Hospices, Policy-Makers Debate ‘Prognosis vs Diagnosis’

Recent information from the National Hospice and Palliative Care Organization (NHPCO) focuses on likely changes in store regarding how CMS looks at diagnoses and terminal prognosis.

For decades, hospice providers have been required to record a dying patient’s principal diagnosis and had the ability to list co-morbidities related to that terminal illness. Now, a recent NHPCO news release said, hospice providers “must reframe the way we think about and characterize our patients and the scope of our responsibility in providing care to them, shifting from submitting a single diagnosis on the claim form to providing a more comprehensive and accurate picture that validates each patient’s eligibility for hospice care by focusing on the basis for their terminal prognosis.”

Hospice providers fear that they will now be required to cover costs related to the co-morbidities as well as the principal “hospice” diagnosis.

NHPCO has posted a video, “Prognosis and Relatedness,” further discussing the issue and giving guidance to hospices. In the video, the central question raised is this: Does this diagnosis or condition contribute to or influence the patient’s terminal prognosis? If yes, NHPCO maintains, it is the responsibility of each hospice to cover the costs related to the condition. Without doing this, the video hints, CMS will resolve the question in ways that hospice providers may find unworkable or unaffordable.

NHPCO is in close talks with CMS and “hospice scope of responsibility is an area of intense and active discussion.” CMS, NHPCO says, is supportive of NHPCO’s work on this. The video says that several reports from CMS and others, along with the recommendations of the NHPCO Relatedness Workgroup, has “convinced NHPCO that this issue is now critical to preserving the Medicare Hospice Benefit as it currently exists.”

The controversy stems from the very document that created the Medicare Hospice Benefit in 1983. Consultant Heather Wilson of Weatherbee Resources, Inc., raises questions about the controversy. Her April 2 blog was titled “Prognosis Vs Diagnosis – Can We Slow Down For A Minute Please?” Wilson notes that the citation for this change comes from “CMS’s non-regulatory contention from the preamble to the first hospice regulations in 1983. This preamble “had not resurfaced until 2013 when the whole Part D brouhaha . . . reared its ugly head.” Wilson identified three points that NHPCO has raised about the issue, and she examined each point.
Point one in NHPCO’s reasoning, she ways, is that this is nothing new, and that the emphasis has always been on prognosis. While the verbiage has been in the preamble for 30 years, Wilson asks why this has not been an issue 20, 10 or even five years ago? Perhaps, she says, it is because more money is now going to hospices. “CMS needs to protect the Medicare Trust fund – that is its job,” says Wilson. And, ‘like most insurance companies, it wants to pay for as little as possible.” Wilson says hospices have “not done this capriciously nor to narrow their scope of responsibility.” She sites language from 418.22(b) about the content of the certification of need for terminal illness. She also maintains that most hospices, not just “some,” have focused on a single or principal diagnosis for all these years. “So no, it has not always been this way.”

Point two in the reasoning is, “If we don’t do this now, it will be worse later.” With intense discussions going on at CMS, Wilson says this “sounds a lot like a threat and/or a promise.”

Point three is “It is the right thing to do.” This, Wilson says, “is the big elephant in the room.” “If ‘it’ is taking care of the whole patient and everything the patient needs to ensure safe, effective and comfortable end of life care then yes, of course, that is the right thing to do. “If ‘it,’” however, is focusing on everything that could possibly ‘influence’ or ‘contribute’ to a patient’s terminal prognosis, in order to broaden the scope of the hospice’s financial responsibility, it is very, very questionable if that is the right thing to do and if it is even feasible.” “The message, loud and clear,” says Wilson, “is hospices better not have long length of stay patients.”

Wilson laments that hospices are increasingly in a “no win situation” because the 1980s Medicare Hospice Benefit just does not work in 2015. She notes that no other health care provider must offer bereavement services while not being reimbursed to do so. No other provider must recruit, train and manage volunteers to achieve the equivalent of at least 5% of patient care hours. No other provider must maintain professional management of patient care, even when the patient is being cared for by another healthcare institution. No other provider must offer 24-hour care when needed “rather than contract for additional help when needed.” And, no other provider must pay for “everything possibly related to a patient’s prognosis out of a meager per diem payment.”

