
HOSPICE NEWS NETWORK

What the Media Said about End-of-Life Care This Week

Volume 14, Number 18 May 4, 2010
A Service of State Hospice Organizations

STUDY EXAMINES NURSING HOME-HOSPICE PARTNERSHIPS

“A Model for Successful Nursing Home-Hospice Partnerships,” an online ahead-of-print article in the *Journal of Palliative Medicine*, examines “the partnerships of successful nursing home–hospice collaborators.” Author Susan C. Miller, PhD, MBA, studied six nursing homes and hospices that identified themselves as successful collaborators. Fourteen members of an advisory committee helped direct the research to ensure that the most relevant issues were addressed.

Seven domains critical to the collaborative success were identified, and important practices that supported the collaboration, as well as persistent barriers to success, were identified.

- * **Administering the collaboration:** Fostering good relations between the leaders of the two groups was identified as critical. One barrier to success was the difference in regulatory roles of nursing homes and hospices. Another barrier was the “lack of agreement/understanding about treatment (curative versus palliative) and about end-of-life care and medications for pain management.”
- * **Interdisciplinary practice:** Identified as crucial for success were the cultivation of “personal relationships based on respect,” and a partnership “that appreciates the strengths of both hospice and nursing home staff.” Identified as barriers were competition, issues over “turf,” and a feeling on the part of nursing home staff that they were being judged by the hospice personnel.
- * **Communication:** Two practices that were identified as important were “open and frequent communication” between the staff of the two groups, and “liaisons used to improve communications.” The main barrier was time constraints on the part of nursing home staff.
- * **Education:** One main educational goal was the instruction of nursing home staff on end-of-life palliative care and hospice philosophy. The other goal was educating hospice staff on the nursing home environment and long-term care issues. The main barriers were lack of time on the part of the nursing home staff to attend sessions, and the high nursing home staff turnover.
- * **Care planning:** Joint, integrated care planning, by the hospice and the nursing home, was identified as an important practice. The main barriers were the failure to invite all required personnel to care planning meetings, and the lack of consistent attendance.
- * **Care provision:** The consistency of the hospice team that provided care in each home was identified as an important practice. Barriers include the differences between the quality of care provided by multiple hospice providers in a nursing home, and a lack of consistent communication about resident needs from the nursing home staff.
- * **Support to resident, family, and nursing home staff:** It was important to offer memorial services for families and nursing home residents and staff, and to provide one-on-one emotional support to nursing home staff. No barriers were reported.

The article also lists many characteristics of the partnership models that reported successful collaborations. Partnerships worked best when:

- * The hospice and the nursing home have similar missions and philosophies of care of the two organizations.
- * The nursing home recognizes the special needs of dying residents and their loved ones.
- * The CEOs provide the vision, support the partnership, and understand each other's "systems, regulations and financing."
- * Hospice visits are purposefully structured, and hospice staff are visible on weekends and more than just on the day shift.
- * Systems are in place to handle conflicts.
- * Both organizations maintain continual dialogue on care planning and provision.
- * Hospices pay nursing home per diem promptly and in full.

In conclusion, the article abstract says, "While successful collaborators were organizationally aligned, hospice leaders' acknowledgement that palliative care provision in nursing homes is complex and unique was important to success. Accordingly, the prevalent partnership model was a product of strategic efforts by leaders aimed at matching their staffing to the nursing home environment and promoting good communication and skills needed for problem solving."

The authors also note that all but one of the nursing homes collaborated with only one hospice. "From this study," the article said, "it appeared the (mostly exclusive) collaborations studied were driven by the nursing homes' satisfaction with the hospices' ability to meet their residents' and facilities' needs without adding undue complexity to their operations." (*Journal of Palliative Medicine*, 2010,13(5), dx.doi.org/10.1089/jpm.2009.0296)

RESEARCH & RESOURCE NOTES

* **The free full text of "Practice Guidelines for Chronic Pain Management: An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine," is online at the link below.** These guidelines update the ones issued by the American Society of Anesthesiologists in 1997. (*Anesthesiology*, 2010, 112(4):810-833, journals.lww.com/anesthesiology/Fulltext/2010/04000/Practice_Guidelines_for_Chronic_Pain_Management_.13.aspx)

