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## New study shows costs of hospice care is less for most end-of-life patients

*Quality care and cost savings coincide*

Hospice managers have long suspected that their care both improves quality and saves payers money. Now there's a major research study of Medicare end-of-life patients that demonstrates that hospice care saves money for most end-of-life patients.

Managers can use the study's findings to demonstrate the value of their services to health system executives and referral sources, including physicians.

The study found that hospice use reduced Medicare program expenses during a patient's last year of life by an average of \$2,309 per person enrolled in hospice care. (Reference 1) Hospice use also saved Medicare a maximum cost savings of about \$7,000 per hospice patient when the hospice care was provided for about two months.<sup>1</sup>

"For the last 25 years or so, people have been interested in the question of 'Does hospice reduce health insurance costs to Medicare?'" says **Donald H. Taylor Jr., PhD**, an assistant professor of public policy studies at Duke University and an assistant professor of community and family medicine and nursing at Duke Medical Center in Durham, NC. Taylor is the lead author of the new Duke study that provides a hearty "yes" to the cost-savings question.

"It seems like a straightforward question to answer, but the tricky part is that people who tend to use hospice are different than those who don't use hospice," Taylor says. "Our study tries to statistically account for the difference between the two groups."

The Duke study is one of the most important to date on the topic of hospice costs because it compares apples to apples among Medicare beneficiaries, says **Jon Radulovic**, spokesman for the National Hospice & Palliative Care Organization (NHPCO). "The methodology used in this study was very thorough," Radulovic says. "What's interesting is the finding that by increasing hospice stay even by a couple of days, you can increase that savings by another couple of hundred dollars."

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The study, which was conducted from 1995 to 2003, identified people who were very similar to hospice users in their demographics and past health care experiences, but had the one difference of not having used hospice care in their last year of life, Taylor explains. Researchers subsequently determined the daily costs of each group. Much of hospice's cost savings could be attributed to one primary difference between the two groups: "People who are using hospice are not as likely to die in the hospital as people who don't use hospice," Taylor says.

## **Hospital care is very expensive**

Recent government scrutiny and media attention have focused on the hospice patients who have very long lengths of stay (LOS) and the hospices that have a disproportionate number of such patients. For example, a recent article in *The New York Times*, highlighted a handful of for-profit

hospices that have exceeded the Medicare cap on per patient expenditures because they have a large number of patients who have long lengths of stay.<sup>2</sup>

But across the nation, the longer-stay patients are less common than the patients who are referred to hospice too late to receive the full benefits and best quality of care, Taylor notes.

The 25th percentile of hospice LOS is five days, meaning that one out of four hospice patients receive hospice care for five days or less, Taylor explains.

If these same patients were to double their lengths of stay, it would save Medicare money, and this is the area in which cost savings efforts should be focused, Taylor says.

As the study notes, the longer LOS would save Medicare money because it is a patient's last week and days in hospital care that is the most expensive health expenditure. Thus, when a hospice patient is referred to hospice care at home two weeks before his or her death, it saves Medicare the difference between what would have been spent in hospital care versus what is spent in hospice care. This amount increases the longer a patient is in hospice care for all but the minority of patients with very long LOS.<sup>1</sup>

Additionally, most people who work in hospice care or who have had loved ones who received hospice care would say that hospice care enhances the quality of care, Taylor says. "And our study shows hospice would save Medicare money," he adds. "There is almost no other example I can think of showing something that improves quality of life and saves money."

## **Goal is quality — not lowest cost**

While the Duke study is welcome news to an industry that is undergoing federal scrutiny and regulatory changes, it also might reinforce the idea that hospice care should reduce health care costs, says **Porter Storey, MD**, executive vice president of the American Academy of Hospice and Palliative Medicine.

"The thing we have to watch about studies is [the reality] that no care is always cheaper than good care," Storey says. "The goal here is not to have the lowest cost."

It's an interesting and fair question to ask whether hospice care should be expected to save money for the Medicare program, Taylor says. "We don't ask whether coronary bypass surgery saves Medicare money," he adds. "It's interesting that the hospice program is subjected to that

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### **Editorial Questions**

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question of whether it saves Medicare money when no other part of medicine is.”

