

# HOSPICE Management ADVISOR

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## Controlling use of medications can cut costs and improve care

*Pharmacy consultants can help you think through drug policies*

Hospices too often find that no single health care professional is coordinating a dying patient's pharmaceutical needs, including both adequate pain treatment and drugs to alleviate other conditions and symptoms.

Without some coordination, it's difficult to determine which medications should be included within hospice care and which should not, experts note.

"One of the most difficult questions for hospice providers is what is or isn't related to the terminal illness," says **Jeffrey Lycan**, RN, president and chief executive officer of the Ohio Hospice & Palliative Care Organization in Upper Arlington. "That's the one question we don't like to talk about. It's difficult to answer."

For example, hospices often will be expected to take over the costs of a patient's medication for chronic conditions that are not related to the terminal illness, but these costs may not be reimbursed under Medicare or Medicaid, Lycan says.

### ***Hospices must coordinate medication use with physicians***

"Some programs will say, 'Gee, I'm sorry, we don't cover those drugs,' and others will say, 'Sure, we cover them if those are things that are needed to provide comfort and symptom support,'" Lycan explains. "That's an access issue."

Even when hospices are clear about which medications they'll provide, there can be problems obtaining the best medications for a particular patient when hospices do not work in a coordinated way with physicians.

Palliative Care Consulting Group of Dublin, OH, conducted a study that found a 30% reduction in medication costs for hospices that took a coordinated approach to medication use, including additional nurse

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education and communication with physicians, says **Phyllis Grauer**, PharmD, president of Palliative Care Consulting Group.

"There are a lot of medications where there are important concerns about side effects and the drug's appropriateness for long-term use, depending on whether the patient has months or years to live," Grauer says. "As a patient gets closer to the end of life, those concerns become less of an issue, and in maintaining a patient's comfort we may use medications that we typically wouldn't use if the patient wasn't in the final stages of life."

For example, a dying patient who has been on a cholesterol-lowering drug for years may no longer need that particular medication, and it could cause unnecessary expense, side effects, or a drug-drug interaction, Grauer says.

Grauer and Lycan offer these suggestions for how hospices may improve access to and use of medications:

### 1. Hire a pharmacist consultant to coordinate care.

"Six years ago, most programs in this country had no idea what their drug cost per patient was. Today, hopefully, we're much further along in knowing what our pharmaceutical costs are per patient," Lycan says.

Some hospices use a pharmacy management company to coordinate pharmacy care, he says.

The Ohio Hospice & Palliative Care Organization was involved in a study that compared costs of drug utilization among nine small or medium-sized hospices, Lycan says.

"We went in and supported them, doing a clinical review of medications and setting up their areas with pharmacies," he recalls.

Among the hospices that received help in coordinating pharmacy care, the average daily drug cost per patient fell from \$12-\$14 to \$6-\$8, Lycan says.

Part of the solution was just taking the time and energy necessary to understand drug costs and to set up policies and procedures, he explains.

### *Clinical pharmacists can help*

"One of the most effective things that occurred and was included in the price reduction was the use of a clinical pharmacist to help drive the process," Lycan says. "The clinical pharmacists knew how these drugs moved through the system and how the costs of drugs worked and how to effectively use drugs for pain and symptom management."

Some pharmacies will hire a clinical pharmacist to assist in drug coordination; others will hire a clinical pharmacist as a consultant or will have a preferred buying group in which one of the services offered is access to a clinical pharmacist, Lycan says.

The Palliative Care Consulting Group is a pharmacy consulting company that offers a variety of services to hospices, Grauer says.

"We coordinate care with respect to a patient's medication management, which is a big issue in health care today, and there are not a lot of good mechanisms to do that," she says.

Pharmacist consultants will assess a patient's entire drug regimen and make recommendations about which drugs could be eliminated or changed due to duplication, unnecessary side effects, or expense, Grauer explains.

Consultants also educate staff and are available to answer any questions they or the prescribing

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#### Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

physicians might have, she adds.

Grauer's pharmacy consulting organization provides hospice nursing staff with a six-hour educational presentation.

"We meet with the medical director separately sometimes, and we introduce what we have to offer, teach them about drug therapy, listen to their concerns, and we talk about communication skills," Grauer says. "From that point, we start with the on-call process. The nurse on admission may call us prior to calling a physician to review all medications, help them review what's related to terminal illness and what's not, and receive recommendations."

