
HOSPICE NEWS NETWORK

Recent News on End-of-Life Care

Volume 19, Number 34

September 22, 2015

A Service of State Hospice Organizations

MEDICARE LOOKING FOR WAYS TO HOLD DOWN HOSPICE COSTS

Seeking to avoid a system that leads to frequent double-payment, officials at Medicare are considering alternatives to the way that hospice care is presently funded. A recent article in *Kaiser Health News* examines the considerations that are taking place within the federal agency about how the Medicare hospice benefit should be structured. Yet, says the article, “Patient advocates and hospice providers fear a new policy could make the often difficult decision to move into hospice care even harder.”

While Medicare-funded hospice patients agree to forgo curative treatments for their terminal illness and instead to receive palliative care, Medicare patients are still eligible to receive coverage for conditions that are not related to their terminal illness. For example, accidental injuries and chronic health conditions would still be covered, despite a patient’s hospice status.

From Medicare’s perspective, the problem arises when they are forced to pay for services twice. “Medicare pays a set amount to the hospice provider for all treatment and services related to the terminal illness, including doctor’s visits, nursing home stays, hospitalization, medical equipment and drugs.” But care that does not directly relate to the terminal condition is covered by additional funds, drawing on regular, non-hospice Medicare benefits.

“If a patient needs treatment that hospice doesn’t provide because it is not related to the terminal illness – or the patient seeks care outside of hospice – Medicare pays the non-hospice providers. The problem is that sometimes Medicare pays for care outside the hospice benefit that it already paid hospice to cover.” **In order to prevent such duplicate expenditures, Medicare has announced that it is considering whether CMS should assume that “virtually all” the care that hospice patients receive should be considered as covered under the hospice benefit.**

If this were the case, hospice organizations would no longer be able to easily refer patients to non-hospice providers – a practice that is currently common, but which diverts costs away from hospices and onto Medicare. “Medicare has been paying millions of dollars in recent years to non-hospice providers for care for terminally ill patients under hospice care, according to government reports.”

The numbers involved are quite large. MedPAC found that, in 2012, Medicare paid roughly \$1 billion to non-hospice service providers for services unrelated to the patients’ terminal illness. “The commission did not estimate how much of that was incorrectly billed and should have been covered by hospices. Prescription drug plans received more than \$33 million in 2009 for drugs that probably should have been covered by the hospice benefit, according to an investigation by

the Department of Health and Human Services' inspector general.”

Medicare officials mentioned last year that changes to the hospice benefit payment system were potentially in the works, citing concerns about duplicate payments. **Such duplication, they said, “strongly suggests that hospice services are being ‘unbundled,’ negating the hospice philosophy of comprehensive, holistic care and shifting the costs to other parts of Medicare, and creating additional cost-sharing burden to those vulnerable Medicare beneficiaries who are at end-of-life.”**

Yet some seniors’ advocates are concerned that a shift by Medicare to place all coverage under the hospice benefit could block patients from receiving the care they need. Rather than a blanket change to the way the hospice benefit is treated, they suggest that Medicare should instead pursue action against particular hospice providers that shift costs in ways that are unethical.

While it is tempting to simply create blanket changes in the law, this could cause great hardship for terminally ill patients with diabetes, for example. “If your blood sugar gets out of control, that could hasten your death,” says Terry Berthelot, senior attorney at the Center for Medicare Advocacy. “But people shouldn’t be rushed off to die because they’ve elected the hospice benefit.” (*Kaiser Health News*, 4/23, [khn.org/news/officials-weighing-options-to-hold-down-medicare-costs-for-hospice/](https://www.khn.org/news/officials-weighing-options-to-hold-down-medicare-costs-for-hospice/))

CANCER SPECIALISTS CONSIDER HOW TO FACILITATE ADVANCE CARE PLANNING CONVERSATIONS

Writing for the journal *Oncology*, Drs. Taira Everett Norals and Thomas J. Smith discuss the importance of advance care planning conversations, and how they as physicians specializing in cancer treatment should handle such conversations with their patients. “Recent data suggest that we are not successfully getting the message across about the importance of advance care planning for patients who have a life-ending illness.” **Norals and Smith argue that physician leadership in initiating advance care planning conversations is key to helping break through denial, and in producing outcomes that lead to higher quality of life for terminally-ill patients.**

Without interventions by physicians to clarify the medical realities of a terminal prognosis, many patients are likely to come to false conclusions. “Half to three-quarters of patients with incurable cancer think that they may be cured by chemotherapy, radiation, or surgery. ... This avoidance has consequences, since those patients with ‘prognostic awareness’ have end of life care pathways that involve little use of the hospital, ICU, end-of-life chemo, or ‘codes’ with almost no chance of success, and much more dying at home with hospice care.”