While the Duke study’s findings are very positive for the hospice industry, it’s unlikely the one study will settle all questions about hospice’s value in the Medicare program. **Stephen Connor**, PhD, vice president for research and international development at the National Hospice and Palliative Care Organization (NHPCO), says, “The thing about hospice cost research is I’m not sure we’ll ever be able to have what is referred to as a definitive study, because we can’t randomize patients to hospice.”

“The study is as good as how well you match subjects,” Connor says. “This study has done a better job than any previous study in doing that, and it’s the best we have at this point.”

The study has caught the attention of the government, and its timing led to notice at the fall meeting of the Medicare Payment Advisory Commission (MedPAC), where one MedPAC member mentioned its findings. (See **December 2007 issue of *Hospice Management Advisor*, p. 139, for excerpt from MedPAC meeting.**)

“MedPAC has some interest in how hospice is financed,” Taylor notes. “The two groups of most interest from a policy perspective are people who use hospice three to four days before death, and there’s a concern whether they reap all of the benefits of hospice care. The second group is of people who use hospice for more than 180 days, which is about 5% to 6% of Medicare beneficiaries.”

It’s this second group that has drawn more attention from MedPAC, Taylor says.

### **MedPAC worries most about long LOS**

MedPAC is worried that these long lengths of stay represent something fraudulent to hospice, Taylor says.

“It appears to us that most of those cases of longer LOS occur when the clinical condition of the patient changes,” Taylor says. “Death is not the simplest thing to predict, and we think more attention should be paid to the shorter LOS.”

The Duke study found that for the entire last year of life, people who received hospice care cost Medicare \$32,727, nearly the same as the \$32,837 cost for people who did not receive hospice care in their last year of life.<sup>1</sup> Also, hospice cancer patients who were in hospice care for 233 days or longer and noncancer patients who were in hospice care for 154 days or longer actually cost the Medicare program more than normal hospital-based and other medical care.

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Policy-makers should focus on decreasing the numbers of people who enter hospice care too late to reap the full quality of life and Medicare cost-savings benefits, Taylor suggests. This could happen with a simple policy change that allows end-of-life patients who wish to continue to receive curative medical care to also receive hospice care, he says. “Most people who are coming to hospice late or for such short periods is because of restrictions on curative treatment for hospice,” Connor says. “What happens commonly is people want to continue some disease-modifying therapy with the goal of remission or cure even up to the point of near death.”

End-of-life patients who don’t receive hospice care until the last few days of their lives are missing out on some of the significant benefits that hospice can offer them, Storey says. “I have had many patients who finally became comfortable when they received hospice care, and they were furious with me because they had been miserable for so long,” Storey says. “They’d ask, ‘Why didn’t I receive that kind of care sooner?’”

The Medicare program makes an unnatural division between end-of-life patients who choose to continue curative treatments and those who choose to enter hospice care and discontinue all

such treatment, Storey says. "Everyone else in countries around the world looks at our system as a real aberration because it puts a financial barrier between hospice care and hospital care," Storey says. "In Great Britain, Australia, and Canada, you can get a CT scan and be referred to a specialist while on hospice care."

Some hospices have gone out of business because they couldn't afford the short-term and intense palliative treatment needed by end-of-life patients who continued to receive medical interventions for their cancer until they were very sick, Storey notes.

By the time such patients are referred to hospice care, they cannot swallow and must receive infusions and additional staff to help them become comfortable, he adds.

If these same patients had been referred earlier, while they still received medical interventions, then the overall hospice cost would have been lower, and it would have been easier and

less expensive for the hospice to make them comfortable, Storey says.

Patients who are referred to hospices sooner are those who have accepted that their disease cannot be cured, and so they're ready to stop curative treatment and receive the symptom relief and other services that hospice can offer to end of life patients. "Most patients who come on to hospice care are getting much more intensive care in what matters to them most: pain, shortness of breath, the family pulling their hair out," Storey says. "But they have to face the reality that they have something that can't be cured."

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## Become more vigilant about Medicare cost reports

### *Bad data could lead to poor reimbursement*

Some hospices pay too little attention to how they complete Medicare cost reports. The result? Bad data at a time when good information is critically needed, as the industry undergoes regulatory scrutiny, one expert says.