Wilson calls for a different focus on the issue here. Specifically, she suggests that advocates spend their time and energy revising the Medicare Hospice Benefit into one that can work with “financial and clinical realities of
2015.” Will this “all-inclusive prognosis,” she ask, be “another (or final) nail in the hospice coffin for many smaller hospice programs?”


Palliative Care Experts: Why Most Patients Don’t Die at Home

Even though many Americans would prefer to die at home rather than in a medical institution, home death is still the exception rather than the rule. Why is this? Molly Walker from MedPage Today undertook email interviews with a number of palliative care experts and the answers she got were illuminating.

One reason cited for why so many patients still die in the hospital is that “surrendering” to death is not seen as a hopeful alternative – particularly by attending physicians. Michael Levy, M.D., explains, “Even if there were enough palliative care available to care for all the patients that need it, many physicians still view it as something less than hopeful and valuable to offer to patients than continuing to fight their disease.” Despite the fact that palliative care is seen to have great benefits when it comes to cost reduction, it is often seen as “giving up” rather than continuing the fight against disease.

Dr. Mohana Karlekar adds to Levy's analysis, explaining that many doctors are hesitant to speak about issues of death and dying head-on. “Doctors are often not comfortable addressing end-of-life issues, and often overestimate prognosis.” How to have end-of-life conversations “was not traditionally taught in medical schools,” leaving many doctors at a loss for how to speak to these issues, or interact with patients and families in such situations. “Physicians often assume people want ‘everything done,’ so what typically happens is that patients end up in the hospital or with an advancing illness, they may not even realize they may be nearing the end of life.”

No one wants to die if they don't have to, but if death is understood to be inevitable, there are many who prefer a natural death rather than an institutionalized fight to the finish with disease. It's clear that, if we want to see more people dying at home rather than in the hospital, more of us will have to have good information on what our prognosis actually is. Yet, as Anna Faul, Ph.D., points out, this isn't always easy in our current medical culture. “At the end of life, society gravitates toward institutions to save lives. ... Although for all of us death is inevitable, we believe that going to an institution at end of life, may prolong life.” This results in a medical system where billions are spent on futile treatments in the last weeks and months of terminal illness, improving neither individual lives, nor the health care system as a whole.

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At the heart of this dysfunctional system lies deep fear. “In the end, our fear of death trumps our desire to die peacefully at home,” says Faul. The United States is a deeply death-denying culture, says Patrick Coyne, M.S.N., which often prevents us from gaining the benefits of realistic thinking. “One of the goals [for our health care system] should be for healthcare providers to have more open and honest discussions with patients and families about their illness and prognosis.” We may be headed in this direction on a national level, but there’s still clearly a lot of work to be done. “To be successful, we need to establish true two-way communication between patients and families and their healthcare providers.”

In addition to institutional issues, and the prevalence of a death-denying culture, those interviewed cite a lack of patient planning as a major obstacle to seeing more people die in the ways that they would most prefer. “Americans do plan for retirement and purchase life insurance but only 25% of them have prepared advance directives,” says Levy. Public awareness is a key factor that cannot be overlooked. “If palliative care had the same public passion and political strength as breast cancer care, it would be available to help all patients who want to die at home to do so.” (MedPage Today, 4/1, www.medpagetoday.com/PrimaryCare/GeneralPrimaryCare/50696)

HOSPICE NOTES

• Andy Land, Director of Hospice and Palliative Care Services at Agnesian HealthCare in Wisconsin, is climbing Mount Everest to raise awareness and support for hospice care. The Hospice Organization and Palliative Experts of Wisconsin sponsors his work. His brother made him a beneficiary of his life insurance policy to help fund the climb as well. Considerable media coverage has been given to Andy’s climb and there is coverage on the website, including a March 24 video news coverage clip by WMTV in Madison, Wisconsin. (Climbing for Hospice, https://climbingforhospice.org/Home.aspx; NBC15.com, 3/24, http://www.nbc15.com/home/headlines/Climbing-Mt-Everest-to-raise-awareness-for-hospice-care-in-WI-297480651.html)