Norals and Smith say that physician-initiated advance care planning can help ensure better results by bringing a dose of compassionate realism to patients who may have no other source for accurate information about their condition and prognosis. “If we can successfully initiate advance care planning discussions with our patients and families, their end-of-life processes will improve, resulting in better care, less use of the hospital, and more honoring of

newly discerned choices.”

The authors provide several recommendations for physicians who want to deepen their competency and facility with leading advance care conversations. First, they recommend that doctors “dispel some of the myths that suggest advance care planning and code discussions are harmful.” They also say that every oncologist should be well versed in what they call “primary palliative care” - the quotidian skills of caring for and communicating with seriously ill patients.

Norals and Smith provide some guidance for how to get these often-intimidating conversations started. How are such conversations started? First, physicians must recognize that the patient desires the conversation. Many patients already have advance directives but have not told anyone about them. Second, it’s crucial that doctors really get to know their patients. Conversations of such depth as end-of-life planning are far less awkward when you actually know the person you’re speaking with. Finally, the authors recommend that all physicians should have a good grasp of the typical outcomes of resuscitation among different patient groups – depending on age and condition. This knowledge will directly impact recommendations on DNR/AND orders.

“Unfortunately, care is becoming more intense during the last month of life, with increased use of the hospital and ICU, and short hospice stays – all indicators of both poor quality of care and missed opportunities for discussions of EOL goals and plans,” the authors conclude. **“All the available evidence says that asking patients about their EOL preferences early in the disease trajectory, and making sure that palliative care skills are brought to bear, will improve their care.”** (*Oncology*, 8/15, www.cancernetwork.com/oncology-journal/advance-care-planning-discussions-why-they-should-happen-why-they-dont-and-how-we-can-facilitate)

HOSPICE NOTES

*** Hospice of the Western Reserve and HMC Hospice of Medina County have completed a merger.** The two Ohio hospices say that no layoffs are planned. Each organization will continue to use its own name for the next year, after which the entire hospice will operate under the name “Hospice of the Western Reserve.” (*Crain’s Cleveland Business*, 9/14, www.craainscleveland.com/article/20150914/NEWS/150919926/two-northeast-ohio-hospices-complete-merger)

*** The CEO of a Tennessee hospice is responding to allegations of overbilling Medicare and TennCare for hospice services.** The hospice leader states that the organization “has voluntarily reached a settlement with the US Department of Justice and the Tennessee attorney general...” She says, “This matter is in no way related to the delivery of quality care...” (*Lebanon Democrat*, 9/15, www.lebanondemocrat.com/article/lebanon/712476)

*** A hospice facility and its manager, operating in the states of Mississippi, Louisiana, Texas, and Alabama, have been ordered to pay approximately \$5.86 million to resolve allegations of fraud in continuous home care hospice.** (*US Department of Justice*, 9/3, www.justice.gov/usao-sdms/pr/hospice-facility-and-its-managermajority-owner-pay-approximately-586-million-resolve)

END-OF-LIFE NOTES

* **Even if doctors want to be clear and honest with patients, that may not always be what patients themselves desire.** An article published in *The Journal of the American Medical Association* concludes that, patients perceive “a higher level of compassion and preferred physicians who provided a more optimistic message. More research is needed in structuring less optimistic message content to support health care professionals in delivering less optimistic news.” (*JAMA*, 9/15, jama.jamanetwork.com/article.aspx?articleID=2441250)

* **Modern death has its own characteristic rituals.** Haider Javed Warraich shares his own experience as a physician pronouncing the death of individuals in a hospital, and the ritualistic patterns that accompany death in modern America. The rituals, he says, used to be different – and they can be different again. (*The New York Times*, 9/16, opinionator.blogs.nytimes.com/2015/09/16/the-rituals-of-modern-death/?_r=1)

* **Nevada Public Radio features a story on a new program that seeks to train more end-of-life caregivers.** “One year into its medical fellowship program for end of life care, partners Nathan Adelson Hospice and Touro University are claiming success.” (*NPR*, 9/16, knpr.org/knpr/2015-09/new-program-aims-train-more-end-life-caregivers)