"The hospice information out there is only as good as what's been filed," says **Robert Simone**, principal of Simone Consultants, a financial and operational home care and hospice consulting company based in Hamden, CT. Simone is scheduled to speak about Medicare cost reports and financial benchmarks for hospice services at a National Association for Home Care and Hospice (NAHC) conference (the 2008 Home Care & Hospice March on Washington and Legal Symposium) to be held April 6-9, 2008, in Washington, DC. "We're trying to tell the industry that it's very important to fill out the hospice cost report accurately," Simone says.

Simone is working with NAHC on establishing a database of hospice cost reports with the goal of pulling out benchmarks, such as the average cost per day for medical supplies, durable medical equipment (DME), etc. "What we're trying to do is provide the hospice industry with the information it has been lacking in the financial

area," Simone explains. "Our first step here is to use the one piece of information that's being filed with the federal government and that has to be filed by all Medicare-certified hospice agencies out there."

The goal is to develop national benchmarks that can be broken down into state, regional, and city comparisons, he says. "What we're trying to do is help the industry take a look at their data and compare it to national data," Simone adds.

### **Some hospices report bad data**

However, as Simone has pored over the Medicare cost reports, he's found that some agencies report data that are likely inaccurate. "There is a major variance in costs, and sometimes there's no rhyme or reason for it," Simone says.

What appears to be happening is that some hospices take shortcuts in completing the Medicare cost report, he says. "Sometimes what happens is they lump the costs all together as ancillary services, putting everything into one category," Simone says. "At the end of the year, they have to go back to all of the invoices and break out the data."

Because re-tracking data is very time-consuming, and the Medicare cost report doesn't impact how hospices are paid, some hospices take the shortcut measure of putting data from a variety of cost items into one category, Simone explains. "That's why we get these outliers, and Medicare gets a distorted picture of hospice costs," he adds.

The problem is that some hospices may not understand the definitions on the cost report, so they don't know how to allocate the funds, says **Dale O. Knee**, MHCA, president and CEO of Covenant Hospice in Pensacola, FL. Knee was elected in December to the 2008 board of directors of the National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA.

"It's been a learning experience for all of us, and I don't believe there is a deliberate attempt to try to mislead or show costs allocated to one place when they should be allocated to another," Knee says. "But there's a general, continuing need to learn how to prepare the cost report accurately."

Hospice organizations need to understand the cost report's definitions, and then they should assign the costs based on the definition, Knee says.

Inaccurate information on the cost report could hurt the entire industry, Simione says. The greatest repercussion would be if the federal government decides to use the cost report data to establish new Medicare payment rates.

"The hospice industry probably is going to go through a major revision in reimbursement," Simione says. "The government is trying to come up with a database and good information so they can revamp the reimbursement system, and the cost report is one of the pieces of information they will use."

### ***Detail all hospice expenses***

Hospices that don't capture all of their expense details and report these accurately in the Medicare cost report could hurt their own industry down the road, he adds.

Also, agencies that provide inaccurate information to the cost report won't be able to benchmark their data with other hospice's data once these benchmarks are established, Simione says.

Simione offers these suggestions on how to improve Medicare cost reporting:

#### **1. Look closely at cost report and its requested data.**

Hospice executives and chief financial officers should make certain they know exactly what is needed in the cost report at the beginning of the financial year.

Many agencies group numbers together in the cost report, instead of breaking them out in detail, Simione says.

When invoices are paid, hospices should make sure the ledger provides details about those payments, he says.

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"If I was the chief executive officer of a hospice, I'd ask the financial person to make sure expenses on the financial statement are broken out in such detail that I can track these costs," Simione says. "You want to know what your cost per day is for drugs and DME because these are high-cost items, and you want to make sure you are controlling those costs."

The goal is to look from month to month and year to year to make sure those costs are being controlled within the agency, he says. "If you see those costs going up, then you need to investigate why it's happening," Simione says. "It also helps when you do your budget."

Most hospice agencies determine their budget based on volume, average length of stay for the year, and they compute their revenue based on days because hospices are reimbursed on a per diem basis, Simione says. "If they know their days and cost per day for drugs and DME, then they can budget better," he adds.

#### **2. Develop a chart of accounts that parallels the hospice cost report.**

"Look at the line items you need to complete," Simione says. "Then take the general ledger and come up with a chart of accounts that parallel that."

The key is to bring the general ledger information over to the cost report, he suggests. Categorize expenses as they come in, and put these in a chart of accounts, Simione says. "Record the information in the proper categories."

