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**August 2007**

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## Trends in Hospice: Palliative Care Growth

*[Editor's note: In this issue of Hospice Management Advisor, there are several stories, including the cover story, about the recent growth of palliative care programs in the hospice industry. Featured in this issue are the palliative care continuum of care provided by a Midwest-based home care and hospice organization and the palliative care hospital services offered by a smaller East Coast hospice. In the September issue, there will be an additional story about a hospice organization that has made palliative care a big part of its mission and business.]*

## **Pioneers in hospice palliative care say trend will continue through this century**

*NHPCO offers a book of models for hospices*

**P**alliative care continues to grow within health care systems and networks, and increasing numbers of hospices across North America are embracing the palliative care approach and philosophy as part of their own missions, experts say.

The number of hospices providing palliative care services has increased dramatically in the past four years, according to a recent survey by the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

A membership survey conducted in 2002 found that 26 percent of hospices provided some palliative care services. The same survey, repeated in 2006, found that 55 percent of hospices provided palliative care services, says **Judi Lund Person**, MPH, vice president of quality for NHPCO.

Among the respondents providing palliative care services, 58 percent said they worked with hospitals or provided hospital-based palliative care, including pain management, assistance with goals of care, and family support, Person says.

Half of the respondents said they offer a palliative care consultation

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team to hospices or to nursing homes, she adds.

The large growth during the past four years proves that palliative care is an idea whose time has come, Person says.

"All of hospice is palliative care, but not all of palliative care is hospice," Person says. "There are patients who will accept palliative care services, but will never move over to hospice."

It's up to hospices to make sure their palliative care services are beyond the Medicare hospice benefit and are providing services to seriously ill patients who are not yet terminally ill, Person says. "We also should help palliative care become integrated into lots of different places in the health care system, including working with nursing homes, working with hospitals and intensive care units, and providing additional support to families."

Some hospice organizations have integrated palliative care into both home care and hospice services.

Palliative care is a natural direction for home care agencies and hospices to take, says **Lin Pekar**, RN, BA, CHPN, CLNC, director of palliative and

chronic care at Heartland Home Health Care and Hospice in Toledo, OH. Heartland has 110 offices in 26 states, with most locations providing both home care and hospice services.

"If you're already in home care and receiving compassionate discussions [through palliative care services], then it's more natural to discuss hospice," Pekar says. "We try to spread the word about hospice, and through the philosophy of palliative care, we're able to do that much better."

Less than a decade ago when Heartland first adopted a palliative care philosophy, home care agencies and hospices had no true collaboration. Now organizations like Heartland are building a continuum of care that benefits patients, Pekar notes. [See story about Heartland's palliative program integration, p. 76.]

According to the NHPCO survey, many hospices already have moved into the direction of providing non-Medicare palliative care services.

"The number of [NHPCO survey] respondents in 2006 was 350, and 55 percent of them said they were providing palliative care outside the confines of the Medicare hospice benefit," Person says.

Nearly three-fourths of these hospices were providing non-hospice palliative care programs, and this was especially true of hospices with a daily census of 100 patients or more, Person says.

"For programs that served an average daily census of between one and 25 patients, 46 percent of them were saying they offered palliative care," Person notes. "You might say small providers couldn't do this, but they were offering palliative care."

One of the smaller hospices that NHPCO identifies as a pioneer in the area of palliative care is the Coastal Hospice in Salisbury, MD. The hospice's average daily census is 85 patients, including inpatients, says **Marion F. Keenan**, MA, MBA, president of Coastal Hospice.

The hospice's board decided to pursue palliative care about two years ago, she says. [See story about Coastal Hospice's palliative care services, p. 78.]

Keenan and other leaders at the hospice attended palliative care sessions at an NHPCO conference, gathering information before they submitted a recommendation to the hospice's board that the organization further pursue palliative care, Keenan recalls.

The result is a partnership with Peninsula Regional Medical Center in Salisbury. Coastal

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### Editorial Questions

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Hospice provides a physician, nurse practitioner, and some social work and pastoral care to palliative care patients in the hospital in exchange for a stipend from the hospital to cover some of the costs, Keenan explains.

"We've had increasing numbers of palliative care referrals," Keenan says. "About 43 percent of the palliative care patients eventually become hospice patients."

While there are some business benefits to providing palliative care, the hospice didn't expand its services in this direction to make money, Keenan says.

"We lose some money on it, and we justify that loss by saying it seems so right for our mission," Keenan says. "We were a hospice before there was ever any reimbursement and before there was a six-month prognosis, so it doesn't seem strange to us."