• A Florida hospice says it is being threatened with shutdown by the state's health care agency as a result of a computer glitch. The state says that it never received required paperwork, but the hospice says, “We have compelling evidence that we did send it in timely.” (10 News Tampa Bay, 4/2, www.wtsp.com/story/news/local/2015/04/01/hospice-lakeland-compassionate-care/70810966/)

• Vietnam War veteran Joseph Hooker, now suffering a terminal illness, fulfilled his longtime dream of visiting Pearl Harbor in Hawaii. During his visit, Islands Hospice paid tribute to Hooker, bestowing a “We Honor Veterans” pin, and a certificate from the hospice. (KHON, 3/25, KHON2.com/2015/03/25/terminal-vietnam-war-veteran-honored-fulfills-dream-of-returning-to-pearl-harbor/)

END-OF-LIFE NOTES

• A family in Michigan is suing the school district where their son is enrolled after district officials said they would refuse to comply with his “Do Not Resuscitate” order. The 11-year-old is “unable to speak or eat and can have up to 100 seizures a day.” His mother says, “If his heart were to stop beating at school, he has a terminal disorder and we have decided not to do anything heroic to bring him back. We would do comfort measures only. We've seen him near death many times and we've seen him come back never quite as he was before.” (Click on Detroit, 3/30, www.clickondetroit.com/news/school-district-refuses-to-comply-with-students-donotresuscitate-order/32094958)

• The Conversation Project has been featured on PBS NewsHour. “A growing national movement to normalize end-of-life discussions and friends has gained traction in recent months... A Boston-based non-profit... is highlighting the importance of talking openly about dying.” (PBS NewsHour, 3/28, www.pbs.org/newshour/bb/new-movement-urges-scary-conversations-death-among-friends-family/)
A report released by UMASS Medical School's Commonwealth Medicine division calls for public awareness of advance care planning, palliative care, and end-of-life options as crucial to improving end-of-life in Massachusetts. The “MA Expert Panel on End of Life Report” comes after the recent passage of a state law that requires health care providers to inform terminally ill patients that hospice and palliative options are available. (UMASS Med Now, 3/26, www.umassmed.edu/news/news-archives/2015/03/umass-medical-school-report-cites-need-for-awareness-of-end-of-life-care-options/)

U.S. senators from both parties are saying that they need end-of-life advocates to keep up the pressure to transform care for the dying. At the Institute of Medicine's National Action Conference, held recently in Washington, D.C., lawmakers suggested that end-of-life issues are no longer the political hot potato they once were. (MedPage Today, 3/24, www.medpagetoday.com/PublicHealthPolicy/HealthPolicy/50640)

At some nursing homes, there may be a growing willingness to be open about death and dying. “Attitudes are beginning to change... thanks to a greater emphasis on bringing meaning and individual choice... to those last years in long-term care.” (Philadelphia Enquirer, 3/29, www.philly.com/philly/health/20150329_At_some_nursing_homes__a_changing_attitude_toward_death.html)

PALLIATIVE CARE NOTES

Palliative care is a “foreign” but vital role for pharmacists, says an article in Pharmacy Practice News. Pharmacists are encouraged to “focus on what's important now.” “If you're within a month of dying, if you can tolerate a blood sugar of 250 and are asymptomatic, then I'd say let's get you a dozen doughnuts.” (Pharmacy Practice News, 3/2015, www.pharmacypracticenews.com/ViewArticle.aspx?d=Clinical&d_id=50&i=March+2015&i_id=1155&a_id=30832)

An article published in Supportive Care in Cancer clarifies how quality indicators can be successfully used in palliative care services. “Training in the advantages of quality indicators and how to use them is indispensable, as are structural changes in the policy concerning palliative care, in order to progress towards systematic quality monitoring.” (Supportive Care in Cancer, 4/2, link.springer.com/article/10.1007/s00520-015-2687-8)

New Jersey hospices are invited to help this Duke University research about serving African Americans

Why is this project important for hospice providers?
Our goal is to help hospices improve their outreach to seriously ill African Americans. This study will help us identify best practices that may be disseminated throughout the hospice field.

