HOSPICE SHARES A GUIDELINE FOR WITHDRAWING LIFE SUPPORT AT HOME

Staff from the Institute of Palliative Medicine at the San Diego Hospice have written a letter to the editor of the Journal of Palliative Medicine detailing a guideline for the withdrawal of life-sustaining treatment for patients in home under hospice care. The guideline is, say the authors, “based on our experience in our inpatient center, homes and local hospitals.” Major challenges of such an action include: 1) Clarifying the goals of care before a patient is moved home and life-support therapy withdrawal (LSTW) occurs; 2) Establishing communication between the Institute and the referring facility and the Institute and the family decision-makers; 3) Addressing cultural and spiritual needs; and 4) Ensuring that a palliative medicine physician is present during LSTW.

The guideline includes “samples of documentation, language for communication, and supply checklists (which can be provided upon request from the authors).” The guideline includes four main steps.

1) The first step is the assessment, information-sharing, and goal-setting process. This includes collecting medical information, assessing the patient’s ability to make decisions, a family meeting, goal setting, explaining hospice, planning for religious rituals, and scheduling the LSTW.

2) The second step is care planning, which includes check lists that help standardize the procedures. Members of the interdisciplinary group are maintained for each patient, providing continuity of care and consistent communication. The patient is admitted to hospice, and the admission nurse and the palliative care physician prepare a list of needed medications and equipment. There is discussion of “withholding nutrition and hydration (prior to LSTW) to prevent excess secretions.” A final planning meeting is held the day before the procedure.

3) The third step is determining the activities of the care planner on the day of the procedure. This includes coordinating transportation, reconfirming roles that each person will play, introducing the team to the family, and preparing for documentation of the process. The palliative care physician also reconfirms prior discussions and decisions by the patient, family, and/or proxy. “At the time of the procedure, a limited time is provided for last goodbyes and any desired rituals before the LSTW is conducted.”

4) The final step is follow-up, which includes a secondary team which will care for the patient if he or she survives removal of the life support. Debriefing for the interdisciplinary team is “essential for process evaluation and emotional support for the team members.”

The writers conclude, “The development of this guideline has greatly enhanced coordination and trust among our interdisciplinary personnel resulting in greater ease and
efficiency of providing this needed service to our community. The family and staff satisfaction in providing this service has been high.” (Journal of Palliative Medicine, 2010,13(5):491-492, www.liebertonline.com/doi/abs/10.1089/jpm.2010.9837)

ARTICLE ADDRESSES AUTHOR'S REFLECTION ON TREATMENT OF PATIENTS WHO FACE CERTAIN DEATH

Dr. Dana Lustbader, of the department of palliative medicine at North Shore Community Hospital in Manhasset, New York, is author of “When Death is Certain,” a personal reflection that appears in the May issue of the Journal of Palliative Medicine. Lustbader relates the stories of four patients and their treatments at the end of life. In her care for them, she dealt with an attending physician who would not let the staff discuss a DNR order with a patient’s son, a nurse attempting to give an unresponsive and dying patient six pills, and a patient whose chose hospice care. One attending physician had called in six subspecialists – neurology, cardiology, renal, gastroenterology, pulmonary, and plastic surgery – for a dying patient. An intensivist greeted her with, “I have six names for you guys to see on Monday.”

Lustbader says, “I have known the physicians caring for these patients for nearly two decades and would refer my own family members to them. They are good doctors. How is it, that care rendered when cure is no longer possible, is so bad? Why is non beneficial treatment offered? Why do six subspecialty consultant notes immediately precede my death note?”

One problem Lustbader cites is the fact that she, and other physicians, cannot bill patients for conversations with families about end of life care, because Medicare requires a “face-to-face” conversation with the patient. She says, “My patients are generally obtunded or dying and cannot participate in these lengthy discussions regarding their care. If physicians actually got paid to have these difficult and time consuming goals of care discussions with family members and surrogates, would they?”

