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IN THIS ISSUE

- Trauma symptoms will look like the set 124
- Here's a sample tool to assess traumatic life experiences . . 126
- Men grieve differently: Here are strategies to help them cope 126
- Therapy thresholds: New codes in place for 2008 . . 128
- Palliative care program stresses teamwork 129
- Determining fair market value for consulting services 130

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Buried trauma can impact hospice patients in unexpected ways

Here's how experts recommend handling it

Hospice professionals need to be aware that end-of-life patients sometimes are dealing with post-traumatic stress from previous traumas, whether they served in a war or were abused as children. These buried memories and feelings can complicate physical symptoms, including patients' pain and suffering.

Some types of behavior often thought to be characteristics of a certain generation could be symptoms of the patient suffering through this unspoken trauma, says **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospital and Health Network in Bethlehem, PA.

When St. Luke's opened an inpatient hospice facility about two years ago, Baxter began to have unanswered questions about some patients' behavior.

"Early on, there was a particular patient who really sparked this gut feeling that something significant was going on," Baxter recalls.

The patient was an 84-year-old woman with pancreatic cancer, and she was admitted to the inpatient hospice unit because of intractable pain, nausea, and vomiting, Baxter says.

Her son was the caregiver, and he was overwhelmed, Baxter adds.

"Her presentation was of a patient who could only make eye contact with her son," he says. "And she was almost writhing in pain, but would only acknowledge that it hurt a little."

Also, the woman couldn't be left alone at night. As her story was revealed, the staff learned that the woman had been in a violent relationship for more than 20 years; her children had been raised in that environment. The care-giving son exhibited high anxiety.

Vollmer had asked the woman some open-ended questions about her life and her marriage, and as they spent time together, the woman confided to having an abusive marriage in which her husband would lock her in closets and batter her physically and emotionally — even in front of the children.

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"So I went back to the team and said, 'Here are the things going on in her heart and head,'" Vollmer says.

The hospice nurses had wanted to document the woman as in need of a routine level of care because her symptoms could be managed with medication, Baxter notes.

"Our position was that her nonphysical symptoms remained acute for two-to-three weeks, and we needed to look at her total suffering, including psychological, emotional, and spiritual suffering, which required an extra level of care," he says.

The woman needed help in alleviating her fears and in gaining trust, Vollmer says.

So Baxter and Vollmer helped to develop a plan of care that included using volunteers who would be dedicated to the patient, as well as having hospice staff visits timed in such a way that the woman was never left alone for more than 20 minutes at a time.

"We left the TV and lights on for her at night," Vollmer recalls. "And if I saw her in the morning, I'd say I'd be back in the afternoon, and then I'd really do that, providing follow-through."

The extra care included assisting the son so that he could be with his mother in a way that was comfortable for them both, Vollmer adds.

The patient told the hospice workers that being there was the best thing that had ever happened to her, she says.

As the patient's life story unraveled, it became clear that the hospice team sometimes missed important cues about a hidden trauma in patients' lives, he says.

"We needed the hospice staff, particularly nurses, social workers and administrative staff, to see these patients in a slightly different light, in terms of the amount of suffering they experienced related to non-physical symptoms," Baxter says.

"Very quickly, we began to see somewhere around 50 percent of the people who were admitted had some kind of story, and it frequently was a silent story," he adds.

Hospice staff observed symptoms that didn't quite fit with the physical aspects of the disease, and they found that patients sometimes would respond to hospice care and services in an unpredictable way, says **Susan Vollmer, MA, MDiv, BCC**, chaplain and bereavement coordinator at the Hospice of the VNA of St. Luke's in Bethlehem.

"A lot of my work with families is in life review," Vollmer notes. "It includes things that were hard to go through, things they regret they had to go through."

As she did this work with hospice patients, Vollmer began to hear stories about traumatic events, including natural disasters, neglect, abuse, and war experiences. **(See story about symptoms of traumatic experiences, p. 124.)**

"It became apparent that there were symptoms related to these stories," Vollmer says. "At times we had people with symptoms who didn't have any stories, so we became more intentional about working with patients and families and finding out what they could tell us about the patient's past."