### ***Consultants can give unbiased advice***

"The other thing we do is help balance what drug manufacturers and direct consumer advertising are saying to the public and health care professionals by providing them with the rest of the story," Grauer says. "We have nothing to gain by recommending certain drugs, so we look at a drug unbiased and help hospices, patients, and their caregivers with suggestions for changing drug therapy to provide better care, particularly if finances are an issue."

#### **2. Select a flexible drug formulary.**

Lycan says the development and use of a drug formulary can be helpful to a hospice because formularies can give a hospice some structure. The Ohio Hospice & Palliative Care Organization does not advise hospices never to go outside the formulary, because hospices need to be able to provide appropriate care; but a formulary helps ensure that a hospice doesn't always pick a physician's favorite drug.

Also, a hospice can advise a pharmacy of the drugs it is using to help ensure those medications are kept in stock, Lycan says. That also can help the hospice negotiate a more competitive price and ensure access to necessary medications, he adds.

"Hospices should develop their own formularies, working with the attending physicians in their practice areas," Lycan says. "We believe the formulary helps to provide structure to their decision making and gives the hospice control and balance over increasing cost and knowledge of various drugs for symptom management."

Grauer says she prefers to call it a drug list, rather than a formulary.

"We recommend basic drugs that are preferred drugs in our patient population," she says.

Having such a list also makes staff training

more efficient and patient care more consistent, Grauer adds.

"I like having a preferred drug list because it provides an educational tool for staff training," she says. "And if those drugs don't work, then when you decide to use something that's not on the drug list, it's a well-thought-out decision."

For example, a hospice drug list might exclude the drug ondansetron (Zofran), which is commonly prescribed to treat nausea in chemotherapy patients. While this drug may have worked for a patient when that patient was actively seeking a cure for cancer, it is the wrong drug to use for most hospice patients because it has a limited mechanism of action, Grauer says.

"It's appropriate with chemotherapy, but it's not as effective for hospice patients," she explains. "And it costs at least 10 times more than other drug therapy for nausea."

#### **3. Advise discontinuation of unnecessary medications.**

"We have recommended discontinuation of unnecessary drugs related to comorbid conditions," Grauer says. "Also, as patients begin to decline, they typically don't want to take as many medications."

### ***Drug needs change at end of life***

For example, women may be prescribed alendronate sodium (Fosamax) to prevent osteoporosis as they age, Grauer says. "But as a patient becomes bed-bound, one of the problems with this drug is that if it's not taken correctly, it can cause erosion of the esophagus," she says.

Patients who take fosamax have to sit up for a while after taking the drug; for bedridden patients, this may be difficult. Plus, dying patients need not worry about osteoporosis, so alendronate sodium can cause more harm than good, Grauer explains.

"Those drugs also are expensive, and you can reduce costs by \$5 to \$8 per day by eliminating unnecessary drugs that are, in fact, causing them problems," she says.

Other examples of drugs that can be eliminated include diabetes medications and cardiac disease drugs, Grauer says.

"My focus is 100% on improving quality of care for the patient," Grauer says. "By reducing the costs to the patient and the hospice, you have the added benefit that by using resources appropriately, you have more resources to put into other areas that promote quality of care and quality of life." ■

# Education needed to improve use of pain drugs

*Teaching about methadone use is crucial*

**D**rug therapy for pain management and end-of-life care traditionally has not been a formal priority in medical education, so hospices often run into obstacles when trying to obtain the most effective and efficient pain medications, experts suggest.

"A lot of physicians have never been exposed to the drugs we use in our area of health care, and there is a lot of prejudice against those drugs based on what clinicians hear from drug manufacturers," says **Phyllis Grauer**, PharmD, president of Palliative Care Consulting Group of Dublin, OH. "Our focus is on patient care and education and explaining the usefulness in this specific time of a patient's life for medications they have not had a comfort zone with previously."

Some hospices will provide free pain consultation for people who are chronically ill and moving toward terminal illness, says **Jeffrey Lycan**, RN, president and chief executive officer of the Ohio Hospice & Palliative Care Organization in Upper Arlington.

"They'll offer suggestions to these patients' physicians, and sometimes those patients are at a point where they need to be hospice patients, and sometimes they are not," Lycan says. "We work with patients and move the care along when other barriers have been placed in front of them and they're not getting the appropriate standard of care for pain therapy."

Hospices often find that access to the necessary pain drugs is hampered by a lack of education on the part of patients, their families, and physicians, Lycan says.

"On the one hand, we want to obtain zero pain, but there is an art to providing enough pain medication so that a patient is able to function," Lycan says. "The goal is to assess the right level of pain medication for a patient."