The hospices surveyed by NHPCO reported they were offering palliative care services to meet an unmet need, to fulfill their mission, and to position their hospice as a leader in the palliative care continuum in the community, Person adds.

The barriers they reported included the lack of reimbursement for services, the perception that physicians didn't place a high value on palliative care services, and the lack of understanding and experience in billing, Person says.

At the Hospice and Palliative Care of Charlotte Region in Charlotte, NC, it was a physician's vision that instigated the hospice's move to palliative care services.

The hospice's medical director had a vision about providing quality end-of-life care for both hospice patients and patients who still wanted to receive aggressive therapy, says **Judith Kinsella**, RN, MSN, CHPN, assistant vice president of medical services for Hospice and Palliative Care of Charlotte Region, which has an average daily census of 450 patients.

The visionary medical director saw a gap in care between the excellent symptom management received by hospice patients and the less optimal care received by chronically ill people who did not meet the hospice diagnosis criteria, Kinsella says. **[See story about a full-service palliative care program in the September issue of *Hospice Management Advisor*.]**

With leadership and drive at the top for palliative care, the hospice started an extensive palliative care program that has grown within a few years to having nine full- and part-time physicians,

plus six nurse practitioners, a disease management coordinator, a social worker, two nurses, two administrative assistants, and a nurse manager, Kinsella says.

The palliative care average daily census is 330 patients, she says.

The hospice has contracted with Charlotte's flagship health care system called Carolina Healthcare System, which pays for some of their palliative care services, Kinsella adds.

"We don't give anything away for free because we can't," Kinsella says. "So what we do is billable visits from practitioners, and all palliative care for the hospital is paid from contracts."

The move into palliative care has been a huge benefit to the hospice organization, Kinsella notes.

"It's ramped up people's view of hospice care overall," she says.

Quality palliative care helps spread the message about quality end-of-life care, Kinsella says.

"We hire people well-skilled in communication, as well as clinical care aspects, and it speaks well for our hospice organization overall," she adds.

Hospice leaders who wish to start palliative care programs, or expand their existing services, could learn more about the pioneers of palliative care from a 200-250-page monograph/book, titled, "Navigating Palliative Care: Positioning Hospice for the 21st Century," that is expected to be published by NHPCO this summer, Person says.

"We're jointly doing a monograph with the Center to Advance Palliative Care (CAPC)," Person says.

NHPCO published a similar monograph in 2001, but the new one provides cutting edge information, she notes.

NHPCO conducted site visits of hospice providers who were doing exceptional work in expanding palliative care, focusing on legal, regulatory, business planning, and the future of palliative care, Person says.

Among the sites visited were Coastal Hospice, a Heartland Home Health Care and Hospice site, and the Hospice & Palliative Care Charlotte Region.

"We made sure we featured providers who had a reputation of having been out there doing palliative care very early compared to other providers," Person says.

The featured hospices are geographically diverse and represent urban and rural, big and small, free-standing and hospital-based hospices.

## Need More Information?

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“Our goal is that providers who read the monograph can take the experiences of these pioneers featured through in-site visits and apply what they’ve read to expand their own programs in their own areas,” Person says.

Chapters will include site visit reports, lessons learned, getting started, developing a business plan, staffing, finance and billing, legal and regulatory considerations, opportunities across settings, quality control, and veteran’s administration organizations, Person says.

“There are lots of resources and links to Web sites and forms for people to take and modify so they won’t have to re-invent the wheel,” Person explains. “It’s a way to help providers jump in and think about how they can partner and do palliative care on their own in their own community — that’s the goal.”

Palliative care programs and services are absolutely essential to the future of hospices, Pekar says.

“When you look at the demographics of the chronically ill, you see that we’re an aging society,” Pekar explains.

“Predictions are that by 2020, we’re talking about 157 million Americans living with one or

more chronic illnesses, and half will have two or more chronic illnesses,” she says. “We need to find a more successful model to improve their outcomes and meet the needs of the chronically ill, and I think palliative care is going to be that innovative strategy to help us get better at disease management.” ■

## Large hospice converted to palliative care philosophy

*Continuum of care from home care to hospice*

**H**earthland Home Health Care and Hospice, based in Toledo, OH, began to look seriously at palliative care in 1999, starting with research into how the 110-office organization could improve chronic disease management.

“We wanted to help our more fragile patients who were living with chronic diseases,” says **Lin Pekar**, RN, BA, CHPN, CLNC, director of palliative and chronic care.

“We decided palliative care would be our strategy for getting better financial and clinical outcomes for these tough populations,” Pekar says.