Through observing these symptoms and seeing in anecdotal evidence how frequently certain symptoms were tied to traumatic life experiences, Vollmer and Baxter developed a two-page tool for assessing traumatic life experiences. **(See sample of traumatic life experiences assessment tool, p. 126.)**

They also developed a one-page form that instructs hospice staff on how to ask for clarifying information from patients who have symptoms of past trauma and PTSD.

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Editorial Questions

For questions or comments, call **Leslie Hamlin** at (404) 262-5416.

Some of the suggestions included in the form are as follows:

- What can you tell me about your life? Your relationships? Your childhood? Your adult years?
- Is there anything in your life that feels scary, frightening, or troubling when you think of it?
- Have you had flashbacks?
- Do you have a history of abuse?
- Do you have a history of painful events, such as injuries, disasters, illnesses?
- How do you sleep at night? Do you have bad dreams? Do you have trouble going to sleep, staying asleep, or waking? Are you afraid of going to sleep?

As patients decline their usual defenses against PTSD, symptoms also decline, and they have less of an ability to control what is happening, which increases the symptoms, Vollmer says.

"People work hard to keep symptoms and painful memories at bay, but once you can't do that as well, the memories don't go away," she explains. "It's their opportunity to rise up because they can't be held down anymore."

As a result, patients may have flashbacks and have panic attacks at night, Vollmer adds.

The traumas largely have been suppressed because of society's judgments and inhibitions about certain types of victimization.

The victims themselves may have felt they deserved the trauma that happened to them, and they certainly know that it's hard for other people to hear their stories, Vollmer explains.

"There's a huge amount of shame attached to the individual and the person's experience, and over time, nobody really wants to listen to this, so they stop talking and bury it," Baxter says.

For example, women in abusive relationships often experience having people tell them to get away from the man without really listening to who the woman is and where she is with regard to independence, Baxter explains.

Baxter offers this case study of a hospice patient with suppressed trauma that was discovered because of physical and behavioral symptoms:

The woman who was in her fifties had a brain tumor. She'd been referred to the inpatient hospice unit from the hospital because of troubling hallucinations and difficulty walking, Baxter recalls.

The woman was married with several children, including a stepchild.

When Baxter met with the woman at the initial assessment, a female social worker accompanied him.

"Every time I asked the patient a question, she would answer the social worker, and she could not make sustained eye contact with me at all," Baxter says.

"When we asked her a general question about herself, and this is a woman who knows she is dying of a brain tumor, her story was about her mother's death two years earlier," Baxter adds. "When we asked her to tell us about her relationship with her mother, her description of that relationship is when she was a young child, and she said her mother couldn't be without her."

As the woman spoke about her life, she revealed that she had been married three times, all to abusive men, including her current husband.

"The first husband beat her when she was pregnant, and she lost the child," Baxter recalls. "The third husband was abusive to her and their children."

When asked about the abuse, the husband said he had stopped the abuse eight years earlier when he stopped drinking, and the patient confirmed this. Also, the patient wanted to return home, but she needed to know she'd be safe, Baxter says.

"She was able to attend a group meeting to say to her husband, 'I need to know you won't hurt me, that you won't drink, and that I can be safe,'" Baxter says.

It took some assistance from Baxter and the hospice staff before the woman had the courage to make her end-of-life desires known.

"The woman sat in bed and pulled up her legs, almost in a fetal position, and she kept her whole body drawn in," Vollmer says. "She probably had never confronted a male before in her life, but she did it."

The patient's husband agreed to her terms, and he brought her home, where she stayed for over a month. Hospice staff continued to visit her and would ask her about her safety at each visit, Baxter notes.

"We were very intentional about having a presence in the home on a regular basis, so the social worker made visits more often, and the home health aide visited at times of the day when there wasn't going to be any other outside help," he explains.

Finally, the woman returned to the inpatient unit to die, but by then her husband's behavior had changed dramatically, Baxter and Vollmer say.

"He was an entirely different person," Vollmer says. "I met him in the hallway on the day she

was brought back to us, and he stood in the hallway and cried."

This was a man who would never have shown that level of vulnerability a month earlier, she adds.