To achieve this outcome, hospices must teach patients and their caregivers that they shouldn't worry about whether a hospice patient will become addicted to pain medication, Lycan says.

Likewise, physicians too often worry about federal investigators looking over their shoulders when they prescribe certain medications because they are uninformed about the legal restrictions

for prescribing these drugs, he notes.

"A lot of doctors don't want to deal with pain medications and want pain specialists to deal with it," Lycan says. "But there are not enough pain specialists to treat all of the people in pain."

Hospices need to inform physicians about the perfectly legal and acceptable ways to prescribe pain medications to hospice patients and also to reassure physicians that hospice nurses have been thoroughly trained to handle pain medications, Grauer says.

Through education, hospices also can teach nurses about the costs of drugs and why one particular type of pain medication would be preferable to another because of its cost or its effectiveness in handling pain, Grauer explains.

"We teach hospice nurses how to communicate with physicians such that the physician knows that we're not just looking at cost or telling the physician what to do," Grauer says. "We tell physicians that the best medication to do the job is the one that's the most cost-effective, and here's why."

## ***Make specific observations***

It's also important to teach nurses how to communicate the patient's symptoms to physicians in a way that enables the doctor to recommend specific drugs, Grauer adds.

For example, the nurse would see that a patient is nauseous and has been vomiting. The nurse might explain to the physician that the patient appears to have gastric stasis and that the hospice would like to recommend the patient be prescribed metoclopramide because it's a more specific drug that is appropriate for the type of nausea the patient has experienced with other medications, Grauer says.

"That way, the physician can feel comfortable that there was some thought and good assessment put into that recommendation," she says. "It puts their minds at ease that they can trust the nurse to be their eyes and ears."

Hospices might have to give special consideration to training staff and physicians about using methadone for pain management.

"One of the things our organization does is use a lot of methadone in our recommendations," Grauer says. "It's a drug that's difficult to prescribe and adjust because it requires a lot of vigilance, so we work with physicians and nurses to adjust that drug."

As a result, patients often have an incredible

response to methadone when it's used correctly, Grauer says.

"It provides a lot of benefits that the typical pain medications do not," Grauer says. "And because we oversee its use, it gives a comfort level to the physician and nursing staff."

When compared with fentanyl transdermal (Duragesic) patches and controlled-release oxycodone HCl (OxyContin), methadone is very inexpensive, and in most cases patients get better control of their pain with fewer side effects, Grauer notes.

The drawback is that methadone is a drug with a lot of patient variability, and if it's not dosed correctly, it can cause considerable toxicity, including overdose, she says.

"It accumulates in the body if you don't adjust the dose over time, so you can't just have a physician say, 'Let's put him on methadone every four hours and call me in a month,'" Grauer says. "It takes a week of careful monitoring and adjusting to get the patient on a good dose."

However, the cost savings of the drug make the extra nursing care well worth the expense, Grauer says.

"Someone on the hospice team is seeing the patient on a regular basis throughout that week anyway," she says. "And if we get the patient stable with fewer side effects and a better quality of life, and the cost is 10 to 15 times less than with other drug therapies, then you can balance it out."

So it's worth the effort to educate nurses about the use of methadone and to show physicians how the hospice is prepared to handle that drug, Grauer says. ■

## End-of-life coalitions forming nationwide

*Projects aim to improve quality of care*

Hospice directors and staff sometimes find that it's difficult to change a prevailing attitude about death and dying when that attitude involves an entire community.

This is where the Rallying Points program, designed to build community coalitions to support end-of-life care, can be a solution.

"You don't need Rallying Points to start a coalition, but the resources are available through Rallying Points," says **Kathleen Jacobs, MA**, coordinator for the Rallying Points Regional Resource Center at The Hospice of the Florida Suncoast in Largo.

"We are a resource center for community," Jacobs says. "We provide technical assistance and mentoring and networking for 140-something active coalitions in 22 states in the East and Southeast." There are additional resource centers in the West and Midwest, she says.

Funded through a grant, the Rallying Points program offers its services free of charge to any organization that is interested in forming a grassroots coalition. Those organizations do not have to involve a hospice, but most do, Jacobs says.

"These are concerned citizens, agencies, organizations, providers, and any interested party," Jacobs says.

The chief advantage of forming a coalition is that it will expand outreach possibilities for any hospice, she says.

"I think coalitions allow a hospice to not only reach people in the community they wouldn't otherwise reach, but also to hear from people in the community they wouldn't otherwise hear from," Jacobs says. "I think it helps a hospice to understand what the community wants in terms of end-of-life care."