There were few palliative care programs tied to home care at the time, and hospice leaders saw this as an opportunity to improve the continuum of care.

“If we had a patient in home care one day who was transitioned to hospice the next day, then our vision for helping the patient really changed because hospice was so holistic,” Pekar explains.

Once home care patients became hospice patients they received aggressive symptom management and psychosocial and spiritual care, she adds.

“We found ourselves asking, ‘Why do patients have to be in the last six months of life before they receive services that help the chronically and terminally ill?’” Pekar says. “So we saw the value of upstreaming those services into our home care.”

When home care services shifted to the PPS reimbursement model, Heartland decided to move away from a purely nurse-driven model and change it to an interdisciplinary care model, Pekar notes.

“We decided to put a social worker on those cases and make spiritual care available to patients having spiritual suffering,” Pekar says.

"It's not like a patient suddenly becomes eligible for hospice and then lives with grief and loss," she adds. "These patients have been living with loss and grief, sometimes for years, before receiving hospice care."

So each patient who enters home care is assessed for palliative needs, such as pain management and comfort issues.

"We redesigned home care services to be palliative and interdisciplinary, and over the next three years we saw a significant improvement in our clinical outcomes," Pekar says. "Interestingly enough, we were able to do it under the PPS reimbursement model."

People often ask Pekar how the organization is able to make palliative care work for the bottom line. "When you start meeting patients' true needs, the financials follow," Pekar says in answer to this question.

"What's unique about Heartland's approach is we didn't make palliative care a bridge program, and it's not a specialty program," Pekar explains. "It's our philosophy of care and our belief that all patients, to some degree, will benefit from holistic care."

Here are some of the ways Heartland has made palliative care work:

- **Work within payment structure:** PPS reimbursement is episodic, giving an organization X amount of dollars for a 60-day episode of home care, Pekar explains.

"In the old days, you were paid every visit, but now you're paid for a 60-day episode, and the way they determine the money is with an assessment of the severity of the patient," Pekar says.

So when the home care agency receives X amount of money to care for a cardiac patient for 60 days, it's up to the agency to decide how they'll spend that money for services for this patient, Pekar explains.

"While the majority of home care agencies will provide nurse-driven care, almost to the exclusion of psychosocial and spiritual care, we approach the patient's care in an interdisciplinary way and bring in a team," Pekar says. "There may be a few less nursing visits, but we'll bring in a social worker and spiritual care counselor when we identify spiritual emptiness or suffering."

- **Make suffering the sixth vital sign:** If pain is the fifth vital sign, then suffering is the sixth, and Heartland has staff measure patient's suffering, using a tool that was adapted from one

developed by Barry Banes, a national expert on suffering.

"Our suffering initiative started three years ago," Pekar says. "It's a natural topic and a language we all share now."

Patients describe their suffering, and the suffering assessment helps the palliative care team determine how best the patient can be helped, she says.

Just like with other symptoms, it's first identified, and then the team makes a care plan and monitors the intervention, Pekar says.

Suffering can intensify physical symptoms and feelings of sadness and isolation, she says.

"Why do patients repeatedly go back to the ER?" Pekar says. "It can be due to physical symptoms, but it can also be due to anxiety and feelings of sadness and isolation."

By bringing in a palliative care team's social worker soon after a patient's suffering is identified, it helps to reduce the patient's ER visits and it helps to keep the patient at home, Pekar says.

"In home care you better be doing that as much as possible because that's a tremendous focus in home care," Pekar adds.

- **Identify fragile patients:** "The other thing we also have put in place are processes to identify what we call 'fragile patients,'" Pekar says.

"Fragile patients are those who are more advanced in their disease process," Pekar explains. "They may or may not be hospice eligible, but they're tooling along in that direction."

These patients are linked early with the hospice staff for education about hospice services, and there are compassionate discussions about their goals of care, Pekar says.

"So very early on, the social worker will ask them if they'd like to know about hospice services that could serve them in the future," she says.

Hospice staff are the most passionate about hospice services, and they often can identify eligible patients and help with the transition to hospice care, Pekar adds.

- **Form partnerships:** Heartland Home Health Care and Hospice has a partnership with HCR ManorCare, a national long-term care and short-term post-acute medical care company, which is owned by the same health care parent company as Heartland. So nursing home care is part of the palliative care continuum of care.

"We work closely with their skilled nursing centers, offering hospice services, and we also

work with hospitals," Pekar says.

About one-quarter of the hospice census includes patients in the long term care company's buildings, Pekar adds.