"He sat with her the entire time when she was dying," Vollmer says.

As the woman was dying, she asked her husband to promise not to drink and to be there for the children and grandchildren, and he made her the promise, while he was holding her hand and telling her how much he loved her, she says.

The hospice staff witnessed the husband's transformation from an aggressive, arrogant, and intimidating man to a humble, vulnerable man, Baxter says. ■

Here are the symptoms that indicate a potential trauma

Experts explain how and why

Past traumatic experiences can result in current physical, emotional, and behavioral symptoms among hospice patients.

For example, a patient who once experienced sexual abuse as a child might be afraid of having the lights out in her room, or she might have trouble speaking with male health care practitioners.

Here are some of the symptoms hospice staff might encounter among patients who have experienced past and even forgotten trauma:

- **Uncontrolled pain:** "This is pain that is out of proportion to the physical findings," explains **Ric Baxter**, MD, hospice medical director and director of palliative care services at St. Luke's Hospital and Health Network in Bethlehem, PA.

"That can work either way: it can be pain that is at a much higher level than the physical findings suggest," he adds. "Or it can be that the physical findings indicate there should be a lot of pain, and instead, the patient is saying, 'I'm fine.'"

The clue is the disconnect between the symptoms and the physical findings and pathological processes underway, Baxter says.

"Suppose you walk into a patient's room and ask if she is experiencing any pain, and she says she's fine, but her body and face are telling you something different," Baxter says. "So the question is why some people can't report their own

pain and other people can take the smallest pain and over-report it?"

In the past, hospice professionals have attributed any under-reporting of pain to a generational stoicism, but they shouldn't make that assumption, Baxter says.

"Often these characteristics are assigned to the World War II generation, and we say they tend to be stoical," Baxter says. "Or with dementia patients, we say they have terminal agitation."

Symptom complexes are stereotyped, and this makes the hospice staff less sensitive to other meanings behind the symptoms, he says.

"They think we just need to medicate the symptoms away," Baxter says. "What we're saying is that maybe it's not just a stoical World War II veteran, and maybe it's not just terminal agitation."

Instead, the symptoms might be related to the process of emotional memories haunting patients more intensely as they are dying.

"Those coping mechanisms break down, and we see manifestations of underlying trauma that they've carried for years," Baxter explains.

When a patient under-reports pain, it begs the question: "Do we really know what the source of this response is, and can we know for sure unless we ask the patient questions?" Baxter says.

Often, hospice patients will not consciously know their own traumatic stories, and yet these buried feelings and experiences are impacting their end-of-life experience, he says.

- **Agitation and anxiety:** Hospice professionals often see patients who become agitated and are unable to soothe themselves, says **Susan Vollmer**, MA, MDiv, BCC, chaplain and bereavement coordinator at the Hospice of the VNA of St. Luke's in Bethlehem.

"We see people who have an inability to see the world as a safe place, and they have an inability to trust others," Vollmer says. "They are suspicious and fearful about anyone who walks into their room."

In the hospice's inpatient unit, there are shift rotations, so a hospice patient might have a number of different people walking into his or her room, she notes.

"Patients can't get out of bed, and they don't know these people, so that can kick into their fears," Vollmer says.

Hospice patients who have suffered from past traumas might have a sense of hypervigilance or hyperarousal, Vollmer says.

Every noise and person they encounter results in heightened anxiety.

"People can become irritable and withdrawn," Vollmer says.

When a hospice nurse observes anxiety in a patient, he or she could ask for a social worker or chaplain to visit the patient and see if there's anything they can do before medication is prescribed, Vollmer says.

"Sometimes, the conversations and support a patient receives can change their need for medication," she adds.

- **Numbness and disassociation:** Another symptom you might note is an emotional blankness, as though the patient has checked out, Vollmer says.

"They can't tell you how they're feeling, and their emotions are far away," she explains.

If you were to ask this patient how he felt about dying, he'd say, 'I think it's okay.'

While some patients might actually feel this way, this reaction also could indicate that the patient has had an unresolved traumatic experience, Vollmer says.

