PRESENTATION ADDRESSES THE DISCONTINUATION OF MEDICATIONS FOR DYING PATIENTS

Speaking at the recent meeting of the American Academy of Hospice & Palliative Medicine, nurse Beverly Lunsford, PhD, said hospice patients can feel abandoned when they are told to stop taking medications for other chronic conditions. Lunsford, coordinator of the graduate program for palliative care nurse practitioners at George Washington University, said, “People have it hammered in their heads to take their diabetes medications, their hypertension medications, and have done it faithfully for [decades]. Now you’re telling them to stop. They may have a real sense that isn’t right. Families may perceive medication discontinuation as substandard care or lack of care.”

It’s important to reassure patients and families that this is not substandard care, Lunsford says, but better yet to handle it “in such a way that they don’t think so in the first place.” A medication review should be conducted for every new hospice patient, and issues of medication should be part of goals-of-care discussions. Lunsford suggests discussing with them which meds they are taking for symptom relief and which for medical conditions that are no longer high priorities. Some drugs may no longer be necessary because the patient has lost weight, or because reduced kidney and liver function make them no longer advisable. Loss of memory and difficulty swallowing may also be reasons to discontinue medications.

Dr. Robert Kaiser, associate professor of geriatrics and palliative care at George Washington University, says that the goal is to “cut unneeded medications so side effects, such as falls and confusion, and drug interactions don’t add discomfort to the dying process.” Lunsford and Kaiser recommend tools for withdrawing drugs, such as the Medication Appropriateness Index, and the Beers criteria listed in the Archives of Internal Medicine (2006;166:605-9).

Lunsford noted that “many health care professionals may not feel they have the time” to deal with the issue – deciding which drugs to discontinue, discussing them with the patient, figuring reduced dosages, and monitoring things on subsequent visits. She emphasizes that it’s important to do so, and to avoid peer conflict by advising them when drugs will be discontinued. (Elsevier Global Medical News, 3/15)

OIG RELEASES UNIMPLEMENTED RECOMMENDATIONS REPORT

The HHS Office of Inspector General has released the Compendium of Unimplemented Recommendations, which “summarizes significant monetary and nonmonetary recommendations that, when implemented, will result in cost savings and/or improvements in program efficiency and effectiveness.” The recommendations to CMS, which result from audits and evaluations,
usually require legislative, regulatory, and/or administrative action. The recommendations related to Medicare-certified hospices include the following:

“CMS should seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification.” An OIG investigation found that: 1) A significant percentage (14%) of hospices were past due for recertification; 2) CMS and state agencies “rarely used methods other than certification surveys and complaint investigations to monitor hospice performance and enforce standards, and infrequently analyzed hospice data, and 3) CMS had not given direct guidance or specific criteria for identifying at-risk hospices to state agencies. CMS did not agree with the recommendation, saying that it was not a regulatory issue and should be addressed by Congress.

“CMS should strengthen monitoring practices for hospice claims” in nursing facilities to make sure they comply with Medicare requirements. OIG found that “82 percent of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement, … 33 percent of claims did not meet election requirements, and 63 percent did not meet plan of care requirements. For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries’ plans of care, [and] 4 percent of claims did not meet certification of terminal illness requirements.” CMS concurred with the recommendation, and is taking steps to implement it. The OIG says that it continues to monitor the implementation, that CMS has “not offered concrete evidence that it has changed its monitoring practices,” and that the “noncompliance rate of 82% warrants systemic change.” (Compendium of Unimplemented Recommendations, 3/2011; http://oig.hhs.gov/publications/docs/compendium/2011/CMP-01_Medicare_A+B.pdf)

RESEARCH & RESOURCE NOTES

Speaking at the annual conference of the American Psychosocial Oncology Society, researchers from the University of South Florida reported that “compared with older cancer patients, younger adults battling the disease reported more pain, more severe pain, and more distress on almost every psychological variable measured.” An article about the study calls the findings “notable” because older patients were more likely than younger ones to have late stage disease and be receiving palliative rather than active treatment. Additionally, “significantly more young adults reported problems with sleep difficulties, sadness, worry, irritability, and sexual concerns.” (Internal Medicine News Digital Network, 3/14)