- **Coordinate care:** When the home care staff identify a fragile patient, and a hospice worker is sent in to speak with the family and patient, there is a coordination of care that takes place, Pekar says.

"Home care and hospice get together, and the key topic is who are the patients who we see as needing a transition, so we can put a plan in place," Pekar says. "We try to approach this in a way that is as seamless as possible, so the patient doesn't feel like he's switching to a whole new company."

Often when the hospice employee first goes out to the home to meet the family, it is a joint visit with a home care nurse, so the patient doesn't feel that it's just a stranger coming to his home, she explains.

"The home care and hospice nurses will meet there together and have a joint presentation, so the patient gets to know the new nurse through someone he already knows," Pekar says.

"The main services we try to bring over to home care is for our social worker with psychosocial care and the opportunity for spiritual care and bereavement care," Pekar says.

"Advanced care planning is another huge passion of ours, and we go beyond the advanced directive form," Pekar says. "It's about having passionate discussions about where you are in the health care journey, and what's important to you."

This could be aggressive pain and symptom management, as well as emotional and social issues, she adds. ■

## Palliative care program is passion for smaller hospice

*Hospice makes it work for community's sake*

When leaders at Coastal Hospice in Salisbury, MD, decided to move toward a palliative care philosophy, one of their first actions was to visit a Center to Advance Palliative Care (CAPC) site at the Palliative Care Center of the Bluegrass in Lexington, KY.

"We chose that hospice because it has a palliative

care program and collaborates well with several medical centers in its area, and we thought their model would fit with us because we're not hospital-based," says **Marion F. Keenan**, MA, MBA, president of Coastal Hospice.

"So we went to that center of excellence in July, 2005, and we were there for a week studying the palliative care program," Keenan recalls. "We started to write our own plan when we were there and wrote a proposal to give to our board."

Hospice leaders presented the palliative care plan to the hospice board a few months later. The plan included collaboration and a contract with Peninsula Regional Medical Center in Salisbury, Keenan says.

"Concurrently, the nurse executive at Peninsula Regional Medical Center, our initial partner institution, also took the plan to its various levels for approval and got that approval," Keenan says. "It was a limited approval on both sides."

The hospice board said the hospice could move forward and begin to implement the plan, which was funded in part by a stipend from the hospital in exchange for palliative care services upon request, she notes.

"We began to do informal palliative care consults, starting around November, 2005, at Peninsula Regional," Keenan says.

Since the hospice's medical director had a long-standing relationship with the hospital and its medical staff, the physician buy-in went smoothly, she said.

"That was a huge asset," Keenan says.

The hospice's medical director gave presentations about palliative care at the medical society meetings and to various medical-surgical departments at the medical center, Keenan says.

The palliative care program requires a primary physician, or another person in charge at the hospital, to make a request for a palliative care consultation, and then the hospice conducts the palliative consultation through a team that includes a physician, a nurse practitioner, a social worker, and a pastoral counselor, she explains.

Plus, the hospice formed a professional medical advisory committee that consists of local physicians, a nurse educator, and people in the community, including an attorney, she says.

The second tier of leadership is a small leadership group that consists of Keenan, a hospice financial director, the hospice medical director, a

clinical vice president, and three leaders from Peninsula Regional. This committee originally met monthly, although such frequent meetings have not been as necessary as the palliative care program matures, she says.

And the final tier is a palliative care workgroup that meets more frequently and consists of all the people in the leadership group plus front-line staff, including a hospice and hospital social worker, a hospital and hospice pastoral worker, Keenan says.

All three groups help resolve any issues that arise as a result of the palliative care collaboration.

For instance, if a hospice pastoral counselor needs to enter an electronic medical record at the hospital, but doesn't have the password, authorization, and training that's necessary, then she might bring this problem to the workgroup, Keenan says.

"Probably what would happen is within the workgroup we'd learn that the authorization isn't functioning, and so we'd take it up to the executive level and try to unclog this little problem," Keenan explains. "Then the chief nurse executive at the hospital would say, 'I know how to do this, and we would troubleshoot and make it easier for the front-line team to handle.'"

The palliative care team often receives referrals to work with a patient in the intensive care unit (ICU) before the patient is discharged, Keenan says.

"We'll talk with the home health agency and maybe consult with them, and we'll provide a nursing consultation to patients who have chronic illnesses where they'll eventually become hospice patients," she says. "Long-term care facilities are also in our palliative care plan, but we have not started with that yet."

The stipend from the hospital helps defray the palliative care team's costs, but there have been costs above and beyond it, she notes.

However, there are benefits to offset any financial drawbacks, however.