"Quite a few times we've seen disassociation, which is a psychological term, but is very important," Vollmer says. "When you're talking about post traumatic stress disorder (PTSD), this is a step back from reality, maybe with memory gaps."

The person might start to tell a story about his or her past, but there will be memory gaps and a flat affect.

"Someone will need to communicate to you a horrific event, but he'll tell it to you like he's reading a grocery list," Vollmer says.

"Or the person will tell the story in the third person," Baxter says. "It's like they're talking about somebody else they witnessed and it's not about them."

Disassociation is a creative way for the mind to protect the person who has suffered the trauma, Vollmer explains.

"Whatever the experience and emotions are, it's too painful to really be there, so the mind says, 'I'll keep you safe and put it at a distance,'" she adds.

- **Past self-destructive and other coping behaviors:** Another clue that someone has undergone PTSD is a medical history of substance abuse, depression, or anxiety, Vollmer says.

"We may also see people who are very controlling and really need to be in charge," she says.

"In my mind, being controlling is a safety issue where the patient thinks, 'I need to take charge because you might not do the right thing,'" Vollmer says.

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For example, a patient might not want to have a male worker or doctor in the room, Baxter says.

"The female patient might be able to make eye contact with the female nurse, but she can't look at her male doctor," Baxter says. "Her body is relaxed when the nurse is in the room, but when the doctor walks in, she's rigid and on guard."

Other symptoms might include obsessive compulsive disorder, panic disorders, and self-harming behaviors, like cutting, burning, Vollmer says.

"Sometimes their self-harm might be in terms of how they handle their illness," Baxter suggests. "A woman who has breast cancer growing that she's known about for years and never said anything about to anyone, is [engaging] in a form of self-harm."

- **Difficulty with sleeping:** "People who have difficulty with sleeping or whose anxiety level goes up when the sun goes down often are people who've experienced abuse or violence that happened at night," Vollmer says.

"The night time is enough of a trigger for their symptoms and behaviors to rise a little higher," Vollmer says.

Whenever these or related symptoms are observed in a hospice patient, it's important to encourage the patient to tell his or her story, Vollmer and Baxter say.

"Telling stories is an important part of what hospice does," Baxter says. "In upwards of 50 percent of patients, we find that stories are important to the patient's dying process."

It's also important for hospice staff to be offered support after listening to these often sad and disturbing stories.

Here's a sample look at a tool designed to assess traumatic life experiences

Hospice uses it to help direct care

A Tool for Assessing Traumatic Life Experiences

Anxiety that:

- is pervasive
- increases when the sun goes down
- increases when patient is alone
- increases in the presence of others
- includes sleep disturbance with troubling dreams
- easily startled
- restlessness over time or unable to be self/other soothed

Physical Contact: exhibits a reaction to touch:

- hesitant
- avoidant
- declines personal care
- fearful
- anxious
- clingy

Pain:

- tolerance is out of the ordinary
- unexplained pain
- not relieved by appropriate pain management plans
- denies with external symptoms
- can't identify with external symptoms

Fear:

- appears emotionally distressed/preoccupied; shows signs of being disconnected from the present;

exhibits flashback behavior (i.e., is re-experiencing an uncomfortable/frightening event); displays emotions in excess

- of visitors/staff/volunteers
- declines care from male nurse/aide/volunteer
- isolates and/or declines visits over time
- can't be left alone or requests not to be left alone
- clings

Family is someone:

- too close
- too distant
- controlling
- angry
- avoidant
- estranged
- addicted or over-using a substance
- overinvolved
- underinvolved

Is patient:

- uneasy in presence of one or more family members
- tense in family gatherings
- unexplainably angry when dealing with a particular family member
- withdrawn

Source: Susan Vollmer, MA, MDiv, BCC, Chaplain and Bereavement Coordinator, Hospice of the VNA of St. Luke's, Bethlehem, PA, and Ric Baxter, MD, Hospice Medical Director and Director of Palliative Care Services, St. Luke's Hospital and Health Network, Bethlehem.

"It's hard to hear those stories," Vollmer says. "When someone trusts us enough to give us their story, what do we do with it and what do we do to take care of ourselves?"

Hospice workers need to support each other and acknowledge that hearing these life stories can be upsetting, Vollmer adds.