Pain Monitor, the monthly email letter of the American Pain Foundation, is online at the link below. (Pain Monitor, 3/2011, action.painfoundation.org/site/MessageViewer?em_id=12882.0)

The Brandenburg Maas Life Transition Center (BMLTC) has launched its Advances in Bereavement (AIB) education initiative. The free program, available nationwide, was “developed to provide access to contemporary topics for hospice bereavement personnel.” Donna Brandenburg, founder of the BMLTC, said, “Our research shows that many hospice bereavement staff simply don’t have access to the latest information available from the field. Cuts in Medicare funding have left many bereavement programs under-staffed and education support under-funded.” (Advances in Bereavement, www.advancesinbereavement.org/; AIB Press Release, 3/16)

The results of a three-year study of end-of-life care in Massachusetts found that 70% of people dying in the state want to be at home. Instead, 70% actually die in hospitals. The

The New York Times reported on a paper originally published in The American Journal of Obstetrics and Gynecology. Babies whose mothers took opioids early in pregnancy “were considerably more likely than others to have congenital problems” such as spina bifida and gastroschisis (intestines on the outside of the body). The paper’s lead author said, “Opioids and their receptors act as growth regulators during embryologic development, which may explain our findings.” (The New York Times, 3/17, www.nytimes.com/2011/03/22/health/research/22risks.html)

PUBLIC POLICY NOTES

Two additional US District Courts have ruled CMS calculations for hospice caps as contrary to the Medicare statute. The law requires the cap to be “calculated by multiplying the number of beneficiaries who received hospice services during the accounting year by the per-beneficiary cap amount, [and] provides that the number of beneficiaries for a given account year must be reduced to reflect the proportion of services a beneficiary received in an earlier or subsequent accounting year.” Under the new regulations, “a beneficiary is included in a hospice provider’s cap only in the year the beneficiary elected the hospice benefit, regardless of whether that individual received hospice care in an earlier or subsequent accounting year, rather than apportioning the beneficiary among the years in which hospice services were provided as required under the statute.” (Payment Matters, 3/10, www.jdsupra.com/post/documentViewer.aspx?fid=478c35dc-32da-4a72-9194-d5784a774190)

Dr. Carol J. Huser, a forensic pathologist in La Plata County, Colorado, says that Washington State’s Death With Dignity Act “requires coroners and medical examiners to lie.” Huser says, “The act says that ‘the patient’s death certificate ... shall list the underlying terminal disease as the cause of death.’ The certificate may not reference the Death with Dignity Act, mention the drug used to terminate life or contain terms such as suicide, assisted suicide, physician-assisted suicide, mercy killing or euthanasia. The manner of death must be certified as natural. … I have no problem with the right of the individual to choose suicide, and I accept that the majority may decide what laws they will be governed by, but the legal requirement for a cover-up is nuts. Death with dignity is a fine phrase, but where’s the dignity in forcing doctors to sign certificates that misstate the facts? I’m no fan of euphemisms or political correctness. Assisted suicide is suicide. Legalize it if you will, but call it what it is.” (The Durango Herald, 3/13, durangoherald.com/article/20110314/COLUMNISTS09/703149988/-1/s)

Georgia law says anyone can be charged with a felony who “publicly advertises, offers or holds himself or herself out as offering aid to another in suicide.” The head of Final Exit Network (FEN) says that means the organization can’t even speak with Georgia residents who have contacted them for help. A recent article in The Sun-Sentinel profiles the case of a woman impacted by the law. “Unfortunately,” says the woman, “Georgia makes it impossible for me to consult with groups like Final Exit Network to learn my options, keep my dignity and
avoid the pain that inevitably awaits me.”  (The Sun-Sentinel, 3/17, www.sun-sentinel.com/health/fl-
nbcol-end-of-life-info-brochu-031720110317,0,6369536.column)