"The whole idea of palliative care is that we see people who were two years away from being hospice eligible," Keenan says.

This goal directs the hospice toward community care, and it has the potential to direct more patients to hospice care and direct them sooner than perhaps they would have before the palliative care program was implemented, she says.

"We have a sense of moral responsibility to our community more than anything else," Keenan

says. "We have the tools to help people and families who are confronting a terminal illness, and our work is very similar to helping people confront a serious chronic illness."

Patients and families in a hospital's intensive care unit (ICU) face many of the same end-of-life issues faced by hospice patients, only they may be facing these issues all at once in a crisis mode.

"Unlike patients with diseases that have existed for a long time, these families are right there, deciding what's right for the patient as a family unit," Keenan says. "We just think it's part of our mission to help them do that, and we'll do it as long as we're not financially undermining our hospice." ■

## How to evaluate a new service: Will it work?

*Look at market, staff, and management to predict success*

As hospice agencies prepare for success within a pay-for-performance environment, ideas for new services or redesigned existing services are popping up everywhere. Seminars, audio-conferences, and newsletters articles describe successful new services implemented by agencies throughout the country. Although these successes are thought-provoking and inspiring, experts interviewed by Hospital Home Health remind managers to evaluate a new service's potential for success from the perspective of their own agency, their marketplace, and their patient population.

Start your evaluation of a new idea by looking first at your ownership and your organization's financial goals, suggests **Jill Rumberger**, PhD, assistant professor of health administration at Pennsylvania State University at Harrisburg in Middletown. "A home health agency that is owned by a hospital may develop a service that is focused upon meeting the hospital's need to discharge certain patients as opposed to create a new source of revenue," she explains. "The most important focus for another agency might be a positive financial return in a specified amount of time," she adds.

Whatever objective you have for the new service, there are specific steps to take to evaluate the program's chance of success, says Rumberger.

Although you want to evaluate the potential financial success of the program, the first three steps are not strictly financial, she points out.

### 1. Evaluate your market

“Is there a market for this service?” asks Rumberger. “This is the first question you should ask yourself,” she says. Based on your current patient population, your community, and your referral services, look at who would use the service, she suggests. Is there enough demand for the service to guarantee a continuing patient base?

Don’t forget to look at your competition in the marketplace, says Rumberger. “If another agency is offering the same or a similar service in the community find out how they are doing,” she says. While the other agency may not share specific numbers and data on their program, talking to mutual referral sources, peers in the agency, or other people in the community will give you an idea of what the other agency is doing and how well it is received. Even if another agency offers the same program, it doesn’t mean that you should not proceed with yours, points out Rumberger. “

Competition can be a good thing because it means that there is a market for the service and one agency may not meet all needs,” she says. “If there is a competitor in the marketplace, you have to determine if there is enough demand to justify two agencies offering the service, or you have to differentiate your service from the other service.”

When management at the Home Nursing Agency in Altoona, PA, developed a chronic disease management program for cardiac and congestive heart failure CHF patients, cardiologists and surgeons in the area were consulted to find out what services would improve home care for their patients, says **Kim Kranz**, RN, MS, vice president of operations for the agency. “We were already caring for many of their patients but we knew we had to change the way we provided that care in order to reduce re-hospitalizations and visits to the emergency department,” she explains.

Cardiac and CHF patients were chosen as the focus of the disease management program after reviewing OASIS data, points out Kranz. “We knew we had a large patient population with these diagnoses and we also knew that this group represented a large percentage of re-hospitalizations,” she says. Talking to physicians gave Kranz a chance to find out what other agencies might be doing for cardiac patients and to find out what physicians thought about services that home care could add, she says. “It also made physicians

aware that we were looking for ways to be proactive and produce better outcomes for their patients,” she says.

Another part of your market analysis should include how you can leverage existing services and patients to promote the new service, says Rumberger. “How many current patients or their family members would be eligible for the new program? she asks. “We struggle to market ourselves in-home health agencies,” she admits. “Word-of mouth advertising is so important, but we hesitate to tell our patients and families about new services,” she says. Even if the patient or family member doesn’t want to become a telehealth patient, they might tell someone else that your agency offers the program, she points out.

### 2. Scrutinize management

“Many times home health agencies will try to add a service for which no one on the management staff has experience,” says Rumberger. Even if you have staff members who can provide the care, it is important to have someone managing the program who understands all of the business and clinical components, she explains.