“Instead,” Lustbader writes, “physicians are financially incentivized to perform more tests and write more notes. If payment was bundled for each hospitalization, thereby eliminating financial incentives for piecemeal work, would care of hospitalized terminally ill patients improve? Might we then provide appropriate palliative care to patients—when death is certain?” (Journal of Palliative Medicine, 2010,13(5):609-610, www.liebertonline.com/doi/abs/10.1089/jpm.2009.0367)

PUBLIC POLICY NOTES

* CMS has issued the Innovator's Guide to Navigating Medicare, which is available online at the link below. The booklet is designed to “assist stakeholders in understanding the processes used to determine coverage, coding, and payment for new technologies under the Medicare fee-for-service program.” The introduction notes that the guide is only a general summary, and that readers should “review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.” (CMS, www.cms.gov/CouncilonTechInnov/Downloads/InnovatorsGuide5_10_10.pdf)
* Palmetto GBA has been awarded the A/B MAC contract for Jurisdiction 11 and the Home Health & Hospice MAC for Jurisdiction C.  (Palmetto GBA Website, 5/25, www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction%2011%20Part%20A%20B)

* New Jersey appellate judges will decide if the family members of comatose Ruben Betancourt could have compelled Trinitas Regional Medical Center to continue life support. Hospital doctors said that he was in a persistent vegetative state, and that further care was futile. Trinitas appealed, and Betancourt died while the case was progressing through the courts. According to legal experts, “The case has the potential to set a precedent in New Jersey and beyond for decisions on end-of-life care.”  (American Medical News, 5/17, www.ama-assn.org/amednews/2010/05/17/prsc0517.htm)

**RESEARCH & RESOURCE NOTES**

* “Guided Imagery for Anxiety,” in a recent *Journal of Palliative Medicine,* notes that guided imagery reduces both anxiety and drugs given for anxiety, and improves patient satisfaction. Separate studies confirm its efficacy over usual care for patients anticipating abdominal surgery or cardiac catheterization. Other studies found it useful in patients hospitalized longer than two days, and for a group of breast and gynecological cancer patients. “Clinical experience and expert opinion support its helpfulness for patients with advanced cancer, although there is little research yet in this population.”  (*Journal of Palliative Medicine,* 2010,13(5):606-607, www.liebertonline.com/doi/abs/10.1089/jpm.2010.9834)

* A study from Spain suggests that moderate alcohol consumption may protect otherwise-healthy people from the onset of Alzheimer’s. Non-smoking women appear to gain the most benefit. The lead author said, “Our results suggest a protective effect of alcohol consumption, mostly in non-smokers, and the need to consider interactions between tobacco and alcohol consumption, as well as interactions with gender, when assessing the effects of smoking and/or drinking on the risk of Alzheimer's disease.”  The study was published in the May *Journal of Alzheimer's Disease.*  (Yahoo! News, 5/25, news.yahoo.com/s/hsn/20100525/hl_hsn/moderatedrinkingmayprotectbrainfromalzheimers)

* Slate’s “Dear Prudence” mentioned Imerman Angels in her column last week, recommending the organization to a lung cancer patient. The organization “carefully matches and individually pairs a person touched by cancer (a cancer fighter or survivor) with someone who has fought and survived the same type of cancer (a Mentor Angel). Cancer caregivers (spouses, parents, children and other family and friends of fighters) also receive 1-on-1 connections with other caregivers and survivors.”  (*Slate,* 5/27, www.slate.com/id/2254999/; Imerman Angels Website, www.imermanangels.org/index.php)

* The May issue of the *Journal of Palliative Medicine* is free online at www.liebertonline.com/toc/jpm/13/5.  (*Journal of Palliative Medicine,* 2010, 13(5))

* In the May *Journal of Palliative Medicine,* Dr. Charles F. von Gunten, of the Institute for Palliative Medicine at San Diego Hospice, moderates a panel of two other physicians and a pharmacist on whether new opioid formulations are “expensive distractions or important additions to practice.”  The discussion covers medications for breakthrough pain, risk evaluation and management strategies (REMS), new oxymorphone formulations, buprenorphine, abuse-

HOSPICE & PALLIATIVE CARE NOTES

* American Medical News notes that the March healthcare reform law requires all CHIP and Medicaid plans to cover concurrent care for children with terminal illnesses. A demonstration project will evaluate the use of concurrent care for all Medicare patients. Dr. Diane Meier, of the Center to Advance Palliative Care, notes that hospice can be a scary choice for Medicare patients. “The Medicare hospice benefit is the jewel in the crown of Medicare in that it's truly interdisciplinary care,” Meier said. “But in order to get this wonderful benefit that is hospice, you must, on the flip side, sign a form giving up the right to regular Medicare. People feel, quite rightly, that it’s like signing a death certificate.” (American Medical News, 5/24, www.ama-assn.org/amednews/2010/05/24/prsb0524.htm)