At Covenant Hospice, there is a clear chart of accounts where the costs are allocated and reported, Knee says. "These can be easily translated and placed on the cost report," he says. "So we're continually assigning costs in an appropriate category, using the definition of that category."

That action is critical, Knee says. "But once again it starts out with having an understanding of the definition of the category," Knee explains. "If you don't understand, there is a tendency to

put costs in the miscellaneous category.”

The key is to have the hospice’s chart of accounts parallel the Medicare hospice cost report. Thus, when you have an invoice for medical supplies, it should be keyed in as medical supplies in the general ledger, Simione explains.

Hospice agencies that use general ledger software packages can develop these parallel accounts quite easily, he notes. “Even smaller agencies have some type of software out there that they could utilize to break down the information,” Simione says.

### 3. Break old bookkeeping habits.

It’s not significantly time-consuming to record the data correctly if you do it up front, Simione says.

“If you’re a new hospice or a small hospice agency, and you only file that Medicare cost report once, it has no bearing on what happens to you individually,” Simione says. “You’re trying to short-cut things for yourself up front.”

However, it’s better for these agencies and for

the industry as a whole to break old habits and develop a more thorough record-keeping system. Hospice agencies that are doing this correctly are looking at their data on a monthly basis, Simione says. “They’re breaking out the data because it’s a management tool,” he explains. “They use performance indicators within the industry to make sure they’re managing their costs properly throughout the year.”

For these agencies, it’s not a mystery about why they are making or losing money because they have ready access to the details that explain where their financial strengths and weaknesses are, he says.

Even if the Medicare cost report were not used for benchmarking or if it is never used by Medicare to determine new payment costs, hospices should complete these accurately, Knee says. “We need to make them as accurate as possible because it’s the right thing to do, and we’re required to do it,” Knee says. ■

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## Patients are suicidal more often than expected

*Poor quality of life often is factor*

It’s an unpleasant reality that hospice professionals sometimes encounter a patient or family members who ask them to assist in hastening the patient’s death.

When this happens, hospice staff can use the situation as an opportunity to make the patient’s care more meaningful, an expert suggests.

Sometimes end-of-life patients who have a diminished capacity to enjoy life will believe that it would be better to commit suicide than continue to decline, says **Liz Arnold**, PhD, an assistant professor in the Department of Psychiatry and Behavioral Medicine at Wake Forest University School of Medicine in Winston-Salem, NC. Arnold conducts research on the issue of suicidal hospice patients, and she’s spoken about this topic at national conferences, including the 2007 National Hospice & Palliative Care Organization’s (NHPCO’s) conference.

Arnold’s research about hospice patients who want to hasten their deaths is ongoing. “I’ve been working in this area for over 10 years, and we’ve learned a lot in the last 10 years, I think,” she says. “Ten years ago, nobody was talking about

any of these things, especially in hospice care.”

Since Arnold is a former hospice social worker, her research has involved interviewing hospice social workers as well. “We surveyed hospice social workers in North Carolina and South Carolina and asked about cases where hospice patients had either considered assisted suicide or suicide,”<sup>1</sup> she says. “We use the term ‘hastening death’ and asked about their experiences with patients and families.”

Hospice professionals occasionally encounter patients or family members who will ask about hastening the patient’s death, but it is not a common question, says **Van Grinwis**, RN, home care manager for CarePartners Hospice & Palliative Care Services of Asheville, NC. In the past two years, Grinwis has heard of about three situations involving such requests.

Obviously, the first thing hospice professionals have to explain to patients and caregivers is that they do not hasten death, Grinwis says. At CarePartners Hospice, patients who make such requests are referred to the medical director, she says. “He takes care of educating the patient and assessing the patient to see what his or her needs are,” Grinwis explains. “He lets patients and their families know what the hospice can offer them.”

Sometimes it’s just a matter of providing patients with pain management, getting them comfortable, either at their home or in an inpatient facility, Grinwis says. “It depends on what it

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is that makes the patient want to end his or her life," she says. "So finding out what it is the starting point of deciding what you're going to do with them and how you're going to help them."

When these requests come from people who have not enrolled in hospice care and who misunderstand what hospice care is about, the answer could be more education. But there are times when these patients may not be enrolled or may not call again, Grinwis adds.