Components of Kranz’s disease management program include telehealth, improved patient education, focused staff education, and access to a pharmacist for consultation. All of these components were in place at the agency so managers and staff members were familiar with them but the services had not been pulled together to address a specific patient population, says Kranz. “We had already invested in some telehealth equipment but we expanded the program to include all cardiac and CHF patients,” she says. “We had also had a pharmacist available for consultation but that service was rarely used by home health nurses.” Because the agency had all of the individual services in place, in addition to management staff with cardiac care experience, there was no need to look for someone with experience for this program, she adds.

If you are looking at a new program for which you don’t have management experience, look for someone to bring into your agency to manage the program, suggests Rumberger. While the expense of a new manager or a consultant will add to the initial cost of the program, it might be the key to ensuring long-term financial success for the program, she adds.

Experience with managing a nurse practitioner program also was helpful at Visiting Nurse Service of New York, admits **Joan Marren**, RN, MEd, operating officer of the agency. “Our agency has had a

nurse practitioner [NP] program since 1998 but the NPs worked only with long-term care patients in our managed Medicaid program," she explains. In 2005, an NP was added to the home health staff as part of a program to improve assessment and care provided during the transition from the hospital to the home, she says. Because nurse practitioners were not new to the agency, managers understood the role of NPs, billing rules related to NPs, and the advantage of having access to an NPs' experience and training for all home health staff members who provided care to patients, she says.

### 3. Review operations' requirements

The next step in reviewing a potential new program is to determine if your staff already have the key skill sets to provide the service, says Rumberger. "Is it a complex program that requires new skills your staff doesn't possess?" she asks. If the answer is yes, how easily can you find or train staff to provide the service? she asks.

"Most of our nurses already have medical/surgical or intensive care experience, so it was just a matter of additional staff education to improve their knowledge of cardiac or CHF patients," admits Kranz. Key points in staff education included facts that showed that visits alone didn't reduce re-hospitalizations for cardiac patients, but more frequent follow-up through phone calls and telehealth monitoring were effective, she says. Nurses learned what to ask and how to evaluate a patient in a phone conversation, so that nurses and patients were comfortable with this type of follow-up, she adds.

In addition to reviewing staff requirements for the program, look at equipment or supply needs as well, suggests Rumberger. Remember that supply or equipment maintenance costs must be built into the financial projections as ongoing expenses, she adds.

### 4. Project financial return

"The financial step is fun," says Rumberger. "Throughout all of the previous steps, you've identified what you need and what it will cost to get the specific equipment, staff, or training for the new program, so this final step is just compiling everything you've already collected" she says. At this step, you answer questions about what it will cost to equip and staff the program, as well as what it will cost to market and manage the program, she explains. "This is the step in which your operating budget is developed".

Also at this step you determine how long you

think you will require to need a profit on the program, Rumberger points out. "Have a specific timeframe to present to your board so that they know to expect a one or three year period before profits are seen," she says. "If you negotiate those expectations upfront, you won't find yourself being told to shut the program down after only six months because administration or the board expected immediate profit"

If your new program is capital intensive and requires purchase of new equipment or extensive staff training, it will require a longer period of time to recoup investment costs, so be sure to give the program time to succeed, suggests Rumberger. At the same time, it is not a bad idea to build in a timeframe for review, she says.

"You can also plan to review the program's performance in six or 12 months to determine if it is performing as expected," says Rumberger. "If you find that outcomes have not changed, or expected reimbursement is lower than projected, you have an opportunity to identify problems and make changes," she says.

If your primary goal was something other than financial profit, quantify how you'll measure that outcome as well, she suggests. Specify how frequently you will report decreases in re-hospitalization, or visits to the emergency department, if that is your goal, she says.

Although your evaluation of a new program's potential for success should be orderly, thorough, and as accurate as possible, Rumberger has one warning; "We tend to stumble when we over think any new program". "

Once you've planned the specifics of the program and negotiated the financial issues with your board, go and implement it," she says.

Kranz agrees and admits, "I'm a risk-taker. Once I have the basic information I need, I trust my instincts and take a leap of faith." ■

## NC nurses examining policy on assisting in executions

*Some nurses want license penalties for participation*

Physician groups' opposition to doctors participating in death penalty executions has put a moratorium on prisoner executions in North Carolina for nearly a year, and now a group of

nurses are following the lead of their state's physician licensing board. The nurses are asking their own licensing board to adopt an ethics policy that would prevent nurses from participating in carrying out death penalties.

"It is clearly against our code of ethics," Raleigh nurse **Cynthia Gallion** told the Associated Press (AP). Gallion has started a petition urging the nursing board to act along the lines of the North Carolina Medical Board, which in January issued a position statement that says doctors can lose their licenses to practice if they take any action that would:

- directly cause the death of a condemned person;
- assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; or
- automatically cause an execution to be carried out on a condemned prisoner.