Through a coalition, hospice representatives sit at the same proverbial table as many other people, giving all sides an opportunity to understand barriers and bridges toward better hospice and end-of-life care.

"I think that helps to disseminate the message to a much larger audience, and it also helps to promote community ownership of [hospice] issues," Jacobs says. "That's how social change happens, I think."

The coalitions that have formed have launched various initiatives that have improved end-of-life care in those communities. One example is a coalition in North Carolina that adopted a program called Support Team Networks in which volunteers are trained to provide care in retirement communities, Jacobs notes.

"Within the course of six months, they provided care to 2,000 citizens in their area," Jacobs says. "It's impressive to see the ripple effect in the community, where the work has not promoted any member organization per se, but has heightened awareness of issues overall."

The first step to forming a coalition is to form

a working group of people who are committed to discovering what a particular community needs, Jacobs says.

"Make sure the group is addressing those needs, and then take an inventory of what resources exist in the community and what they could bring," she suggests.

The list typically might include people and organizations working on end-of-life issues with an eye toward changing end-of-life policies, Jacobs says.

"You can provide end-of-life services as a hospice, you can provide end-of-life education at a college, and you can promote public policy as a lobbyist or attorney," she says. "But to come together as a coalition is to ask, 'What can we do together that we can't do on our own?'"

If the coalition's goal is to affect public policy and opinion, then the group should take an

inventory of who already is doing this in the community and how the group might work with those people to be more effective, Jacobs explains.

"Depending on what piece of the puzzle the coalition wants to impact, they can look at finding stakeholders for that piece," she says.

In fact, one of the coalition's chief strengths is that no one owns it, Jacobs says.

"It may have a leader, but the community agenda and changes in the community's needs and desires are what drive a coalition," she says. "It's a very nice cooperative opportunity for all people in the community who are interested in paving the way, and they don't all have to be health care providers."

*(Editor's note: More information about Rallying Points and about forming a coalition is available at [www.thehospicerallyingpoints.org](http://www.thehospicerallyingpoints.org).) ■*

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### Special Report: Making the Satisfaction Grade

## Can't get no satisfaction? Communication is the key

*Here are a few tips from pros*

*(Editor's note: The September issue of Hospice Management Advisor included articles focusing on hospice client satisfaction. In this issue, hospice officials offer tips on how to improve client satisfaction.)*

Everyone who works in hospice has a list of ideas for what needs to be done to improve client satisfaction, but one theme appears to be a common thread throughout the hospice world: communication.

"Communication is always a challenge," says **Jan Jones, RN, BSN, FAAMA**, president and chief executive officer of Alive Hospice in Nashville, TN.

"We're looking at how we communicate with the families, what can be expected at the time of death, and how to improve tools we use to communicate," Jones says. "Pain management is an area where we certainly perform well, but we also feel there are ways we can improve in terms of communicating with families about pain management efforts being made."

Honing employees' listening skills is a goal of Bayada Nurses in Moorestown, NJ, says **Mark Baiada**, president of the company. Bayada has

more than 115 home care offices nationwide that work with hospices and care for patients with terminal illnesses.

Nurses are trained to listen actively and observe clients' facial expressions to look for nonverbal communication, Baiada says.

"We teach them to look at the person's face to see if the person is communicating fear, discomfort, or worry," Baiada says. "The patient may be fearful and cannot express how he's really doing."

Communication skills constitute an important aspect of coordinating patient care among a multidisciplinary team, says **Christie Franklin, RN, CHCE**, vice president of professional services, acquisitions, and start-up for AseraCare of Fort Smith, AR.

When hospices coordinate care, it's important for the patient and caregiver to understand which services will be provided, Franklin notes. "The case manager will review that with the patient and family, and with the facility staff if the patient is in a facility," she adds.

There are other important aspects of improving client satisfaction that hospices need to implement. Jones, Baiada, and Franklin offer these additional suggestions for improving hospice client satisfaction:

- **Focus on pain management, even if patients do not have complaints.**

"Typically we find that families perceive pain to be at a higher level than patients do," Franklin says. "This is something that we're working on,

an area where we might be able to do something differently.”

AseraCare has held a series of inservice training sessions on pain management this year, offering a focused approach to palliative care, Franklin says.

After AseraCare began to use the family satisfaction survey promoted by the National Hospice & Palliative Care Organization of Alexandria, VA, pain management was one of the top three priorities identified in survey results, Franklin notes.

“We always focus on pain management, and one of the indicators we are focused on is the amount of pain medication received,” Franklin says. “We really look at pain management, how often the patient was treated with respect, and the overall rating of hospice care.”