### ***Counseling and suicide prevention are needed***

Common strategies for dealing with suicidal hospice patients are to provide counseling and suicide prevention, Arnold says.

Sometimes patients mistakenly think that hospice professionals could take an active role in helping them hasten their death, she says.

"People sometimes confuse passive means of hastening death, like disconnecting someone from life support and withholding medicine, from an active means, but these are two different issues," Arnold says. "Most professional hospice organizations do not support legalization of assisted suicide."

### ***Hospices need to resolve all unmet needs***

Arnold's research has found that the most common reasons why hospice patients want to hasten death are having a poor quality of life and a concern about suffering.

Social workers also report that suicidal patients may have a decreased ability to participate in enjoyable life activities, Arnold says.

Social workers and other hospice professionals can help suicidal patients by listening to their concerns, without lending support to the idea of hastening their lives, Arnold suggests. "With

patients and family members it's important to give them permission to have that conversation about hastening death," she says. "Just because you're willing to listen doesn't mean you're supportive of it."

This conversation allows the hospice to identify and address any unmet needs, Arnold says. "You could say, 'Tell me why and how you reached this decision to hasten your death, Why is this something you feel like you need to do?'" she says.

The hospice industry should have more conversations about this issue because it can be very stressful for hospice providers who have suicidal patients, Arnold says.

Let the patients voice what they're feeling and experiencing, Arnold suggests.

Listening shows that the hospice professional cares, she says. "A lot of times people consider hastening death because they have things going on that are impacting their quality of life negatively," Arnold says.

### ***Reference***

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## **Rising rate of MRSA boosts need for education**

*ID of infection, proper isolation techniques key*

**A**ntibiotic-resistant infections are not new to the hospice setting, but headlines throughout the country have increased public awareness of the potential risk of infection.

According to a study by the Association for Professionals in Infection Control and Epidemiology, methicillin-resistant *Staphylococcus aureus* (MRSA) accounted for only 2% of all *Staphylococcus aureus* health care-associated infections reported to the Centers for Disease Control and Prevention (CDC) in 1972. Today, MRSA accounts for more than 60% of *Staphylococcus aureus* infections.

Infection control experts point to the need for hospice staff members to be knowledgeable about these organisms in order to minimize risk. Unfortunately, even with increased publicity of MRSA in the community, not all health care providers recognize the infection.

“We don’t always know who has MRSA or any other antibiotic-resistant infection because a patient can be a carrier without having an active infection,” says **Marcia R. Patrick**, RN, MSN, CIC, director of infection control at Multicare Health Systems in Tacoma, WA.

Although testing of all hospice patients is not practical or necessary, Patrick recommends an increased awareness of the signs and symptoms of bacteria-resistant infections so that treatment can be provided early.

### **Patients at risk**

Patients at highest risk for MRSA or vancomycin-resistant enterococci (VRE), the two antibiotic-resistant organisms seen in the community, are those with wounds, catheters, a history of boils, or patients on dialysis, says Patrick. It is critical to recognize these patients higher risk for infection and monitor them carefully, she says. “MRSA often appears as a spider bite that doesn’t heal or a wound that won’t heal,” Patrick adds.

Northwest Community Home Care in Arlington Heights, IL, has an active staff education program designed to heighten awareness of these infections for all staff members, says **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist. Staff education includes guidelines that identify different organisms and describe the type and duration of isolation necessary to prevent spread of the infection, she says.

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**For information about the methicillin-resistant *Staphylococcus aureus* study** conducted by the Association of Professionals in Infection Control and Epidemiology, go to [www.apic.org](http://www.apic.org). Select “Research Foundation” on the top navigational bar, and then select “National MRSA Prevalence Study.”

## **Methods to Prevent Spread of MRSA Infection in Home**

- Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the home.
- Towels used for drying hands after contact should be used only once.
- Disposable gloves should be worn if contact with body fluids is expected and hands should be washed after removing the gloves.
- Linens should be changed and washed if they are soiled and on a routine basis.
- The patient’s environment should be cleaned routinely and when soiled with body fluids.
- Notify other health care personnel who provide care for the patient that the patient is colonized/infected with a multidrug-resistant organism.

*Source:* Centers for Disease Control and Prevention, Atlanta.

Inservices include case scenarios that give nurses a chance to discuss the challenges faced by home care providers when a patient must be isolated, points out Quaritsch.