The North Carolina Nurses Association (NCNA) has not come out in favor or opposition to the nurses' efforts to spur a position statement from the licensing board, but the president of the NCNA acknowledges that participation in executions is in opposition to the ethics of nursing.

"For the past five years, the CNN/USA Today/Gallup poll has ranked nursing as the most honest and ethical of all professions," says **Dennis Sherrod**, EdD, RN, president of NCNA. "The American Nurses Association, of which the North Carolina Nurses Association is a constituent member, has a long history of opposing nurse participation in executions."

Additionally, Sherrod says, the NCNA "is a strong advocate for quality workplaces and quality patient care, and opposes any public or private entity mandating that nurses participate in executions as a requirement for employment."

Sherrod refers to prisons requiring that nurses participate in executions as part of their jobs. The NCNA, which does not license nor discipline nurses, once forbid nurse participation in executions, but eliminated that restriction several years ago, leaving the decision up to the individual nurse.

### ***Solution lies in legislation, board says***

The North Carolina Board of Nursing, however, has stated that it cannot discipline a nurse for participating in an execution unless the state legislature amends the Nursing Practice Act to prohibit nurse participation.

The state medical board, on the other hand, is authorized under state law to discipline physician

members who violate its ethics policies, so no legislation was necessary for it to issue its policy statement.

The medical board's declaration in January that any doctor who participates in an execution violates medical ethics and could face sanction effectively shut down the state's capital punishment system; no executions have been carried out since then (as of the time *Medical Ethics Advisor* went to press). The issue has arisen again and been referred to the commission on standards and practices, which thus far has taken no action on it, according to Tina Gordon, the association's executive director.

State law does not require that a nurse attend an execution. However, court records and depositions from prison officials indicate that at least two nurses have been present at the past several executions.

"We are still exploring the situation and looking into our options," says **Gail Pruett**, RN, director of nursing education and practice for the NCNA. "I don't think we'll have anything [along the lines of a public policy] for a while."

[For more information, contact the North Carolina Nurses Association, 103 Enterprise St., Raleigh, NC 24607. Phone: (919) 821-4250.] ■

## **Hospice as continuation of care not just end of the road**

*Open access could help patients avoid 'terrible choice'*

Hospice evolved from the need to provide medical and social support to terminally ill patients in the last weeks of their lives. But while the benefits hospice can provide have expanded, the perception that hospice is where patients go to die has, until recently, stayed the same.

According to **Richard Payne**, MD, director of the Duke Institute on Care at the End of Life at Duke University Divinity School in Durham, NC, patients at end of life who might benefit from what hospice has to offer — medical, social, and spiritual support — have been faced with what has come to be known as the "terrible choice:" To qualify for Medicare hospice benefits, most patients have had to resign themselves to giving up advanced medical treatments such as chemotherapy and dialysis.

But that's changing, as evidenced by a movement

toward “open-access” hospice programs that allow patients to continue the treatments that, while not life-saving, can make the quality of the end of life much better.

“We’re not talking about people like Elizabeth Edwards or Tony Snow, who have incurable conditions but who aren’t likely to die in six months,” says Payne, referring to the wife of presidential candidate John Edwards and the White House spokesman, both of whom recently have had recurrences of cancer.

“But what hospice can do is provide open access to people who are likely to die in six months but who can be made more comfortable through palliative chemotherapy or radiation, antiretroviral drugs — treatment that is not going to cure them, but will make the last weeks or months of their lives much more comfortable,” he explains.

### **‘Terrible choice’ forced by money**

Medicare’s rules on hospice care do not require that hospice programs deny patients advanced medical care. But at a benefit of \$130 per day for such care, the ability for a hospice program that’s not backed by a larger institution to offer that kind of care to its dying patients is not likely.

To qualify for hospice benefits, a patient must be diagnosed with a condition that is likely to result in death in six months or less. For many patients and their doctors, that requirement in and of itself is enough to delay entering hospice.

“Physicians in their training are taught to cure,” points out **Roseanne Berry**, RN, chief compliance officer for VistaCare, an Arizona-based national hospice provider. “There is much more education going on now in end of life [in medical schools], but some doctors have had little or no training in how to help their patients die.”

The challenge for hospice providers, Berry says, is to help patients and physicians see hospice not as the end of the road in treatment, but as another layer in the continuum of care — a natural continuation of the care the patient has had up to the point where hospice becomes a consideration.