"It's not something they need to take home to keep them up at night," she adds. "It's important to have the gift of a hospice team and to rely upon our team members, as well as to know how to care for ourselves and to receive the support we need." ■

Grief counselor offers ideas for dealing with male grief

Here are some common misconceptions

TTrue or false: If a male caregiver/family member doesn't show any emotion, then he is coping well with his grief over his loved one's dying.

The answer is "false." This is a common misconception among some hospice workers and the public when it comes to dealing with male care-

givers, family members, and patients.

"There are a lot of ways to grieve that don't have anything to do with crying or showing emotion," says **Keith A. McDaniel**, MFT, CT, a grief counselor with the FirstHealth Hospice and Palliative Care of Pinehurst, NC.

People handle grief according to how they learned to express their feelings and emotions growing up, McDaniel says.

"I'm in my early 50s, and people in my generation didn't have fathers who knew how to share feelings and emotions because their fathers didn't," McDaniel says. "If our fathers didn't know how to share feelings and emotions, then it's difficult for the sons to know how to do that, and it's a re-learning experience."

McDaniel saw his own father cry only twice.

"If you think about it with kids, when they get into athletics, the coach will say, 'Shake it off, you're okay,' and so we're conditioned to have that stiff stance and stuff our emotions," he adds.

This type of emotional conditioning has a lasting influence and doesn't dissolve at the end of life.

"So then as an older male when we have a traumatic event occur, we don't have the tools to express those emotions," McDaniel says. "It's okay to be angry, but it's not okay to be sad."

The key is for hospice professionals to offer male patients and family members an action-oriented way to express their grief, he says.

For example, a hospice could invite men to participate in a volunteer session of fixing or making something because men sometimes can work through their grief by working with their hands, McDaniel says.

"Men typically are doers, and they'll get involved in things that allow them to work with their hands," he explains. "One man created an urn for his wife's ashes in his workshop."

Making or creating something is a way of expressing grief without outward emotions, McDaniel says.

Exercise, such as golf and walking, also can be good strategies for dealing with grief, and hospice counselors can encourage men to return to their favorite exercise past time, he says.

Hospices also could provide male-only support groups, although it can be difficult to get men to show up, he notes.

"We've had as many as five men come to a support group meeting, and these have been older men," McDaniel says. "It's very powerful when

you have five or six men expressing their grief and crying with other men."

While it took a great deal of encouragement to fill the support group, once the men began to attend the meetings, they opened up and began to share their feelings, he adds.

Another strategy for working with grieving men is for nurses and social workers to sit back and not push them to open up, McDaniel suggests.

By just being with them, practicing being a presence in their lives, the hospice workers might earn their trust.

"Just be there and talk about what they like to do, like what their hobbies are and those kinds of things, as opposed to trying to get directly to how they feel about their illness," McDaniel says.

Men also might be open to journaling.

"I think journaling is wonderful," McDaniel says. "The other thing is I deal a lot with dreams. I always ask the bereaved person if he has had any dreams about the loved one or dreams in general."

Men usually are not hesitant to talk about their dreams, McDaniel says.

Hospices might offer men massages and other types of therapeutic interventions, he says.

"I learned after my dad died to get massages, because I knew the grief would get stuck in my body and massages help to keep the grief flowing," McDaniel says.

After a loved one has died while in hospice care, the husband or caregiver might need to get away for a while.

"One man after he lost his wife said, 'I don't know why, but I think I need to go to the coast,'" McDaniel recalls. "So he took a week to spend it alone traveling and just reflecting and keeping a journal."

When the man returned, he said the time away had made all the difference.

"One man, while his wife was dying, would go to Wal-Mart or somewhere like that, once a week and he'd buy a fishing lure — one at a time," McDaniel says. "He collected these lures during the time of his wife's illness, and then when she died, he knew he needed to go out and fish for a week."

"The main thing to keep in mind is that everyone grieves differently," McDaniel says. "Just because your father is not showing emotions does not mean he's not grieving."

Hospices can encourage men to attend support

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groups or inquire about grief services by distributing fliers and mailings, as well as by contacting men directly, he suggests.