Although nurses use standard precautions in patients’ homes, not all nurses were handling patient education in the same way before the awareness program, she admits. “Now, all of the nurses have a checklist that they use to ensure that patients and family caregivers are taught about laundry procedures, the need to clean the patient’s area frequently, and the need for gloves or aprons when dealing with body fluids,” she says.

### **Prevention recommendations**

One part of Northwest Community Home Care’s protocol for antibiotic-resistant infections is the need to culture any unimproved wound at the two-week point, says Quaritsch. “Pressure ulcers are more difficult to culture in the home, so they generally have to be biopsied in the hospital,” she adds.

Once MRSA or VRE are diagnosed, patients are started on antibiotics, and caregivers are taught how to keep the patient’s area, linens, and clothing clean to prevent the spread of the infection, she says.

It is difficult to treat patients with MRSA in the home because you have to rely upon family caregivers who may not be able to take care of themselves, as well as a patient who requires

additional care, says Quaritsch. "They are also reluctant to ask for help, so it is up to the nurse to notice if additional help is needed, or if the patient must be transferred to another provider until the infection is controlled," she says. It is not unusual for a patient with MRSA to go to an extended-care facility for a brief time to ensure proper treatment of the infection, Quaritsch adds.

The best way to approach diagnosis of MRSA and VRE is to realize that MRSA is everywhere, says Patrick. "It all goes back to basic hygiene and washing hands," she says. "Teach patients and staff members to wash hands and the risk of infection decreases." (See tips from the CDC on preventing spread of the infection, p. 8. See Q&A, below. For more on MRSA, see "MRSA rampant among patients on dialysis," *Hospice Management Advisor*, June 2007, p. 71.) ■

## CDC answers questions related to MRSA

*Awareness and identification of risks important*

Although the prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) is not as high in hospice care as it is in hospitals, the Centers for Disease Control and Prevention addresses the risk and identification of the infection as well as precautions to take to prevent spread of any antibiotic-resistant infection in non-hospital settings on its web site.<sup>1</sup>

### • What are "nonhospital health care settings"?

They refer to residential settings (e.g., long-term care and skilled nursing homes), home care, hemodialysis centers, and physicians' offices.

### • What are multidrug-resistant organisms?

They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Common examples of these organisms include:

- MRSA. Methicillin/oxacillin-resistant *Staphylococcus aureus*;
- VRE. Vancomycin-resistant enterococci;
- ESBLs. Extended-spectrum beta-lactamases (which are resistant to cephalosporins and monobactams);
- PRSP. Penicillin-resistant *Streptococcus pneumoniae*.

### • Which multidrug-resistant organisms are most commonly seen in nonhospital settings?

MRSA and VRE are the most commonly encountered multidrug-resistant organisms in patients residing in nonhospital health care facilities, such as nursing homes and other long-term care facilities. PRSP is more common in patients seeking care in outpatient settings such as physicians' offices and clinics, especially in pediatric settings.

### • What conditions increase the risk of acquiring these organisms?

There are several risk factors for both colonization and infection:

- severity of illness;
- previous exposure to antimicrobial agents;
- underlying diseases or conditions, particularly:
  - chronic renal disease;
  - insulin-dependent diabetes mellitus;
  - peripheral vascular disease;
  - dermatitis or skin lesions;
- invasive procedures, such as: dialysis, presence of invasive devices, urinary catheterization, repeated contact with the health care system, previous colonization of by a multidrug-resistant organism, and advanced age.

### • Should patients colonized or infected with these organisms be admitted to non-hospital health care facilities?

Nonhospital health care facilities can safely care for and manage these patients by following appropriate infection control practices. In addition, nonhospital health care facilities should be aware that persons with MRSA, VRE, and other infections may be protected by the Americans with Disabilities Act or other applicable state or local laws or regulations.

### • What can be done to prevent or control transmission of these pathogens in my facility?

The CDC's recommendations for preventing transmission of MRSA/VRE in hospitals consist of standard precautions, which should be used for all patient care. In addition, the CDC recommends contact precautions when the facility (based on national or local regulations) deems the multidrug-resistant microorganism to be of special clinical and epidemiologic significance.

The components of contact precautions may be adapted for use in non-hospital health care facilities, especially if the patient has draining wounds or difficulty controlling body fluids.