Pain management education has included instruction by pharmacists, who join in conference calls with hospice staff, Franklin says.

“We have some drug formularies that we review for educational purposes, and we give an overview of all the medications utilized for a hospice,” Franklin explains. “We had courses in Pain Management I and II, plus the overview of medications and how to use them.”

- **Improve staffing and access after hours.**

“One thing that’s always a challenge for hospice programs and for us, as well, is how after-office care is delivered,” Jones says. “As a result of information gathered on patient and family satisfaction surveys, we’ve made changes in our after-hours staffing.”

For example, several people surveyed said the hospice didn’t have someone to respond in a timely fashion after hours, Jones recalls.

“So that’s our trigger to look more in depth at what’s happening with our triage system and our after-hours staff and how we need to build it into our budget for more staff,” Jones says.

This is how a quality improvement project should work once a problem is identified, Jones notes.

“When we see a trend like that, we delve more deeply and we certainly go to patient records and talk to family members and get specifics about what their issue was,” Jones adds. “We talk to staff, including triage staff, to find out what it was they experienced, and from that we begin to gather data and look at what needs to be changed, where the gaps are, and what our expectations are for what was delivered.”

For instance, hospice management realized that the after-hours staff were dealing with a higher

volume of calls than they used to. As a result, it was unrealistic to expect them to handle all of these cases as rapidly as management wanted them to, so the hospice included another triage position in its budget, Jones says.

- **Put the client first.**

One speaker who taught Bayada’s staff about pain management said this to hospice nurses: “Remember one thing when you come to the door of a client’s home: Just remember to show love,” Baiada recalls.

“When you show love when you’re in the home, you’re helping patients with all of the needs they have, including the physical and emotional,” Baiada says. “So you have to prepare yourself to be of service in a loving and caring way, and to be reliable and have the skills in place so you can do a good job.”

### ***Families must be able to trust staff***

Likewise, the client’s satisfaction is more important than scheduling concerns, Baiada says.

“If the family is dissatisfied with a nurse, then bring in someone new,” Baiada says. “Especially in hospice care, staff support is so important because it’s a time of crisis for most families, and if one thing goes wrong, they lose trust.”

- **Educate staff about client satisfaction surveys and quality improvement.**

AseraCare hospices provide short educational sessions through the “lunch and learn” training program, Franklin says.

These hour-long sessions are conducted by teleconference and are attended by executive directors and directors of clinical services first, Franklin says.

AseraCare held these training sessions to show staff how the company planned to use a new client satisfaction survey, including details about the scoring guide, frequently asked questions, and some sample information on the reports generated from the survey information, Franklin explains.

A second teleconference session teaches staff how to complete the survey’s spreadsheet and provides them with data to enter during the call, Franklin adds.

“We go through the steps of entering data and have the information technologies department on conference call to answer any follow-up questions,” Franklin says. “Then we go over the reports and how those are to be reviewed and utilized, and we continue with the training.” ■

# Are you missing serious illness in older patients?

*Improve assessment of geriatric patients*

An elderly woman presents with a chief complaint of constipation, with few symptoms of acute abdomen. Would you suspect appendicitis in this patient?

You may find a misleadingly benign physical assessment in older patients, despite the presence of a potentially lethal illness, warns **Karen Hayes**, PhD, ARNP, an instructor at the School of Nursing at Wichita (KS) State University. "Some nurses may feel uncomfortable assessing older adults because of all the challenges and comorbidities that characterize the elderly patient," she notes.

You'll need to be able to recognize an altered and often nonspecific presentation of disease in elderly patients, says Hayes. "By using a heightened index of suspicion with astute assessment skills, the nurse may avoid inappropriate triage or missing a serious illness," she adds.

Another challenge is that it is difficult to distinguish the effects of normal aging from serious illness, emphasizes Hayes. "The combined effects of genetics, lifelong health habits, medical problems, environment, and sociocultural influences make elderly patients quite different from one another," she says.

To dramatically improve assessment of geriatric patients, do the following:

- **Do not let ageism bias your assessment.**

Functional disability or confusion is not a consequence of aging, Hayes notes. "A history of inability to perform activities of daily living should be carefully assessed," she says.

A sudden decrease in functional ability can be an early sign of a serious illness, says Hayes. "For example, an exacerbation of congestive heart failure may interfere with an elderly person's ability to bathe and dress independently," she notes.