"You can say, 'We're having a men's group, and we'd like you to come,'" McDaniel says.

"I think often times that men are looking for ways to express or deal with their grief, but they don't know what's out there, and they don't know that there are counselors who deal with grief," McDaniel says. "When you start to get enough men to come in, they'll start telling their buddies that it's okay." ■

Therapy thresholds: New codes in place for 2008

HHPPS requires agencies to start preparation now

Three different therapy thresholds, a new payment model for non-routine medical supplies, and additional questions for OASIS are just a few of the changes in the Centers for Medicare & Medicaid Services' (CMS) Home Health Prospective Payment System (HHPPS) for 2008.

While some items related to OASIS and diagnosis codes were not expected to be finalized until mid-September or early October, **Mary St. Pierre**, MA, BSN, vice president for regulatory affairs at the National Association for Home Care and Hospice (NAHC) in Washington, DC, began preparing early. "Agencies will have to change software, change OASIS forms, and change billing forms," she says. "There are now 153 case-mix groups and 51 different clinical and financial items that need to be addressed by each agency."

Case-mix creep

There is a reduction in payment for all home

health agencies to account for "case-mix creep," points out St. Pierre. The reduction in the national standardized 60-day episode payment rate will take place over a four-year period. The reduction will be taken at 2.75% per year for three years beginning in CY 2008 and at 2.71% for the fourth year in calendar year (CY) 2011. "The increase in payments based on case mix that home health agencies have seen over the years is due to improved coding and documentation rather than the actual condition of the patients, so CMS is adjusting reimbursement," she adds.

It is hard to predict how agencies will do financially under the new payment system because the case mix is so complex, says St. Pierre. Therapy thresholds are now set at six, 14, and 20 visits compared to the single 10-visit threshold in the previous system, and early episode vs. late episode must be documented, she points out. (For an item-by-item comparison of HHPPS changes, visit www.cms.hhs.gov/center/hha.asp.)

Agency managers should be working with their software vendors now to make sure that changes in the PPS system are reflected in the software, suggests St. Pierre. "OASIS forms need to be updated and staff members need to be educated about the changes," she says. "Not only are there new codes but staff members will need to differentiate between early and late episode care for accurate reimbursement."

The 2008 PPS also requires agencies to report data for two additional quality measures — emergent care for wound infections, and deteriorating wound status and improvement in status of surgical wound — to the 10 measures currently reported, for a total of 12 measures to be reported on the Home Health Compare web site.

The first step to prepare for the new PPS is to carefully review CMS documents, says St. Pierre. Then, meet with software vendors and evaluate your OASIS forms, printed or electronic, she says.

The key to successful preparation is to start now, suggests St. Pierre. "Everyone needs time to reprint forms if they are using paper, or reprogram electronic forms, as well as update software to handle the changes," she points out. In addition to making the changes, be sure to allow enough time to test the forms or software changes to make sure that your processes flow smoothly on Jan. 1, she adds.

Another important part of preparing for the new PPS is to thoroughly educate your staff, recommends St. Pierre. "Clinicians do have to

answer a few different questions and use some different codes, and they must be careful to accurately document items, such as infected surgical wounds, abscesses, chronic ulcers, gangrene, dysphagia, tracheostomy, and cystostomy, because scores are now given for these conditions." ■

This article originally appeared in the October 2007 issue of Hospital Home Health.

Palliative care program stresses teamwork

Uses hospitalists trained in palliative care

What makes an award-winning palliative care program? In the case of the program at the University of California at San Francisco, it's the combination of a collaborative approach to individualized patient care; extensive use of hospitalists; and a program that educates practicing physicians and medical, nursing, and pharmacy students and residents.

Those are some of the factors cited by the American Hospital Association when it recently named the UCSF program as one of the three winners of its annual Circle of Life Award for innovative efforts to provide end-of-life care.

"One of the problems in modern hospitals is that all these professionals — doctors, nurses, social workers, pharmacists, physical and occupational therapists, and chaplains — typically work independently," notes **Eva Chittenden**, MD, assistant professor of medicine at UCSF and acting director of the palliative care service at the UCSF Medical Center. "One of the things we do is break down these barriers. We all discuss the patients and learn from one another, and end up giving patients better care that's comprehensive and individualized."