In addition to standard and contact precautions, the following procedures also may be considered for nonhospital health care facilities:

- **Patient placement.** Place the patient in a private room, if possible. When a private room is not available, place the patient in a room with a

patient who is colonized or infected with the same organism, but does not have any other infection (cohorting). Another option is to place an infected patient with a patient who does not have risk factors for infection.

— **Group activities.** It is extremely important to maintain patients' ability to socialize and have access to rehabilitation opportunities. Infected or colonized patients should be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and the patients observe good hygienic practices.

The following are recommended for prevention of MRSA /VRE in hospitals and may be adapted for use in nonhospital health care facilities:

— **Obtain stool cultures or rectal swab cultures of roommates of patients newly found to be infected or colonized with VRE, and nasal swabs for MRSA.**

— **Adopt a policy for deciding when patients can be removed from isolation** (e.g., VRE-negative results on at least three consecutive occasions, one or more weeks apart).

• **How should clusters or outbreaks of infections be handled?**

Consult with state or local health departments or an experienced infection control professional for reporting requirements and management of MRSA or VRE outbreaks.

## Reference

1. Centers for Disease Control and Prevention. *Multidrug-Resistant Organisms (MDROs) in Non-Hospital Healthcare Settings*. Web: [www.cdc.gov/ncidod/dhqp/ar\\_multidrugFAQ.html](http://www.cdc.gov/ncidod/dhqp/ar_multidrugFAQ.html). ■

# Hospice rotation proves beneficial to med students

*Residents learn surprising things about dying*

A third-year medical student sits with an end-stage lung cancer patient who is in hospice. The patient wants to talk, but not about pain or death or advance directives; he wants to know the student's plans for the future.

"I can't believe it," the student would tell his instructor later. "Here is this patient who's dying, and he's interested in knowing my plans for the future."

Such are the sometimes eye-opening lessons

learned by Albany (NY) Medical College students who, for the past year, have been required to do a hospice rotation in their third year. The message is that an often-repeated comment by physicians to dying patients — "there's nothing more I can do for you" — is one of the least true, says **John Balint**, MD, professor emeritus at the medical college and founder of the medical ethics center at Albany Medical.

"The fact is, when a patient is dying is when you can sometimes do more for them than you could before," says Balint, who pushed for years to have a hospice rotation added to the requirements for Albany med students.

For medical students whose primary focus is acute medicine and healing, that's an important distinction, he adds.

## Observing hospice care at work

Balint says once there were adequate hospice staff available for the rotation, the requirement was implemented in 2006. Every third-year student spends a week at hospice, almost exclusively with patients and staff in the home care field.

"They do home visits, sit in on a consultation visit where someone is being referred into the hospice program, and sit in on team meetings to see how the team contributes to the care of the patient," says Balint. "A week is too short a rotation to really learn about hospice, but it gives them an idea of what it can do."

Many students are surprised at the smiles on the faces of hospice patients. "That's why we say that telling a patient [that there's no more that the health care team can do] is not true, because the students recognize that just being there and being interested in the patient does a lot," he says.

The value of just being there is an aspect of hospice medicine that surfaces frequently in the essays students are asked to submit at the conclusion of their rotation. Students are asked to write about the three most important things they learned, and why they chose the three that they write about. "The essay is the major measure of whether we are achieving what we want to achieve, and that is that they understand what hospice is all about," says Balint.

Every student thus far (there are 140 third-year students) has written about the effectiveness of the team approach and the benefits it provides to hospice patients, he reports. Two-thirds typically write about the differences between acute care, with the aim of healing, and hospice care and its

## Need More Information?

▣ **John Balint**, MD, Professor of Medicine, Albany (NY) Medical College. Phone (518) 262-5378.

goal of supportive care at the end of life. "They often comment on spiritual healing and how interesting it is that patients who know they are dying can be smiling and cheerful," he adds.

Even though the rotation is short, its impact is palpable. Albany Medical College teaches a four-year course in clinical ethics that delves into palliative care, but until the rotation, students don't have any personal exposure to palliative care.

Albany Medical is thought to be the first medical college in the country that requires a formal hospice rotation, Balint says, and "it's turned out to be everything we hoped it would be." ■

## Prescribing changes during palliative care

A study intended to determine how prescribing for comorbid illnesses and symptom control changes during the palliative phase of a terminal illness found older people take more medications and says medications for comorbid conditions should be reviewed in the context of their original therapeutic goals.