* The work of Hospice of Central Ohio was recently featured in an article in the Newark Advocate. The article profiles the patient, Debbie Brewer, the hospice nurse, the social worker, the pastor and the family. (The Newark Advocate, 5/24, www.newarkadvocate.com/article/20100524/NEWS01/5230311)

* Gentiva Health Services’ purchase of Odyssey Healthcare for $1 billion “is going to shake up several industries,” some observers say. Gentiva’s focus has been in-home care, mostly of seniors, while Odyssey’s has been hospice. Their merger is “a transaction that can overnight change other industry player strategies,” one analyst said. The Investors’ Business Daily article calls the purchase “a wise strategy as Medicare and Medicaid restrain and even reduce payments to providers of health services.” Trading Markets says that the purchase will create “the largest U.S. healthcare provider focused on home health and hospice services.” The company will have operations in 30 states, and an average daily patient census of nearly 14,000. One analyst notes that hospice operating margins can be as much as 20% if the company achieves a certain scale of operations, while even small hospices can reach 20%. (Investors' Business Daily, 5/28, www.investors.com/NewsAndAnalysis/Article/535783/201005282244/Gentivias-Odyssey-Buy-Sector-Game-Changer.aspx; Trading Markets, 5/24, www.tradingmarkets.com/news/stock-alert/gtiv_odsy_gentiva-to-buy-odyssey-healthcare-for-about-1-bln-in-cash-update-952361.html)

* “Empathy: Provider Friend or Foe” is an essay by Bridget C. Wohlers, a palliative care nurse at Unity Hospital in Rochester, New York. Wohlers writes of her relationship with an ovarian cancer patient with whom she strongly identified, and relates an incident in which she broke down in tears when the patient and her husband cried. Wohlers wondered if this meant that she could not keep a necessary distance from the patient, and decided that it does not. She says, “Without a second thought, we joyously celebrate the medical victories of our patients. Just as strongly, we can acknowledge the agony of not reaching the goals we all long for. If you never feel the emotions exhibited by your patients or their families, if you are unable to understand all the possibilities and be present no matter what, how can your patients count on you, trust in you, believe that you are working for them and with them, regardless of the outcome?” (Journal of Palliative Medicine, 2010,13(5):611, www.liebertonline.com/doi/abs/10.1089/jpm.2009.0394)

OTHER NOTES
James O'Connell, MD, president of Boston Health Care for the Homeless Program, was a speaker for the recent conference and discussion of homeless shelters in New Hampshire and Vermont. O'Connell founded the Program’s medical respite program, “which has 104 beds dedicated to acute, sub-acute, peri-operative, rehabilitative, recuperative, and palliative end-of-life care for homeless men and women who would otherwise require costly acute care hospitalizations.”  

(Media Newswire, 5/24, media-newswire.com/release_1119328.html)

Glatfelter Insurance Group is the national sponsor of Hospice News Network for 2010. Glatfelter Insurance Group provides property and liability insurance for hospices and home healthcare agencies through their Hospice and Community Care Insurance Services division. Ask your insurance agent to visit their website at www.bccis.com.

Hospice News Network is published 45-47 times a year by a consortium of state hospice organizations. Copyright, 2010. All rights reserved to HNN subscribers, who may distribute HNN, in whole or part, to provider members of the subscribers' state organizations. If readers need further information, they should consult the original source or call their state association office. HNN exists to provide summaries of local, state and national news coverage of issues that are of interest to hospice leaders. HNN disclaims all liability for validity of the information. The information in HNN is compiled from numerous sources and people who access information from HNN should also research original sources. The information in HNN is not exhaustive and HNN makes no warranty as to the reliability, accuracy, timeliness, usefulness or completeness of the information. HNN does not and cannot research the communications and materials shared and is not responsible for the content. If any reader feels that the original source is not accurate, HNN welcomes letters to the editor that may be shared with HNN readers. The views and opinions expressed by HNN articles and notes are not intended to and do not necessarily reflect views and opinions of HNN, the editor, or contributors. Only subscribing state hospice organizations have rights to distribute HNN and all subscribers understand and agree to the terms stated here.