“We’re getting there, but we still have about one-third of hospice patients die within a week of admission, and while we’re glad to provide that

care, it certainly doesn’t give us the chance to provide the best care we could for those patients,” Berry adds.

In 2005, only about a third of the 2.4 million people who died in the United States were in hospice care, Payne says, perhaps half as many as could have benefited from hospice programs.

He says Medicare policy makers argued that by giving patients a choice of staying in traditional health care or opting into hospice care that would allow the government to save money and still give patients what they need to die comfortably.

“But where do you draw the line?” asks Payne, addressing advances in medicine that blur the line between palliative and curative care. “How do you decide if something is given with palliative intent vs. curative intent?”

Larger hospices can offer more in the way of palliative care because they can spread their costs over a larger population, he points out.

“If you have 1,000 patients and 900 are getting relatively low-intensity therapies that cost less than \$130 a day, you can spread around the remainder to provide higher-cost care to the other 100 patients who need it,” he says.

As the baby boom generation and its parents age, they are demanding more choices than just a place to die comfortably, Berry says, so hospice services are changing to meet that demand.

“I bet you have seen more changes in this area in the last two years than you’ve seen in the 10 years prior to that,” she suggests. “But you have to have those conversations. We’re great at planning parties, planning vacations, planning everything but the end of our lives; but having those conversations lets us say, ‘If you’re eligible for hospice care, if your doctor has certified that you are, then let’s remove the barriers and look at hospice as another part of your treatment.’”

The question that remains, Payne says, is how to afford it. While Medicaid is saving money by paying only \$130 per day in benefits, for many patients the costs skyrocket because of expensive trips to the emergency department or hospital admissions that could be avoided with advanced care provided within the hospice setting, experts say.

“It’s a good thing to do to offer patients these

## **COMING IN FUTURE MONTHS**

■ Learn the low-down on COPS

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options, and it does diminish the psychological barrier of the terrible choice," says Payne. "If there is a way to provide the care they need in hospice — team-oriented, physical, psychosocial, and spiritual well-being — and provide some medically oriented therapies with palliative intent, it makes a lot of sense medically, and it's a reasonable health policy."

Open access means providing these types of therapies, Payne continues. A hospice does not get paid any differently when advance treatment is provided, so open access can mean providing more care at a financial loss. And if Medicare determines that the treatment is curative, not palliative in intent, it could withhold funds for that patient completely.

### **Removing obstacles and fear**

Patients who might be eligible for hospice often are kept away by fear and lack of understanding, Berry and Payne agree.

"We want to remove the obstacles. We tell patients you don't have to have a caregiver in your home. You don't have to have a [do not resuscitate] order, you don't have to have advance directives to come into hospice," explains Berry. "Medicare allows hospices to have their own philosophies, so we do what we can to remove as many of the obstacles as we can, get them into hospice, and then work with them to plan how they want their end of life to be."

Payne says the psychological barrier of looking at hospice as a place to go to die is one of the biggest obstacles.

By not choosing hospice, or by choosing it only in the last days of life, Berry says, many people are giving up a valuable system of care and support.

"Most of our services are provided in the patient's own home," she points out, often with providers the patient has come to know and trust.

"One big concern among patients at the end of life is abandonment. They don't want to be abandoned by their primary care or oncology provider," she says. "In hospice, we can tell them that we will work with their providers, and we are just another layer of care and another set of providers who are here to enhance the care their doctors say they should have."

Payne advocates educating patients and their health care providers and support systems (family, clergy) about hospice, so that the decision to choose hospice is made ahead of time as a part of

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continued care, not as a last resort.

"The No. 1 complaint I hear from patients is, 'Why didn't we get this sooner?'" says **Ronald J. Crossno, MD**, medical director for VistaCare Hospice in Temple, TX. "Thirty-five percent of eligible U.S. patients receive hospice care. Twenty-five percent of these patients get hospice care for less than seven days [before they die].

"An earlier referral means the patient can still go see the grandchildren and it improves the transition. If you're hurting or in pain, you can't deal with the other issues relative to dying."

Berry says that patients who enter hospice shouldn't think they have to give up hope.

"But you have to have the prognosis [of death likely in six months], and those prognoses are very hard for physicians because they want to be optimistic," she explains.

Palliative care physicians can be a good resource if a patient — or his or her physician — is having a difficult time concluding that hospice is an option.

"Palliative care specialists deal with all of the issues that terminally ill patients face. The specialist makes arrangements and goes beyond the social worker," Crossno explains. He says 25% of U.S. hospitals had palliative care specialists in 2005, but expects that number to jump by 2010. ■