* **"Got Volunteers? Association of Hospice Use of Volunteers With Bereaved Family Members' Overall Rating of the Quality of End-of-Life Care" appears in a recent *Journal of Pain & Symptom Management*.** The study examined whether "bereaved family members in hospice programs with increased use of volunteer hours per patient day report higher overall satisfaction with hospice services." Hospice programs with the highest volunteer usage (0.91 volunteer hours per patient week) were viewed most favorably by bereaved family members compared to those with the fewest volunteer hours (0.245 per patient week). (*Journal of Pain & Symptom Management*, 2010, 39(3):502-506, <http://dx.doi.org/10.1016/j.jpainsymman.2009.11.310>)

* **"Assessment of Factors Influencing Preservation of Dignity at Life's End: Creation and the Cross-Cultural Validation of the Preservation of Dignity Card-Sort Tool,"** online ahead-of-print in the *Journal of Palliative Medicine*, found a "simple, rank order card-sort tool that

may help clinicians identify patients' perceptions of key factors influencing the preservation of their dignity in the last chapter of life." (*Journal of Palliative Medicine*, 2010, 13(5), dx.doi.org/10.1089/jpm.2009.0279)

* *PubMed* has an abstract of "Communicating Terminal Diagnoses to Hispanic Patients," published online ahead-of-print in the *Journal of Palliative & Supportive Care*. The abstract concludes, "These results suggest that discussing end-of-life issues with the diverse category of Hispanic patients and families will be enhanced by eliminating language barriers, increased understanding of the role of family members, and knowledge of cultural factors and beliefs related to end-of-life decisions." (*Journal of Palliative & Supportive Care*, 2010, 3/23; *PubMed*, www.ncbi.nlm.nih.gov/pubmed/20307361)

* The *PBS* webcast of the debate on the ethics of rationing end-of-life care, held at the University of Virginia's Miller Center of Public Affairs (see *HNN*, 3/23) is online at the *PBS* link below. (*PBS*, 4/26, www.pbs.org/newshour/bb/health/jan-june10/miller_04-26.html)

* "Vigilant at the End of Life: Family Advocacy in the Nursing Home" reports that on a study that found that families "often felt the need to advocate for their dying relative because of low expectations or experiences with poor quality nursing home care." Staff members did not always fully inform them about the dying process. The authors say, "Enhancing communication, preparing families at the end of life, and better understanding of hospice are likely to increase family trust in nursing home care, improve the care of dying residents, and help reduce family burden." (*Journal of Palliative Medicine*, 2010, 13(5), dx.doi.org/10.1089/jpm.2009.0398)

HOSPICE & PALLIATIVE CARE NOTES

* Cahaba GBA reminds hospices that CR6791 went into effect in April and affects claims submitted on or after the 29th. The change "requires hospices to report a separate level of care revenue code line each time the level of care changes (for routine, respite and general inpatient levels of care). Units must reflect the number of consecutive days at that level of care. The service date reflects the first date that level of care began for that consecutive period." See www.cms.gov/transmittals/downloads/R1897CP.pdf for CR6791, and www.cms.gov/MLN Matters Articles/downloads/MM6791.pdf for the Medicare Learning Network article that accompanies it. (*Cahaba GBA Website*, 4/9, www.cahabagba.com/rhhi/news/20100409_hospice.htm)

* Oakland's *KTVU* recently presented a special report on the California Medical Facility in Vacaville, the first licensed hospice (in 1996) in any prison. The hospice is staffed by prison volunteers, and so many apply to participate that only one in 40 is accepted. The written article and accompanying video are at the link below. (*KTVU*, 4/25, www.ktvu.com/news/23261407/detail.html)

* In New Jersey, Mercer County veterans with terminal illnesses are getting a boost from the Samaritan Vets Helping Vets program, which was funded with a \$150,000 grant from the Hamilton DAV Chapter 41. The grant, which will be spread over five years, will be used to supplement hospice care that's normally covered by agencies such as Medicare, Medicaid, VA, and other insurance. The article says, "Chapter 41 veterans and their spouses will get direct in-home care, support and respite, regardless of where they are getting hospice support, but if they reside in

Mercer, Burlington, Camden, Gloucester or Atlantic counties, they must be served by Samaritan Hospice.” (*The Trentonian*, 4/29)

* ***The Denver Post* recently profiled the work of Denver Hospice. In Colorado, according to the article, “A growing number of people are opting to use hospice services, either private facilities or in-home care, when facing end-of-life situations.”** Nationally, about 29% of people 65 and older use hospice as they face death. Arizona has the highest rate of use, at 49%, and Colorado is second, at 45%. (*The Denver Post*, 4/27, www.denverpost.com/newsheadlines/ci_14963126)