- **Consider abnormal lab values.**

"Due to the aging process, normal bodily functions are just not as efficient as they used to be," says **Kelly A. Karpik**, BSN, RN, RRT, clinical

manager for the emergency department at Rhode Island Hospital in Providence. "Renal and hepatic systems are examples of organs that are affected with age."

You need to be aware of abnormal lab values for kidney and liver function in elderly patients, as these will affect the amount of drug to be administered, she explains. For this reason, it is important to know which drugs are metabolized by the kidneys and which are metabolized by the liver, Karpik adds. "Elderly patients will have different doses of medications, determined by the kidney and liver's ability to metabolize the drugs."

For example, if kidney function is impaired in an elderly patient, creatinine clearance may be reduced, she says. "If this is so, then half-life will be prolonged, and an adjustment in dose is necessary."

Karpik gives the example of the antibiotic levofloxacin, which is used to treat community-acquired pneumonia, bronchitis, and urinary tract infections. The usual dose used to treat pneumonia is 500 mg for seven to 14 days, but while an elderly patient with reduced creatinine clearance would be given the same initial dose of 500 mg, subsequent doses would be only 250

mg per day, based on a creatinine clearance of 20 ml to 49 ml/minute, she notes.

- **Assess liver and kidney function.**

In many elderly patients, there is a diminished ability to metabolize medications due to aging body systems, she says. "If you couple that with impaired renal and/or hepatic function due to pathology, then you can surely achieve therapeutic medication effect with a lower dose of almost all medications."

## ***Doses can vary fourfold for older patients***

For instance, an adult male patient might receive a 2 mg dose of lorazepam for anxiety, whereas an elderly male patient might experience the same effect with only 0.5 mg, Karpik notes.

- **Avoid being influenced by the patient's interpretation of his or her own symptoms.**

If an elderly man tells you he has "the flu," ask what specific symptoms he is experiencing. "Pneumonia may be the hidden problem," says

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**'Due to the aging process, normal bodily functions are just not as efficient as they used to be. Renal and hepatic systems are examples of organs that are affected with age.'**

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Hayes. "Often the problem is much more serious than the elderly patient is willing to admit."

- **Take a thorough medication history.**

If an elderly patient reports confusion, dizziness, falls, or fluid and electrolyte imbalances, remember that the most commonly prescribed drugs for older patients can cause these symptoms, advises Hayes. These drugs include cardiovascular agents, antihypertensives, analgesics, sedatives, and laxatives.

In addition, drug interactions are increased in the elderly because of the multiple medications they use at home, says Hayes. "An accurate medication history is critical," she says.

The best way to prevent errors is to always question whether the drug is needed, check that

it is the smallest possible dose, and ensure there are no drug allergies or interactions with other medications, says Hayes. "Often, older adults have many allergies," she notes.

- **Know that the patient's age and unrelated conditions may affect that rate of absorption.**

Drugs given intramuscularly, subcutaneously, orally, or rectally are not absorbed as efficiently as drugs that are inhaled, applied topically, or given intravenously, notes Hayes. In addition, conditions such as diabetes mellitus and hypokalemia can increase the absorption of drugs, whereas pain and mucosal edema will slow absorption, she adds. "The extended biological half-life of drugs in older adults increases the risk of adverse reactions," says Hayes. ■



## CMS proposes new patient choice requirements

*Hospital-specific rules to be extended to SNFs*

By **Elizabeth E. Hogue, Esq.**  
Burtonsville, MD

As many providers already know, the Balanced Budget Act of 1997 (BBA) requires hospitals to share with each patient as part of the discharge planning process a list of available home health agencies (HHAs) that:

- are Medicare-certified;
- serve the geographic area in which the patient resides;
- request to be listed by the hospital as available.

In addition, the BBA prohibits hospitals from limiting or steering patients to any specific HHA or qualified provider that may provide post-hospital home health services.

In proposed rules published on May 18, 2004, the Centers for Medicare & Medicaid Services (CMS) proposes to incorporate these provisions of the BBA into Conditions of Participation (COPs) applicable to hospitals and to extend these requirements to skilled nursing facilities (SNFs). If these COPs are finalized, it is likely indicative of a trend of extending the BBA's patient choice requirements to all providers,

including home medical equipment companies and hospices.

CMS' proposed requirements are as follows:

1. Hospitals must include in discharge plans a list of HHAs or SNFs that are available to patients. The facilities included on the list must participate in the Medicare program and must serve the geographic area in which the patient resides as defined by the HHA. In the case of SNFs, the facilities must be in the geographic area requested by the patient. HHAs must request to be listed by hospitals as available.