The result of the Idaho Senate’s vote on House Bill 187 will “determine whether or not patients’ legal end-of-life wishes will be upheld.” Some groups call the bill a “fix” to the conscience law passed last year, which allows Idaho healthcare professionals to refuse to honor advance directives. AARP opposes the current bill, saying, “This bill still leaves patients’ legal rights as expressed in their advance directives in limbo, allowing all health care professionals in Idaho to refuse to honor a patient’s dying wishes when it violates their conscience. The bill isn’t a fix to the conscience law, rather, if passed; it will just be part of the problem and will continue to complicate Idahoans care at the end of their life.” See www.aarp.org/states/id/ for more information. (PR Newswire, 3/18, www.prnewswire.com/news-releases/fate-of-idaho-patients-
legal-end-of-life-rights-rests-with-senate-vote-118246899.html)

OTHER NOTES

The Rev. Dr. Walter J. Smith, president and CEO of HealthCare Chaplaincy, offers several vignettes of persons in spiritual distress because of illness. He says, if you know someone like this, “Don’t be afraid to reach out to them in a gentle way. Recognize that people cope with health crises and grief in their own way and at their own pace. Most importantly, offer to be there for them. Listen to what they say and what they don’t say. If your friend is in a hospital, ask if they’d like for a chaplain to visit. I’ve learned from many years of observation that professional chaplains are particularly able to help people -- regardless of faith or beliefs -- to find meaning and comfort.” (The Huffington Post, 3/15, www.huffingtonpost.com/rev-dr-walter-j-smith-sj/spiritual-care-is-everyon_b_832424.html)

Oncologist John Marshall says that his daughter’s comment that “hospice has got to suck” really took him aback. She viewed hospice as “going off and sitting around waiting to die.” Marshall says that both physicians and patients can view a decision to enter hospice as a kind of relief when everything else has been tried, but “much of the outside world may be seeing hospice as this terrible, sad, awful place where all you do is sit around and wait to die.” He concludes, “We need to be sensitive about this. We need to hear that other perspective on what hospice is and we need to educate the public. It is our job to educate the public and our government on end-of-life care, resource utilization, and this perspective -- just what end-of-life is all about -- because, as we know, it’s inevitable for all of us. We’re not really sure when, but it is going to be our turn at some point. And hopefully when our time does come, it will be more of a relief than, as my daughter puts it, sucks and waiting to die.” (Medscape Today, 3/16, www.medscape.com/viewarticle/738680)

In Chinese culture, talking about death may be considered bad luck. Consequently, the families of elderly, dying Chinese may not know what the patient would want at the end of life. If they guess wrong, “the price for upholding tradition is living with guilt.” In Bellingham, Washington, geriatric nurse Sandy Chen Stokes founded the Chinese American Coalition for Compassionate Care, which educates both immigrants and health care providers about end-of-life care for Chinese-Americans. (The Bellingham Herald, 3/15, www.bellinghamherald.com/2011/03/16/1919009/cultural-beliefs-a-barrier-to.html)

The aging population of the US requires pharmacists to “know, understand and be involved in issues related to the elderly and end-of-life care. … Pharmacists can improve end-of-life
care through medication review assessments. A pharmacy evaluation should consider factors including patient characteristics, polypharmacy, drug interactions, drug dosage management, elimination pathways, medication risk/benefit profile, patient administration access, drug-related adverse events and cost-effectiveness.” (Chain Drug Review, 2/28)

In *H&HN* (Hospitals & Health Networks), Dr. Diane E. Meier and Rich Umbdenstock, CEO of the American Hospital Association, write that patients with complex illnesses comprise only 5%-10% of patients, but account for two-thirds of the country’s healthcare costs. In spite of this, “these patients and their families report untreated symptoms, unmet needs, high caregiver burden and low satisfaction.” The authors say, “The rapid growth of hospital palliative care programs in the last decade has positioned hospitals and health professionals to respond to the unmet needs of a seriously and chronically ill patient population with significant care needs. Hospitals with strong palliative care programs linked to implementation of these new delivery models are well-positioned to achieve the quality and health care value objectives at the heart of American health reform.” (*H&HN*, 2/1)

Lisa Ashley has been selected as the Michigan Hospice and Palliative Care Organization CEO. Previously, she was executive director of the Hospice of Little Traverse Bay, and is a Certified Hospice and Palliative Care Administrator. (*Michigan Hospice and Palliative Care Organization Press Release*, 3/18, [www.prlog.org/11384069-state-hospice-organization-hires-ceo.html](http://www.prlog.org/11384069-state-hospice-organization-hires-ceo.html))

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