polls show most Americans would prefer to die at home, only about 25% do, the report found. Where people die (location of death) — in a hospital, nursing home, hospice or at home — largely depends on the state or community where they live and the health care resources available there. These factors continue to outweigh patient preferences, the report stated.

The report gave states one of five grades in this area with the top grade reserved for states in which more than 60% of deaths occurred at home, a level below the expressed desire of more than 70% of Americans. But no state received an "A" grade in this category and most states received grade "D," indicating fewer than 30% of patients were able to die at home.

Although the number of organized palliative care programs is growing, such programs are still not the norm, the report found.

Although almost half of all deaths take place in hospitals, many hospitals still do not offer pain management programs and hospice services.

A self-reported survey conducted by the American Hospital Association (AHA) in 2000 and included in the report, found that only 42% of U.S. hospitals reported offering a formal pain management program, and 23% and 14% offered formal hospice or palliative care programs, respectively.

The AHA defines the recommended services as follows:

a) Pain Management: A formal program that educates staff about how to manage chronic and acute pain based on accepted academic guidelines.

b) Hospice: A program providing palliative care and supportive services that addresses the emotional, social, financial, and legal needs of terminally ill patients and their families. This care can be provided in the hospital or at home under the auspices of the hospital.

c) Palliative Care Program: A program providing specialized medical care, drugs, or therapies to manage acute or chronic pain and / or control other symptoms. The program, run by specially trained physicians and other clinicians, also provides services such as counseling about advance directives, spiritual care and social services to seriously ill patients and their families.

While the number of organized palliative care programs in hospitals is increasing, the report stated, such programs are not yet the norm and do not easily fit into the coverage and payment policies of Medicare and other insurers.

"Funding for these programs often depends on cobbling together resources from different departments and funding streams, including short-term grants," the authors state. "Their continuation is jeopardized whenever any of these resources disappear."

No states earned an "A" in this category.

Care in the ICU

Nationwide, 28% of Medicare patients who die are treated in ICUs in their last six months of life, though the rates vary widely, even within individual states.

Patients in ICUs typically are subjected to the heavy use of technology, the report said, sometimes at the expense of attention to comfort or against expressed treatment preferences.

For example, a study of cancer patients being treated in the ICU found that 55%-75% had

moderate to severe pain, discomfort, anxiety, sleep disturbance or unsatisfied hunger or thirst, the report noted. Another study of ICU cancer patients established that patients' expressed treatment choices — detailed in advance directives — did not affect whether life-support efforts were initiated.

Nearly half of the 1.6 million Americans living in nursing homes have persistent pain that is not noticed and adequately treated.

"The percentage of nursing home patients who are considered to be in persistent pain was calculated by finding the percentage of patients in pain, when first asked, who were still in pain when asked again, 60 to 180 days later," the report said.

States where fewer than 25% of nursing home residents have persistent pain would have received an A. (None qualified.)

State pain management policies

Some state laws on controlled substances create formidable barriers to good pain management. The report assessed pain policies using six criteria and assigned a point value to each:

- State policy explicitly addresses the needs of terminally ill patients (1 point).
- The state has a comprehensive pain management policy or has adopted the model pain treatment guidelines issued by the Federation of State Medical Boards (0 = no or none of the guidelines adopted; 1 point = adopted one or two of the guidelines; 2 points = adopted several guidelines; 3 points = adopted most or all).
- State policy includes provisions that have the potential to impede prescribing pain medication, particularly restrictions on medical decision making that could affect dying patients (-1 to -3 points, with -1 point = only a few negative provisions; -2 points = several; -3 points = significant restrictions).
- State policy reassures physicians that they can treat pain with opioids without undue regulatory scrutiny (1 point).
- State policy defines what constitutes good medical practice for pain management (2 points).
- State policy expresses concern about the undertreatment of pain (1 point).

SOURCES

- **Last Acts Coalition**, Partnership for Caring Inc., 1620 Eye St. N.W., Suite 202, Washington, DC 20006. Telephone: (202) 296-8071.
- **American Hospital Association**, Liberty Place, Suite 700, 325 Seventh St. N.W., Washington, DC 2004-2802.

States were given grades, according to their overall score, which ranged from –3 to +9. States in the A group scored +8 to +9 overall; those in the B group scored +6 to +7, etc.

Seven states (Alabama, Florida, Kansas, Nebraska, North Carolina, Utah and Washington) received an "A" grade. Ten states received an "E" grade: Alaska, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Louisiana, New York, and Wisconsin.

Numbers certified in palliative care

Medical and nursing students do not receive adequate palliative care training and little training is available to professionals already practicing in the field.

As of January 2002, 7,623 U.S. nurses were certified in hospice and palliative care as certified hospice and palliative nurse (CHPN). The Hospice and Palliative Nurses Association has provided this certification since 1994. To be certified, CHPNs must demonstrate both knowledge and competency in hospice and palliative nursing.

On a positive note, the report said, large hospice programs are beginning to acknowledge the benefits of having certified nurses on their staffs. Several programs and state hospice organizations sponsor review courses and provide financial assistance to nurses interested in certification; others offer certified nurses higher salaries.

But while accreditation standards for medical schools now include the mandate to cover end-of-life care, the requirement contains no clear standards for that instruction. As the Accreditation Council for Graduate Medical Education does not yet accredit palliative medicine residencies or

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fellowships, a limited number of these programs currently exist.

In a statement responding to the release of the Last Acts' report, the American Hospital Association (AHA) claimed the document did not accurately reflect the many improvements that hospitals and providers have made in recent years.

"The report and report cards bring needed attention to a difficult issue," said AHA president **Dick Davidson**. "But what is not reflected in today's report are the collaborative efforts and partnerships that many hospitals are engaged in outside their walls."

In many communities, hospitals are partnering with independent hospices and other organizations to develop new services to offer patients and their families, he said. "It is important that families, caretakers, and health leaders learn more about care at the end of life and the role we all play in provide that care."

"We know most states can cite examples of excellent care and progress being made to improve care," says **Judith R. Peres**, Last Acts' deputy director and the leader of the report's research team."

CME *Questions*

CME subscribers: *Please save your monthly issues with the CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.*

1. According to the article, what is a hospitalist physician?
A. A physician who assumes primary responsibility for the care of a patient once he or she is admitted to the hospital.
B. A staff physician employed only by one hospital.
C. A physician who sees hospitalized patients only on a fee-for-service basis.
D. All of the above

2. When the patient's primary care provider and hospitalist disagree on an aspect of a patient's treatment?
A. The PCP is always right.
B. The hospitalist is always right.
C. The best outcome is achieved if the hospitalist and PCP can make the decision together.
D. None of the above

3. Medicare outlier payments are:
A. A mechanism allowing Medicare payments in addition to standard DRG for complicated cases.
B. A mechanism vulnerable to abuse through overcharging.
C. Typically around 3.5% of a hospital's total Medicare inpatient reimbursement.
D. All of the above

4. The AMA and CareGain, Inc. propose what kind of model to expand insurance coverage and reduce health care costs?
A. Third-generation HMO
B. Defined-contribution health care accounts
C. Single-payer, government-run system
D. None of the above

The fact remains, however, that overall care for the dying is still inadequate in this country and drastic improvements are called for, Peres says. "Dying patients and their families still suffer more than they should. We still have a long way to go to improve health care and policy for this segment of the American population."

The full report is available on-line at www.lastacts.org, including individual state-by-state reports giving state information in fuller detail. ■