Collaboration a necessity

Interdisciplinary, collaborative work is essential to such a program, notes Chittenden, asserting that "you can't be a palliative care service without being a collaborative."

Nevertheless, it is the way the collaborative unfolded at UCSF that helped earn it national recognition. On a daily basis, the team meets at 9 a.m. on the wards. It includes a physician, a social worker, often a pharmacist, a chaplain, and

often a nurse as well as trainees — fellows, residents, medical students. "We meet in a room and discuss all the patients on the service," says Chittenden. "Then, depending on the needs of the patients that day, we break into smaller groups and work with them — or we may see the patient as a team." Often, however, the size of that team is limited for fear of overwhelming the patient and family.

The team often will touch base in the afternoon as well as to reconvene and discuss what has happened during the course of the day, says Chittenden.

Every other week there is a formal interdisciplinary meeting for two hours. It includes all the physicians on the service; the head of the chaplaincy program and the chaplains; and nurses who are leaders but may not round with the team on a daily basis. Complementary alternative medicine providers are also present, says Chittenden. "We will discuss the patients in a larger framework, and talk about service needs and administrative issues," she explains.

Individualizing care

Providing "individualized" care, says Chittenden, "means we are focusing the care on the goals and values of that particular person." In other words, the team does not use a "one-size-fits-all" approach.

"We sit down with the patient, and whoever is important to them, and start by asking that person, 'What's important to you?' 'What are you looking for in the future?' 'What worries you?' 'What do you want to accomplish with the time you have left?'" Chittenden relates. "We discuss their hopes, goals, dreams, worries, anxieties, and fears, and then try to make the medical care we provide fit those feelings, to help achieve those goals." Those goals, she adds, can be medical, social, psychological, or spiritual.

"Let's say, for example, that someone's goal is to get home and spend time with their family — and we're talking about meaningful time," Chittenden offers. "That patient has to have excellent symptom management. If they have severe pain or shortness of breath or significant nausea, they are not going to enjoy their time with their family." Too often, she notes, providers will focus on the disease, and not on issues such as these.

If a spouse or child is in complete denial about the situation, a chaplain or social worker may be brought in for conversations to help everyone

understand the patient's status and feelings. "If it is a cancer patient, they can help decide if the patient will have another round of chemotherapy," says Chittenden.

"The patient may consider the burdens greater than the benefits; they may not want to go to the clinic every few weeks to get an infusion that will make them feel sick if the potential benefit is less than 10%."

Using trained hospitalists

The hospitalist group at UCSF is one of the first of its kind in the country, say Chittenden. "We have a large group — at this point, maybe 25 to 30," she says. "We have a core group of six on the service who are certified in palliative care." One of the benefits is that, as hospitalists, they are in the hospital all day long. "This is wonderful, because we need to spend time with the patients and their families," says Chittenden. "We are used to working with an interdisciplinary team."

In addition, she says, it adds to the job satisfaction of the hospitalists. "I like the fact personally that I get to do both types of work [general hospital care and the palliative care]. They are very different," Chittenden shares.

The hospitalists can perform this dual role, she explains, because of their training. "In our [basic hospitalist] training, we often do learn about some of the core skills in palliative care, but we have gone on to get more training, which is critical," Chittenden notes.

Chittenden adds that research by her group shows that having hospitalists in a hospital improves the chances of your palliative program being successful — even if they are not on your service. "They may be an additional source of referrals," she explains.

Education part of hospital's mission

Training the next generation of providers "is a core part of our mission," says Chittenden. "We have education programs in our medical school, nursing school, and pharmacy school — in pre-clinical and clinical areas." In addition, she says, there are programs for medical residents, and for practicing physicians. "We also have a fellowship program — for residents who finished internal medicine and who want to have one or two years in palliative care training."

The clinical elective for fourth-year students has been available since the palliative care pro-

gram began in 1999, and now 30% of the students elect to take it, Chittenden says. "It's a little early to tell if [graduates of the two-week hospital program] will work with us," she adds.