* **The first 2010 issue of *The Joint Commission Home Care Bulletin* has two notes for hospices.** One reminds them to “check their current state law to ensure that the provision of palliative services doesn’t place them in a position of requiring a home health license.” The other suggests four Life Safety Code areas that should be regularly reviewed: exits, fire protection, staff education, and occupancy types. (*The Joint Commission Home Care Bulletin*, Issue One, 2010, www.jointcommission.org/NR/rdonlyres/CD13AC39-C506-4C2B-9BC8-2D14B5115C9F/0/HCB_Issue_1_2010.pdf)

* **During the design process for the Pepper Family Hospice Home and Center for Care, the Hospice & Palliative Care of Northeastern Illinois “envisioned a setting where patients, family members, visitors, volunteers and staff could find respite, comfort and tranquility.”** The Center is the region’s first freestanding hospice home, and “special consideration was given to the exterior landscaping as well as with bringing the outdoors in—each patient room was designed with large picture windows and oversized French doors to flood the area with natural light and offer expansive views of the gardens. The protected patios outside each patient room accommodate a patient’s bed or wheelchair, and still have room for a bench for visitors.” (*Hospice & Palliative Care of Northeastern Illinois Website*)

* **Hospice of Michigan has announced a 52-week campaign, “Stories at Sunset,” to raise awareness of hospice. The campaign will feature true stories of caregivers and loved ones, and first-hand stories from the Hospice’s staff, volunteers and donors.** The article suggests studying the outcome of the campaign, since “most research shows patients and families find the most influential person that helps them decide is their physician or a physician’s agent (such as a nurse case manager or social worker).” (*Journal of Palliative Medicine*, 2010, dx.doi.org/10.1089/jpm.2010.9839)

OTHER NOTES

* **“A Graying Population, A Graying Workforce,” in *The New York Times*, reports on professional caregivers, calling them one of the fastest-growing groups in the US workforce, and one of the oldest. The article cites a recent study by PHI National that found that 28% of home care aides are over age 55, compared to 18% of the overall workforce. The PHI website, with a link to the report, is at phinational.org/. (*The New York Times*, 4/24, www.nytimes.com/2010/04/25/us/25care.html)**

* **Eva Markvoort, former beauty queen, started her blog in 2006 because she, like many other cystic fibrosis patients, was isolated because of infections. The blog’s name, 65-RedRoses, came from her inability to pronounce the name of the disease she was diagnosed with as a child. Markvoort got a double lung transplant, but they shortly began to fail.**

Markvoort's mother said, "She had already processed the concept of dying. And for her, she came to terms with it quite quickly. For her it was like, 'Oh, my gosh, I don't know how much time I have. I have things to say.' There was a sense of urgency on her part." One video, in which she talks about her coming death, shows Markvoort saying, "I think I'm very lucky, because I've loved more than you could possibly think, could possibly imagine. So I'm celebrating that: celebrating my life." Markvoort died March 27. The blog can be found at 65redroses.livejournal.com/. (CNN, 4/27, www.cnn.com/2010/HEALTH/04/27/blog_terminal_illness/index.html)

* **A husband-wife team of physicians in the Houston suburb of Kemah pled guilty to health care fraud charges that accused them of "prescribing one or more controlled substances to nearly every patient they saw and then coercing many into signing blank forms for narcotics that were never administered."** US Attorney Jose Moreno said, "Dr. Arun Sharma was known as an easy touch for Hydrocodone, Soma and Xanax. As time went on, the doctors began prescribing stronger narcotics such as oxycodone, methadone and fentanyl patches." (*The Houston Chronicle*, 4/26, www.chron.com/dispatch/story.mpl/metropolitan/6977183.html)

* **The United Kingdom's Channel 4 "appears to be trying to drum up viewership by backing a project to televise the mummification of a terminally ill volunteer. The body of the candidate to be embalmed might then end up being displayed in a museum."** Other projects, which have already been aired, include an autopsy and an on-screen suicide. The article says, "Are these examples of giving the public objective information? Or are they tawdry examples of appealing to voyeurism? The practice is old; there are centuries of examples. It's just that we think of ourselves as so much more refined than the eleventh century." (*Journal of Palliative Medicine*, 2010, dx.doi.org/10.1089/jpm.2010.9839)

Thanks to Don Pendley for contributions.

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