STUDY IDENTIFIES IMPORTANT BUT UNDER-UTILIZED EOL NURSING SKILLS

“Nurses’ Identification of Important yet Under-Utilized End-of-Life Care Skills for Patients with Life-Limiting or Terminal Illnesses,” in the current Journal of Palliative Medicine, identified “skills that were endorsed by more than 60% of nurses as extremely important and also endorsed as not currently practiced by more than 25% of nurses.”

The skills were grouped into five different areas:

* **Communication:** Informing patients of how their lives would be affected by their illnesses; Educating patients sufficiently about their illnesses and treatments; Discussing with patients and families what the patients’ deaths might be like; Speaking “honestly and straightforwardly” with patients; Talking willingly about dying; and “being sensitive to when patients are ready to talk about death.”

* **Technical skills:** “Acknowledging and treating anxiety and depression”; Knowing what kind of care patients need as they are actively dying; Teaching patients and families how to provide symptom control.

* **Affective skills:** Making sure patients’ social situations are considered when treatment plans are made.

* **Patient-centered values:** Refraining from being judgmental or blaming about lifestyles, and showing comfort around patients who are actively dying.

* **Patient-centered care systems:** Always explaining if patients must be kept waiting; Focusing on the patient during care, and minimize interruptions; Assuring patients they will not be abandoned prior to death; Assisting patients and families “get consistent information from the healthcare team,” and taking “as much time as needed” when dealing with patients.

The authors say, “A major finding of this study is that experienced nurses have identified unmet end-of-life care educational needs and health care systems deficits that prevent delivery of optimal end-of-life care,” and also say that this could be used as a template for developing curricula to address these needs. A second finding concerned the nurses’ identified needs for developing more effective skills in end-of-life conversation. Third, the study “suggests that clarity of team members’ roles and interdisciplinary communication are seen by nurses as contributing importantly to quality end-of-life care, yet are lacking in actual practice.” And last, the study identified barriers in the health care system that prevent effective end-of-life care. (Journal of Palliative Medicine, 2010,13(6):753-759, www.liebertonline.com/doi/abs/10.1089/jpm.2009.0423)
“Gaining Community Physician Support,” in the current Insights, says that hospices are the invited guests of community physicians “each and every time we are asked to participate in the care of patients.” The article, by Dr. Daniel Maison, chief medical officer of Florida’s Treasure Coast Hospice, discusses the motivations of physicians in decision-making, practical information that helps hospices serve the needs of physicians, and how to help physicians “come to understand why your [hospice] program is as necessary and wonderful as you know it to be.”

Hospices often assume that they get referrals because of their excellent care, but Maison says that most physicians assume that most hospices give excellent care. The common motivators for any decisions are: 1) Because it’s the right thing to do; 2) Some benefit is gained by the person who decides; 3) It benefits someone else, and 4) “We have always done it that way.” Further investigation into physician motivation is needed.

Maison suggests five ways of gathering information from physicians: 1) Ask them individually; 2) Survey them; 3) Conduct a focus group; 4) Create an advisory board, and 5) Ask key physicians to join your hospice board.” Each has advantages and disadvantages, and more than one method may be needed to get the information you want. But all will help you gather the data you need, will give a hearing to every physician who participates, and will create “buy-in” to your program. Maison cautions that you shouldn’t be discouraged if your first attempts don’t give you as much information as you wanted or hoped for – “the process of information gathering is often as helpful (or more so) as the data collected.”

Maison cautions that what physicians say they want and what they actually want may be two different things. He cites the example of a physician who complained that he “lost control” of patients he sent to hospice. So the hospice called him for needed decisions, and he then complained that they were bothering him. Maison suggests “addressing their stated needs publicly,” and taking care of their unspoken needs “without speaking of them.”