2. Lists must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate, as determined by discharge planning evaluations.

3. Hospitals must document in patients' medical records that the list was presented to patients or to individuals acting on patients' behalf.

4. As part of the discharge planning process, hospitals must inform patients or patients' families of their freedom to choose among participating Medicare providers of HHA and post-hospital extended care services and must, when possible, respect patients' and families' preferences when they are expressed. Hospitals must not exclude qualified providers that are available to patients.

5. Of the HHAs or SNFs to which patients are referred, discharge plans must identify those facilities in which hospitals have a disclosable financial interest, as specified by the Secretary of Health and Human Services, as well as any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

Although commentary on the proposed regulations does not carry the force of law, it provides a

window on the point of view of regulators and enforcers that providers are well advised to consider, as follows:

- Hospitals would not be required to duplicate lists in patients' medical records. Hospitals would have the flexibility to determine exactly how and where required information would be documented in patients' medical records.
- Hospitals would have the flexibility to implement the requirement to present lists in a manner that is most efficient and least burdensome. Commentary on the proposed COPs indicates that hospitals could simply print lists from the Home Health Compare or Nursing Home Compare sites on the CMS web site ([www.medicare.gov](http://www.medicare.gov)) or develop and maintain their own lists. When patients require home health services, the CMS web site list could be printed based on the geographic area in which patients reside. When patients require SNF services, hospitals can provide a list of facilities in the geographic area requested by patients.

### **Lists cannot endorse quality of care**

• When hospitals develop their own lists, they will have the flexibility to design the format of the lists. The lists, however, cannot be used as either a recommendation or endorsement by hospitals of the quality of care of any particular providers. Hospitals will not be required to include agencies and SNFs on lists that do not meet all of the criteria described above.

- Lists provided by hospitals must be legible and current. That is, lists should be updated at least annually.
- CMS further suggests that hospitals share lists with patients or individuals acting on their behalf at least once during the discharge planning process. But CMS points out that lists may need to be presented more than once during the discharge planning process to meet patients' need for additional information or as patients' needs change.
- No specific form or manner in which hospitals must disclose financial interests will be required. Hospitals could simply highlight or otherwise identify those entities in which a financial interest exists directly on lists of HHAs and SNFs. Hospitals also could choose to maintain separate lists of those entities in which they have financial interests.

- Lists provided to patients who are enrolled in managed care organizations (MCOs) should

include available and accessible HHAs and SNFs in a network of the patient's MCO. In the course of discussing discharge planning with patients, hospitals also will have the option to determine whether beneficiaries have agreed to excluded services or benefits or coverage limitations through enrollment in MCOs. If this is the case, hospitals may inform patients of the potential consequences of going outside the plan for services.

### **Compliance monitored via certification**

- Compliance with the proposed COPs would be monitored as part of the hospital survey and certification process. Anyone aware of instances in which patients are inappropriately influenced or steered toward a particular agency or SNF in a way that violates the regulations could file a complaint with the state survey agency. State surveyors would then investigate and follow up with the complainant.

Stay tuned for more new developments in the continuing story of patients' right to freedom of choice of providers.

*[Editor's note: More information about this topic is available in How to Form Alliances Without Violating the Law. Send a check for \$55 (price includes shipping and handling) to the address below.*

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## **Living wills called useless; power of attorney preferred**

*Patients can't anticipate specifics*

Living wills don't work; furthermore, it's a waste of time to promote them to patients, according to researchers at the University of Michigan (UM) in Ann Arbor.<sup>1</sup> Even aside from what's best for patients, health care staffers who spend time and effort teaching patients about living wills may fall victim to a false sense of complacency, the researchers say.

They base their conclusions on a comprehensive review of hundreds of studies of living

wills, end-of-life decisions, and the psychology of making choices. The authors are criticizing a legal instrument that has become so ingrained in American medical culture that federal law requires hospitals to tell their patients about living wills, and the laws of almost every state specifically recognize the validity of living wills.

**Carl E. Schneider**, JD, the Chauncey Stillman Professor of Law at the UM School of Law, says living wills don't fail for lack of effort, education, intelligence, or good will. They fail because of basic traits of human psychology, he says. For instance, studies show that people have great trouble predicting their own preferences about even simple, everyday things like what snacks they will want or what groceries they will buy next week.

"If they have trouble predicting what is familiar," Schneider asks, "why should we expect them to succeed when they are predicting what they will want in circumstances they have never experienced and can't foretell?"