What is involved in participation?
You will complete a short online form about your hospice and a brief telephone survey about your hospices’ practices.

We would like to include a diverse group of hospices (small or large; for profit or nonprofit, serving few or many African Americans) from all 50 states and the District of Columbia.

How will my hospice benefit?
In addition to a small honorarium, your hospice will receive two free webinars on outreach to African-American patients led by leading national expert, Dr. Kimberly Johnson, Associate Professor of Medicine at Duke University.

How do I learn more about the study?
Call (919-) 660-7531 or e-mail Kimberly.s.johnson@dm.duke.edu
JERSEY NOTES

• The Courier-Post online is publicizing a National Healthcare Decisions Day event on April 16 from 1:00-4:30 p.m. at Virtua Health & Wellness Center, 401 Young Avenue, Morristown. “The event will include free health screenings, nutrition tips, advance directive workshops with social workers, elder law attorneys, and more.” To register, call Jeff Kleeman at 609-707-7339. http://www.courierpostonline.com/story/news/local/south-jersey/2015/04/08/end-life-decisions/25462263/

• Sharon Caccamo of Life Choice Hospice has earned the Certified Volunteer Administrator (CVA) credential, bestowed by the Council for Certification in Volunteer Administration. The CVA credential was created in the early 1980s as a professional development tool for individual practitioners who mobilize and manage volunteers. Caccamo, a member of the Hospice Veteran Partnership of New Jersey, joins a group of over 1,370 CVAs worldwide.

Atlantic Health System has been chosen by Fortune Magazine for the seventh year in a row as one of the 100 Best Companies to Work For, recognizing the rewarding working environment provided for our employees. We are currently seeking a Full-Time Nurse Practitioner for Chilton Medical Center. Responsibilities: Provide palliative care for patients facing chronic, complex conditions and their families at various locations within the flow of patient care; Participate in comprehensive medical and psychological evaluation of patients and families, skilled and meticulous symptom management, discharge planning and continuity of care; Serve as clinical and educational role model and mentor; Provide care and support in collaboration with the primary care team; Ensure compliance with practice standards and codes. Qualifications: Minimum three years nursing experience, including care of patients with complex, chronic, and/or life-threatening conditions, and those at the end of life; clinical nursing care in oncology or hospice care preferred. Hospice and Palliative Care Certification or eligibility desirable. Knowledge of medications, and prescriptive authority. We are an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability or protected veteran status. EEO/AA/M/F/DV For more information and to apply, please visit: http://jobs.atlantichealth.org/jobs/descriptions/nurse-practitioner-pompton-plains-new-jersey-job-1-5224995

The Center for Hope Hospice, a unique provider of Hospice and Residential Services (AL), located in Union County, New Jersey, seeks a Part Time/Per Diem QAPI RN. Using our state of the art Electronic Medical Record and on-site audits, the successful candidate will: Review clinical documentation to measure our compliance with Medicare and other requirements; Educate and mentor staff for documentation as a tool of professional communication; Summarize and report results to management; and, Act as an in-house resource to research, recommend and develop methods of improving compliance with existing and new regulations and standards. The successful candidate will be an RN with New Jersey licensure, experienced in Hospice and the Medicare Benefit. BSN preferred. Hours are 8 – 12 hours/weekly on average with flexible days and hours. EEO/AA/M/F/DV Resume and cover letter in confidence to HR@cfhh.org. [041715]

The Center for Hope Hospice, a unique Union County based non-profit providing hospice and residential services, seeks a strong, dedicated, caring and energetic Full-Time Registered Nurse, as a Shift Supervisor, with a minimum of 2 years demonstrated supervisory experience. We seek a supervisor who will thrive in a varied and challenging environment and is comfortable working in our facilities and providing high quality home care services. The successful candidate will be a proven and strong leader and independent thinker with excellent nursing and interpersonal skills. The Center offers an attractive starting salary; generous personal time off; and, a full benefits package. Some evening and weekend hours are required. Interested candidates should send a resume and cover letter to HR@cfhh.org. No phone calls please. [041015]