In conclusion, Maison says, “Remember that change will not occur overnight, and that patience and persistence can and will pay off.” Treasure Coast Hospice is nearly five times as large as when Maison went to work there. “Although by no means the only factor in our growth, actively engaging the physicians we serve has had lasting and cumulative effects on the health and growth of our hospice organization.” (Insights, Summer/2010)

PUBLIC POLICY NOTES

* Oregon Representative Earl Blumenauer (D) will reintroduce a “revamped” bill that would pay physicians for discussing advance planning with patients. Both Medicare and Medicaid would cover the EOL conversations. The new bill makes advance directives transferable between states. Backers of the old bill were accused of supporting “death panels.” (OPB News, 7/7, news.opb.org/article/8193-blumenauer-revive-advanced-care-planning-bill/)

* President Obama made a recess appointment of Dr. Donald Berwick to lead CMS. The appointment was considered somewhat unusual because the Senate is only in recess for two weeks, but Republicans had made clear that they would stall the appointment as long as possible, and CMS has been without a permanent administrator for nearly four years. The
article says, “One of Dr. Berwick’s first tasks will be to work with Congress to avert a 21 percent cut in Medicare payments to doctors, scheduled to occur late this year.” (The New York Times, 7/6, www.nytimes.com/2010/07/07/health/policy/07recess.html)

* One of the questions being raised in Maine about medical marijuana dispensaries is how much profit they can make considering their legal status? Private groups can run the eight distribution centers as non-profit centers by paying “reasonable compensation” to the members’ directors or officers of the non-profit. However, the state failed to define “reasonable,” and with patients allowed to buy $1,400 of marijuana each month, groups outside the state have expressed interest in running the centers. The dispensaries must be run by Maine residents, so the “flatlanders” are moving in. The article says that “the state will have to pay very close attention to be sure that patients, not profits, are the pot providers’ principal priority.” (Portland Press Herald, 6/29, www.pressherald.com/opinion/california-gold-rush-in-reverse-for-maine__2010-06-29.html)

* “Hospice and Heart Disease: Missed Opportunities,” originally published in the Journal of Pain & Palliative Care Pharmacotherapy, reports that in 2005, only 18.36% of hospice-eligible patients dying of heart failure actually got hospice care. The reasons cited for this include the lack of “reliable prognostic indicators, the lack of a consensus on when to stop life prolonging therapies, and the relatively high cost of life-prolonging (versus life-enhancing) pharmacotherapy.” (Journal of Pain & Palliative Care Pharmacotherapy, 2010,24(1):23-6; Obesity, Fitness & Wellness Week, 7/17)

* July 6 is the effective date for CR 6778, which will “begin editing to ensure that the place of service (Q5001-Q5009) is appropriate for the level of care.” There are three reason codes: 32458, for general inpatient care in a place of service that is not appropriate for general inpatient care; 32459, for respite care in a place of service not appropriate for respite care; and 32460, which indicates continuous home care in a place not appropriate for continuous home care. Hospices are reminded to get the appropriate revenue codes from the link below and update the appropriate Q codes. (Cahaba GBA Website, 7/2/ www.cahabagba.com/rhhi/news/20100702_codes.htm)

RESEARCH & RESOURCE NOTES

* A study to determine “the frequency and predictors of refusals of DNR in advanced cancer patients admitted to an acute palliative care unit” found that only 4% of more than 2300 patients refused a DNR order. Patients with blood cancers and advance directives were less likely than others to refuse. Those with moderate to severe pain, more nausea, and no advance directives were at higher risk of refusal. The authors say that “this study demonstrates possible predictors of complicated DNR discussions.” (Cancer, 2010,116(12):3061-70, dx.doi.org/10.1002/cncr.25045)

* Hospice Foundation of America announces the Hospice Information Center, part of the “HFA CARES: Hospice Foundation of America’s Conversations, Advice, Resources and Education Series.” The educational resource makes it easier for family and friends to understand hospice. The Center, online at www.hospicefoundation.org/infocenter, offers personal testimonies, the basics about hospice, EOL and hospice resources, and an opportunity to ask questions. The site is funded by “a grant from the Centers for Medicare and Medicaid Services (CMS) to support

* Electrical stimulation may be more effective than pharmaceuticals for the relief of certain kinds of pain. Tiny wires may be implanted in the spinal cord, against painful joints, or even in the brain. Pain from nerve damage responds best to this kind of treatment. There are the usual surgical risks, in addition to the possibility of infection or bleeding in the spine. Patients must also avoid MRIs, which may damage the implants or overheat. (The Los Angeles Times, 7/5, www.latimes.com/news/health/la-he-pain-control-20100705,0,5360155.story)