Schneider and fellow researcher **Angela Fagerlin**, PhD, a research scientist with the UM School of Medicine and the Veterans Administration Ann Arbor Healthcare System, recently released a study in which they analyzed how living wills actually were used and how much they reduced the end-of-life debates they were intended to address.<sup>1</sup> The researchers' basic conclusion was that a living will is "a nice idea, but it doesn't work," Schneider says.

The living will, Fagerlin notes, was designed by bioethicists who wanted to give patients a chance to spell out what treatment they would want and what treatment they would reject if they became unconscious or unable to make their own decisions for some other reason. The idea of the living will is to allow people to maintain control even at the end of life.

Unfortunately, Schneider says, courts have proven reluctant to uphold living wills, largely for good reason. "The courts recognize that the document was signed before the patient was in the current state and before they could even understand what specific issues are being contested," he says. "Courts are likely to say that the living will is not legally binding."

Fagerlin notes that a living will likely would

not have made any difference in the Terri Schiavo case in Florida, in which a patient's husband and parents fought a long legal battle over whether she should be kept alive. The media have suggested that the Schiavo case was a good example of why everyone should have a living will; but in reality, "if she had had a durable power of attorney saying she wanted a particular person to make that decision for her, then there would be no conflict," Fagerlin says. "That is a good example of the usefulness of a durable power of attorney vs. a living will."

Schneider says he can imagine circumstances in which living wills may be useful for patients facing imminent death who know their medical

circumstances and who have strong and specific beliefs about them. But far more often, he says, living wills offer a false promise of control over end-of-life treatment. The best patients can do, the researchers argue, is to use a durable power of

attorney to appoint someone to make decisions for them when they can no longer make their own decisions.

Schneider says the way many health care providers encourage patients to complete living wills is part of the problem. Often, the living will starts as a blank form for patients to fill out in writing, stating their individual preferences. The instructions might suggest that patients write down whether they'd want to be kept on life support machines if they had a catastrophic accident or were terminally ill.

When a living will is called into play, it is very common for family members and others to find room for argument, Schneider says. Is the patient "terminally ill" as required to invoke the living will? If the doctor says the patient has a 50% chance of living six months, a case can be made on both sides regarding whether the patient is and is not terminally ill. And what about pain relief? Does that include inserting a Foley catheter to relieve a full bladder?

"People sign these documents thinking they have made some important decisions, but in reality, they have no way to anticipate the specific circumstances," Schneider says. "You end up with someone saying, 'But he has a living will,' and someone else saying, 'Yeah, but it doesn't apply to this situation here.'"

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'People sign these documents thinking they have made some important decisions, but in reality, they have no way to anticipate the specific circumstances.'

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But health care institutions cannot instruct staff to stop promoting living wills altogether because the federal Patient Self-Determination Act requires hospitals to tell patients about living wills and other advance directives. Fagerlin and Schneider instead recommend focusing much more on the alternatives to living wills.

“Durable powers of attorney only require a few simple choices, and they don’t differ significantly from the existing system of allowing family members to make medical decisions about incompetent patients,” Schneider says. “They also allow the decision maker to use the information about the patient’s condition that’s available at the time a decision is needed, rather than asking the patient to guess about something far in the future. And they’re inexpensive.”

Legally, the hospital is relieved of the burden to make decisions for the patient when a durable power of attorney is in play, he notes. The durable power of attorney is legally clear and enforceable — everything a living will is not. “They’re documents that the court understands, and the court can just say yes,” Schneider explains. “But when you present them with a living will that has all these vague terms and health care situations the court is unfamiliar with, they often start looking for someone else to make the decision for them, like the bioethics committee. The ball comes right back to you.”

## Reference

1. Fagerlin A, Schneider CE. Enough: The failure of the living will. *Hastings Center Report* 2004; 34:30-42. ■

## News From the End of Life

### Nurse supervisor accused of stealing pain meds

Michigan Attorney General Mike Cox has announced charges against a Howell, MI, nursing home nurse supervisor, accusing him of stealing prescription painkillers from hospice patients. Jeffrey Joseph Wolos, 32, of Swartz Creek, MI, was arraigned in 53 District Court

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in Howell. The charges arise from a chain of events at Medilodge nursing home in Howell, culminating on Dec. 8, 2003.

Cox alleges that Wolos tampered with and stole patients’ pain-relief medications and delivery systems. Wolos faces three charges: one count of knowingly possessing a Schedule II narcotic drug; larceny by stealing prescription medication; and physical abuse or harmful neglect of a patient by removing or diminishing the strength and content of prescribed medications for control of chronic pain. ■

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