* **Dr. Kenneth W. Lin, MD, MPH, explores what it means to move beyond the rhetoric of “death panels” in a video commentary published on Medscape.** “Little seems to have changed since I was a medical student 15 years ago and placed a chest tube in a near-comatose patient within days of his death, and also participated in the failed cardiopulmonary resuscitation of an elderly woman with metastatic colorectal cancer.” (*Medscape*, 9/10, www.medscape.com/viewarticle/850557?nlid=88303_1521&src=wnl_edit_medp_wir&uac=68861EJ&spon=17&impID=825120&faf=1)

* **What really matters at the end of life?** Dr. BJ Miller, a palliative care doctor and Executive Director of San Francisco’s Zen Hospice Project, shares insights about end-of-life care in the recent TED Talk “What Really Matters at the End of Life.” (*Legacy*, 9/11, www.legacy.com/news/this-is-terminal/what-really-matters-at-the-end-of-life/3518/)

* **Preparing for the end of life is powerful.** *The Star Tribune* tells the story of a 71-year-old woman who died after firefighters decided to suspend life-saving measures. There was grief and confusion in her treatment and death. “If there had been a POLST form, I think it would have been a nonissue.” (*Star Tribune*, 9/12, www.startribune.com/health-beat-the-power-of-preparing-for-end-of-life-treatment/326918461/)

* **Erica Jong has published a new book exploring the “Fear of Dying,” and one review is not favorable.** “As undisciplined as a spoiled child, it lacks both palpable plot and real characters other than its frazzled and self-involved narrator. ‘Dying’ is a collection of distractions, not a cohesive work of fiction.” (*Buffalo News*, 9/13, www.buffalonews.com/life-arts/book-reviews/review-its-dying-erica-jong-is-afraid-of-now-20150913)

* **Jessica Vogelsang writes about what her mother’s death taught her about the incredible attachment many of us have to animals.** (*The Huffington Post*, 9/10,

www.huffingtonpost.com/jessica-vogelsang/what-the-death-of-my-mother_b_8113152.html)

* **Sara Bobkoff describes the “miracle” of her father’s death.** “All that was left of his autobiography was my sister, myself, and the soft white pearls of what were once his thick, black curly hair.” (*The Huffington Post*, 9/16, www.huffingtonpost.com/sara-bobkoff/how-my-estranged-fathers-_b_8141994.html)

* **Dr. James Stalwitz, writing in *KevinMD* blog, shares a referral he writes for his patient, “Mr. Ron C.”** Stalwitz shares that he gave the patient choices for interventions to deal with his metastatic lung cancer. He included in these choices, the options to do nothing. But Mr. C. saw this as desertion, and now wants to choose another doctor. The blog shows the risks of such an offer and explores the dilemma it presents to both physician and patient. (*KevinMD*, 9/14, <http://www.kevinmd.com/blog/2015/09/treating-cancer-doing-nothing-is-also-a-choice.html>)

* **Dr. Earl Stewart, Jr., writes in *KevinMD* about caring for dying patients.** Stewart says, “Caring for the dying patient is as much a challenge as it is rewarding. It is a challenge because no longer are we tasked with the job of ascertaining a treatment and sometimes cure for a potentially reversible medical illness, but our chief purpose in care at that point is to maximize comfort.” This difficult work, says Stewart, calls for recognizing that the end of life is as significant as the beginning of life. (*KevinMD*, 9/17, <http://www.kevinmd.com/blog/2015/09/caring-for-the-dying-patient-is-a-rewarding-challenge.html>)

PALLIATIVE CARE NOTES

* **Race/ethnicity doesn’t seem to play a major role in the quality of inpatient palliative care received by patients.** That’s the good news. The bad news is that rates of inpatient palliative care remain low across the board. (*Journal of Clinical Oncology*, 8/31, jco.ascopubs.org/content/early/2015/08/31/JCO.2015.61.6458.abstract)

* **Robert Fine, MD, FACP, FAAHPM, clinical director of the Office of Clinical Ethics and Palliative Care at Baylor Scott & White Health, writes about the changes in palliative care that he’s seeing in his work.** Fine makes an organizational case for palliative care. Leaders at Baylor Scott & White Health have developed a program to lower costs, improve quality, and reduce readmissions. (*Health Leaders Media*, 8/31, healthleadersmedia.com/page-1/QUA-320159/The-Organizational-Case-for-Palliative-Care##)