* Scientists and medical marijuana advocates are researching the effectiveness of the drug. The latest research shows that marijuana, or some of the compounds in it, are effective at relieving some symptoms, but there are drawbacks, and some are potentially serious. “Conventional drug researchers see promise mostly in harvesting marijuana’s ingredients for more traditional medicines and avoiding consumption methods like smoking that can hurt patients’ health.” Some marijuana supporters are not happy about the development of those potential drugs. Allen St. Pierre, executive director of the National Organization for the Reform of Marijuana Laws, says, “When they get through the FDA with their cannabis-based drugs, no legislature in the country will allow doctors and patients access to whole, smoked marijuana.” (The Denver Post, 7/4, www.denverpost.com/headlines/ci_15437322)

* The Veterans Administration and the Department of Defense have published an updated Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The intent of the guideline is: to promote evidence-based management of individuals with chronic pain; to identify the critical decision points in management of patients with chronic pain who are candidates for opioid therapy; to improve patient outcomes, i.e., reduce pain, increase functional status and enhance the quality of life; to decrease the incidence of complications, and to allow flexibility so that local policies or procedures, such as those regarding referrals to, or consultation with, substance abuse specialty, can be accommodated.” (VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp)

END-OF-LIFE NOTES

* Helen Rippier Wheeler, who writes the “Senior Power” column in The Berkeley Daily Planet, took on end-of-life issues last week. Among the topics she covered were women as long-term caregivers, elder abuse and neglect, and the stories of several senior citizens and their difficulties with long-term care and caregivers. Wheeler is the author of several books on women’s issues. (The Berkeley Daily Planet, 7/5, www.berkeleydailyplanet.com/issue/2010-07-06/article/35752)

* At Harvard Medical School, actors are performing scenes from ancient Greek plays as “a way to help doctors better navigate new moral quandaries around death and dying.” The End of Life program uses the “tragédies to spark discussion among medical students and professionals about the ethics of treating patients facing painful, prolonged deaths.” The author says, “Several professors, doctors, and students who have taken part in End of Life agree that the 90 minutes of raw, honest theater and emotional discussion add a dimension of reality to medical ethics education that textbooks cannot.” (Boston Globe, 7/7,
* NHPCO president and CEO Don Schumacher recently interviewed Julia Quinlan on the occasion of the publication of Quinlan’s second book, *My Joy, My Sorrow: Karen Ann’s Mother Remembers*. Quinlan and her husband established the Karen Ann Quinlan Memorial Foundation, and eventually, the Karen Ann Quinlan Hospice. Quinlan says, “I think one of the greatest experiences of my life was to sit in New Jersey’s Supreme Court and hear the arguments in my daughter’s case. That decision … opened the doors for conferences and discussions on death and dying.” (*NHPCO NewsLine*, 7/2010)

OTHER NOTES

* Anne Studholme, an attorney representing a number of disability rights organizations, has filed a friend-of-the-court brief on behalf of Ruben Betancourt and the case against Trinitas Hospital, online here: www.northjersey.com/news/opinions/97784574_Uncomfortable_facts_in_end_of_life_case.html. Studholme answers an article by Patricia Codey and Elizabeth Ryan, whose friend-of-the-court briefs support the hospital, which is online at www.northjersey.com/news/opinions/95169044__A_step_toward_compassionate_end_of_life_care_.html. (*NorthJersey.com*, 7/5)

* Six rural communities in Minnesota have been chosen for Stratis Health’s Rural Palliative Care Community Development Project. The project establishes or strengthens palliative care programs, and the chosen communities will “receive one-on-one support and technical assistance.” See www.stratishealth.org/expertise/longterm/palliative.html for more information. (*Minnesota Hospital Association Press Release*, 7/2, www.mnhospitals.org/index/news-mhaindex-action/story.2839)

Thanks to Deborah Whiting Jacques, Don Pendley and Tracy Rathe for contributions.

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.hccis.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.