Thursday, April 16

**National Healthcare Decisions Day**

**Your decisions matter**

Step 1. Ask someone to be your health care proxy.
Step 2. Tell your proxy the kind of care you want if you can’t speak for yourself.
Step 3. Complete the New Jersey healthcare proxy form and place it in a visible location.
Step 4. Encourage someone else to do the same.
Items may be listed as a “Save the Date” service before registration information is available. Events not sponsored by NJHPCO are open to the public unless otherwise specified. Details about NJHPCO-sponsored events are posted at www.njhospice.org no later than six weeks before in-person programs and three weeks before webinars. Non-members are welcome to register for fee-paid educational events. NJHPCO Webinars are marked WEB — further information can be found at www.njhospice.org under “Upcoming Events” as the dates approach.

WEB THURSDAY, APRIL 23, 3:00-4:30 p.m. - “Compassion Fatigue: Managing Caregiver Stress”

THURSDAY, MAY 7, 9:30 a.m. - noon, NJHPCO Presents “Painting the ‘Relatedness’ Picture: Strategies for Successful Hospice Clinical Operations” at American Cancer Society, North Brunswick.

THURSDAY, MAY 7, 11:45 a.m.-4:00 p.m. - “Spiritual Healing: Caring for Patients, Families and Clinicians” at Overlook Medical Center. Information: 1-800-247-9580.

WEB THURSDAY, MAY 7, 3:00-4:30 p.m. - “Working with Challenging Situations: A Problem Solving Model”

TUESDAY, MAY 12, 5:30-8:00 p.m. - NJHPCO Presents “Ethics In Practice – Introduction to Ethical Principles and the Ethical Decision-Making Process” & “Ethics In Practice – Safety Issues” at Cherry Hill Public Library. Carries nursing and social work contact hours.

WEB THURSDAY, MAY 14, 3:00-4:30 p.m. - “ICD-10 Series - Part 1: Overview and Plan”

WEB TUESDAY, MAY 26, 3:00-4:30 p.m. = “ICD-10 Series - Part 2: Drilling Down to the Details”

WEB THURSDAY, MAY 28, 3:00-4:15 p.m. - “Ethical Issues: Professional Boundaries & Pitfalls”

WEB THURSDAY, JUNE 4, 3:00-4:30 p.m. - (Volunteer Manager Series) “Education/Training: Assuring Prepared & Confident Volunteers”

THURSDAY, JUNE 4, 5:15-9:00 p.m. – NJHPCO “Spirit of Hospice” Awards Dinner at Sheraton Eatontown.

WEB THURSDAY, JUNE 11, 3:00-4:30 p.m. - “What You Need to Know About the Two Nursing Home Tags Most Relevant to Hospices”

WEB THURSDAY, JULY 9, 3:00-4:30 p.m. - “Utilizing Aides in Patient Communication”

WEB THURSDAY, JULY 29, 8:30 a.m. - 6:30 p.m. - NJHPCO Presents “A Core Curriculum Review for Hospice and Palliative Nursing Practice and Certification Examination” at Natl. Conference Center / Holiday Inn, East Windsor.

WEB THURSDAY, JULY 30, 3:00-4:30 p.m. - “Hospice Contract Review: Complicance and Current Issues”

WEB THURSDAY, AUGUST 6, 3:00-4:30 p.m. - (Volunteer Manager Series) “Program Development”

WEB THURSDAY, AUGUST 13, 3:00-4:30 P.M. - “Effective Communication within the Healthcare Team”

WEB THURSDAY, AUGUST 27, 3:00-4:30 p.m. - “Countdown to ICD-10: Deadline October 1, 2015”

WEB THURSDAY, SEPT. 24, 3:00-4:30 p.m. - “The Hospice Nursing Home Partnership: How to Do It Right”

THURSDAY, NOV. 12 - NJHPCO Annual Conference and Exposition at Sheraton Eatontown.
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