* **An article in *Journal Star*, Peoria, IL, tells the story of the work and successes of the palliative care program.** Dr. Phillip Olsson, medical director of OSF Hospice and the Richard L. Owens Hospice Home, shares about the work of palliative care and the benefits to patients and families. (*Star Tribune*, 9/16, <http://www.pjstar.com/article/20150916/NEWS/150919475/1994/NEWS/?Start=1>)

* **The end-of-life choices of one dying man in Albuquerque highlights the value of palliative care at the end of life.** These choices also reveal the dignity that can come with accepting a terminal prognosis with equanimity and poise. *Albuquerque Journal* printed “Seeking comfort

in his final days,” the story of Norbert Schueller, who is dying with throat cancer. Schueller declined medical treatments that would leave “him unable to eat by mouth and unable to speak, plus weeks of debilitating chemotherapy and prescriptions for painkillers.” He wrote a letter to the cancer center leadership in early September, asking, **“Why chemotherapy when the drugs will not cure the cancer? Why addictive, mind-numbing painkillers when ibuprofen would suffice? Why had the medical process become as complicated and complex as the legal process?”** Schueller is seeking palliative care instead of hoping for a cure. Schueller says, “It seems to me that when the medical circumstances indicate imminent death, palliative care means making the patient comfortable and reducing pain since a cure cannot be effectuated.” New Mexico “earned a ‘C’ grade from the National Palliative Care Research Center because less than half of all hospitals in the state with 50 beds or more offer a palliative care program.” The University of New Mexico will begin providing palliative care training in 2016. Norbert’s (*Albuquerque Journal*, 9/17, <http://www.abqjournal.com/644966/news/patient-seeks-comfort-not-futile-treatment-in-final-days.html>)

PAS NOTES

*** A bill that would legalize physician-assisted suicide has reached the desk of California Governor Jerry Brown.** “If Gov. Jerry Brown signs the bill, California would become the fifth state to allow doctors to prescribe lethal medication to terminally ill patients who request it, after Oregon, Washington, Vermont and Montana.” (*Newsweek*, 9/14, www.newsweek.com/physician-assisted-suicide-bill-reaches-jerry-browns-desk-372061)

*** Supporters of “the right to die” in New York State are encouraged by the progress of PAS legislation in California.** “We expect New York to follow California in passing death-with-dignity legislation,” says Sen. Diane Savino (D-Staten Island). (*Syracuse.com*, 9/15, www.syracuse.com/state/index.ssf/2015/09/physician-assisted_suicide_supporters_in_ny_buoyed_by_california_lawmakers.html)

*** While physician-assisted suicide is unethical, says Lynn A. Jansen, the voluntary cessation of eating and drinking (VSED) at the end of life can be morally acceptable.** Yet, even voluntary cessation of eating and drinking is fraught with ethical questions. “Advocates for PAS often present VSED as an alternative treatment option for end of life suffering that avoids moral controversy. But, in reality, VSED raises challenging moral questions about the permissibility of physician collaboration in patient decisions to end their lives as a means to ending their suffering.” (*Annals of Family Medicine*, 9-10/2015, www.annfam.org/content/13/5/410.full)

PAIN NOTES

*** The CDC says that opioids are “not preferred” as treatment for chronic pain.** “New draft guidelines... [could] sharply reduce the prescribing of opioids for both chronic and acute pain in the U.S. The proposed guidelines may also trigger a turf battle between the CDC and the Food

and Drug Administration over which agency has primary responsibility for the safe prescribing of medication.” (*Pain News Network*, 9/16, www.painnewsnetwork.org/stories/2015/9/16/cdc-opioids-not-preferred-treatment-for-chronic-pain)

*** Proposed legislation in Massachusetts would ban prescribing OxyContin to children.**

“The bill would ban the drug being given to Massachusetts residents under 17 in hospitals or being dispensed from pharmacies, even if they have a prescription.” (*Mass Live*, 9/16, www.masslive.com/politics/index.ssf/2015/09/massachusetts_bill_seeks_to_ba.html)

Correction: In last week’s HNN (Volume 19, number 33), Rev. Edward F. Dobihal Jr. was erroneously identified as the first medical director of the hospice in New Haven, Connecticut. Rev. Dobihal was a founder of the hospice and the first chairman of the board.

Thanks to Don Pendley for contributions.

Hospice News Network is published 45-47 times a year by a consortium of state hospice **organizations**. *Copyright, 2015. 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.