Of the internal medicine residents, five have gone on to do palliative care fellowships. "This is really new," Chittenden observes.

UCSF also has established the Palliative Care Leadership Center to educate and mentor hospitals around the country interested in starting their own programs. "A group from an interested hospital makes application and comes to our program, which is a very intensive two-day course," Chittenden says. "There is a lot of individual attention and mentoring as they go through a set of modules we created, followed by a year of telephone mentoring." ■

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Determining fair market value of consulting services

By **Elizabeth E. Hogue, Esq.**
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As many providers already know, the so-called "Stark law" prohibits physicians from making referrals to providers who render "designated health services" (DHS), if referring physicians have an ownership or investment interest in, or compensation arrangement with, the provider. Designated health services generally include home health, home medical equipment, infusion services, and outpatient hospital services, among others. Likewise, providers of DHS generally cannot bill for services provided to patients referred by physicians who have ownership or investment interests in or compensation arrangements with them that violate the Stark law.

Exceptions to these general rules were published in the form of final regulations on Jan. 4, 2001, the so-called "Phase I" Stark rules. On March 26, 2004, "Phase II" Stark regulations were published as interim final rules in the *Federal Register*. These Phase II regulations further clarified exceptions to the statute described above.

The Phase II regulations provided specific guidance regarding the use of physicians to provide consulting services to physicians who also

make referrals as follows:

(1) Many providers utilize the services of referring physicians as consulting physicians to their organizations. These consulting physicians perform a wide variety of appropriate services to providers. There is an exception for personal service arrangements that may include payments to referring physicians for consulting services.

In order to meet the requirements of this exception, providers must:

- Enter into a written agreement with physicians, signed by providers and physicians, that specifies the services covered by the arrangement.
- The arrangement must cover all of the services to be furnished by referring physicians to providers.
- Aggregate services provided do not exceed those that are reasonable and necessary for the legitimate business purposes of providers.
- The term of each arrangement is for at least one year. To meet this requirement, if an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the remainder of the first year of the original term of the agreement.
- Compensation paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
- The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(2) Also, as described above, providers must pay for services from consulting physicians at fair market value. Many providers have asked how they should determine fair market value.

Currently, the Stark II rules make it clear that fees paid to referring physicians for their services will be considered to be at fair market value only if hourly payments are calculated using either of the following two methodologies:

- The hourly rate is less than or equal to the average hourly rate for emergency room physician services in the relevant physician market,

provided there are at least three hospitals providing emergency room services in the market.

- If there are fewer than three hospitals that provide emergency room services in the geographic area where the provider operates or if providers choose to do so, they may pay physicians at an hourly rate that is determined by averaging the 50th percentile national compensation level for physicians with the same physician specialty or, if the specialty is not identified in the survey, for general practice in at least four of the following surveys divided by 2,000 hours. The surveys are:

- Sullivan, Cotter and Associates, Inc. — Physician Compensation and Productivity Survey
- Hay Group — Physicians Compensation Survey
- Hospital and Healthcare Compensation Services — Physician Salary Survey Report;
- Medical Group Management Association — Physician Compensation and Productivity Survey
- ECS Watson Wyatt — Hospital and Health Care Management Compensation Report
- William M. Mercer — Integrated Health Networks Compensation Survey

As of Dec. 4, 2007, the above formulas will no longer apply. Nonetheless, providers must be able to demonstrate using some reasonable basis that compensation paid to consulting physicians who also make referrals is at fair market value.

Providers could, for example, conduct what amounts to a “salary survey” of providers that operate in the same geographic area regarding the amount per hour that other providers pay consulting physicians. Such a survey is likely to produce a range of hourly rates. Providers should document the results of these surveys and pay physicians at rates that do not exceed the highest end of the range.

The above described change with regard to the use of formulas to calculate compensation at fair market value is an appropriate and very welcome change. The formulas proved difficult, if not impossible, for home care providers to use. Providers can now avoid the frustration of trying to comply and breathe a sigh of relief. ■

This article originally appeared in the October 2007 issue of Hospital Home Health.

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■ A study discussing hospice patients who are suicidal

■ Build up partnerships in long term care and other facilities

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