Published in the *Journal of the American Geriatric Society*, the Australian study reported that chronic comorbid conditions are commonly encountered in people with life-limiting illnesses, with the most frequently seen being cardiovascular diseases, including hypertension; chronic obstructive pulmonary disease; and diabetes. "Management of these comorbid problems needs to be actively reviewed in response to the systemic changes encountered in the palliative phase of a life-limiting illness," the researchers wrote.

The study was conducted in Adelaide, South Australia, where specialized palliative care services funded by the state government provide consultative specialist nursing, medical, and allied health support for general practitioners and community nurses who are the primary point of care. Palliative care services there are organized as regional whole population networks.

Because one study aim was to improve specialized palliative care delivery, eligibility criteria were broad, says lead researcher **David Currow**, BMed, MPH. All adult patients referred to the service with any form of pain in the preceding three months were eligible after providing written informed consent. Patients who were expected to die within 48 hours or who lived outside the geographic region served by the team were excluded.

As part of the study, enrolled patients underwent community-based nursing reviews at baseline, biweekly for three months, and then at least monthly until death. Data collected included a list of medications taken regularly at each specialist nursing review. Medication reports included generic drug name, dose, route of administration, indication, frequency, and pattern of use (regularly or as needed). Medications were divided into two categories: those for comorbid conditions and those for symptom control for the patients' life-limiting illnesses. Areas of overlap such as antidepressants or anti-epileptic medications (both of which also are frequently used for neuropathic pain) were classed with symptom-control medications.

### Logical findings

According to Currow, many of the study findings appear intuitively logical but have not been documented previously. It is clear, he says, that as health care practitioners recognize the palliative phase of life-limiting illnesses, comorbid conditions must be actively managed.

Generally, new medications were added to patients' regimens for symptom control as the primary life-limiting illness progressed. Although there was a statistically significant decrease in medications for comorbid medical conditions, this

## COMING IN FUTURE MONTHS

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■ Study highlights quality disparities among minorities

reduction occurred at the time at which an increase in symptom control medication was noted. That overlap coincides with a period of decreasing function, the researchers said, and future research is needed to define whether the overlap is contributing to an acceleration in declining global function.

Medications for comorbid conditions, especially for secondary prevention, may be continued for longer than clinically indicated, Currow says, with a consequent potential risk of iatrogenic harm. He says there may be opportunities to prevent morbidity and even premature mortality in a person with a life-limiting illness, especially in older people, if medications for comorbid conditions are more actively managed. Likewise, judicious use of symptom-control medications is needed because there is the risk from many of these medications for adverse reactions and adverse medicine interactions for which other strategies may lessen potential harm.

Although the study found that clinicians reduced the number of medications for comorbid conditions, there were an increasing number of medications for symptom control introduced that met high-risk criteria. Given the frailty of the population receiving palliative care, the researchers said, and the predictable decline in functional status, minimizing medications that meet the consensus-derived Beers' risk criteria is important.

The study found that adverse drug reactions and interactions increase when more medications are taken. "The risk of an adverse medication interaction is greater than 80% when more than seven medications are taken regularly," Currow asserts. "Significant drug-drug interactions have been documented in a population receiving palliative care.

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In the setting of a life-limiting illness, pathophysiological changes such as cachexia can lead to changes in metabolism, excretion, and volume of distribution of long-term medications that need to be considered when assessing their ongoing net benefit. The underlying indications for the management of long-term conditions such as hypertension or diabetes may also change with cachexia-associated weight loss at the end of life."

### ***Don't stop meds completely***

The researchers caution they are not suggesting that medications for comorbid conditions should be stopped simply because a person has a life-limiting illness, noting that many medications for comorbid conditions need to be continued judiciously to maintain optimal function and comfort for the patient.

Now that their study established a baseline, the researchers say, other hospital units need to collect similar longitudinal data to compare with these findings. Also, specific work needs to be performed to adapt the Beers' criteria to the palliative care population. And guidelines and frameworks suggested in the literature for managing comorbid illnesses for people with a life-limiting illness need to be prospectively evaluated to define the magnitude of reduction in any adverse outcomes in that population with continually changing physiology. ■