
HOSPICE NEWS NETWORK

Recent News on End-of-Life Care

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TIME FOR COMMUNITY-BASED PALLIATIVE CARE TO MOVE FORWARD

In a new blog post by Kathy Brandt of the KB Group, readers receive feedback on several community-based palliative care sessions of the 2016 NHPCO Management and Leadership Conference. Brandt offers feedback from several presenters who addressed key themes of developing community-based palliative care.

One theme she emphasizes is the growing importance of value-based care in the health care industry. She explains, “For hospice and palliative care providers, value-based care offers an opportunity to participate in networks that are responsible for delivering high-quality, low cost care.” One presenter at the conference, Dr. Reed Tuckerson, points out that hospice and palliative care meet all three objectives for improvement that have been identified by the Institute for Healthcare Improvement (IHI), which position them well to grow in this new environment. The three objectives of IHI are “improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.” Hospice and palliative care, however, need to demonstrate outcomes based on data.

A second issue Brandt shares is the fact that “palliative care activities are invisible to payers.” Brandt praises Brian Cassel and his knowledge of this issue. Because Medicare does not offer reimbursement for palliative care, and because there is no single CPT code, providers cannot easily compare the cost of palliative care to usual care. **Cassel argues that palliative care providers must work harder to make palliative care more obvious in the data.** “‘As a field we need to do more to solve the issue with identifying palliative care in the data.’ The biggest challenge for programs seeking reimbursement for non-hospice palliative care is demonstrating that palliative care can lower costs and improve patient outcomes.”

There is an increasing focus on the health of populations, and this topic came up in sessions and comments at the conference. Put simply, hospice and palliative care need to be “at the table in order to be seen as one of the solutions to improving the health of populations.” “Greer Myers, President of Turn-Key Health, presented a unique visual depiction of the evolution of end-of-life care,” and Brandt shares it in her blog.

Risk-sharing agreements are important. Brandt points out that palliative care on a fee-for-service basis is not sustainable for providers or payers. It doesn’t allow payers to control the cost or quality of care. **Risk sharing agreements between providers and payers may address some**

of these issues by allowing “the provider to receive more comprehensive payment that covers ... costs for an interdisciplinary palliative care service for a defined population of patients.” Again, it is clear that data is central to proving the value of palliative care.

In closing, Brandt explains, “The difficulty of demonstrating the efficacy of community-based palliative care, combined with the lack of a funding stream that can support it, explains why it is taking so long for community-based palliative care.” The transition to value-based care is happening quickly, says Brandt. **If hospices and palliative care organizations do not make the transition quickly to value-based models, other providers will.** *The KB Group*, 04/27, <http://www.the-kb-group.com/-!CommunityBased-Palliative-Care-It's-Time-to-Just-Go/o1vab/5720e5760cf269c350f18e8e> www.the-kb-group.com/#!CommunityBased-Palliative-Care-It's-Time-to-Just-Go/o1vab/5720e5760cf269c350f18e8e)

FORTY-FOUR EXPERTS WEIGH IN ON ISSUES OF AGING

The number of Americans over age 75 has grown from 4% to 6% of the population in the past few decades. *Senior Care* spoke to forty-four aging experts, asking them about the kind of care and challenges people encounter as they get older. Many more Americans will need long-term care, in one form or another, than those who expect that they will. Many have not considered their needs for care, and *Senior Care* challenges all to do so. According to their data, eighty-six percent of Americans will use informal caregivers, sixty-one percent will use home health care, half will use nursing homes, and nearly twenty percent will use assisted living. Almost three quarters of those who need long-term care have to pay the costs out of pocket. Medicare covers little of the cost, and few who need it qualify for Medicaid.

Senior Care asked four questions of each of the forty-four experts in long-term care and aging. The questions were: “Why is there a drastic difference in people's perception vs reality?” “What are the consequences for not being prepared?” “How would you close the discrepancy gap?” And, “What advice do you have for consumers about their future care needs?”

The experts seem to agree that people are often not dealing with the realities of caregiving needs as they age, because they are in denial about aging and what it means. There is also not a powerful motivator to plan until something hits close to home. Also, our health care culture is currently driven by crisis management rather than proactive and preventative care. Because of this lack of planning for long term care needs, care choices are often made by others, and may not align with the patient’s values and goals. Long-term care costs can wipe out life savings and even lead to bankruptcy.

More public awareness and a change in the culture around aging can help address this gap in planning. More media attention and the removal of stigma attached to aging would also help. If people are able to become their own advocates, they can hopefully set up the kind of care they would like and can afford ahead of time. Data, and the responses of each of the 44 persons interviewed, are available online. As for consumers themselves, they are advised to be their own advocates, talk with family about long-term care plans, and build a team of advisors. (*Senior Care*, 04/2016, www.seniorcare.com/featured/misconception-on-aging/)

HOSPICE NOTES

* **American Academy of Hospice and Palliative Medicine is asking its members to contact their Congressional representatives about supporting the Hospice Commitment to Accurate and Relevant Encounters (CARE) Act, H.R. 2208.** If passed, this bill “would allow timely provision of face-to-face encounters by expanding the types of professionals who can perform these required visits to include physician assistants and clinical nurse specialists.” It would also increase the time that hospice had to complete the face-to-face visit to seven days. (*American Academy of Hospice and Palliative Medicine*, 04/2016, cqrcengage.com/aahpm/app/write-a-letter?0&engagementId=102593)

* **In a multipart article series, *The Kansas City Star* covers the experiences of hospice nurses and their patients.** They consider the experiences of people who choose hospice, and the lives of those who feel called to it as a profession. (*The Kansas City Star*, 04/23, www.kansascity.com/news/local/article73547107.html; *The Kansas City Star*, 04/25, www.kansascity.com/news/local/article73750322.html)

* **Writing about patient-centered care for patients with kidney disease, the authors of an article in *Nephrology News and Issues* encourage doctors to consider the patient’s values and goals when making plans for care.** They articulate three best practices in this regard: “Nurture a shared decision-making relationship, provide meticulous pain and symptom management, and provide or collaborate with supportive care or hospice in the treatment of seriously ill kidney disease patients. As renal professionals, it may never be ‘easy’ to face these issues with patients, families, and caregivers; however, applying these best practices will help in providing quality supportive, end-of-life care to patients.” Specifically, they encourage providers to appropriately work with hospices. (*Nephrology News and Issues*, 04/26, www.nephrologynews.com/providing-supportive-care-to-patients-with-kidney-disease/)

END-OF-LIFE NOTES

* **Art Caplan, from the Division of Medical Ethics at the New York University Langone Medical Center, encourages doctors to talk to their patients about end-of-life issues more frequently.** He points out that patients are just as uncomfortable and uncertain as doctors are, but says that this is a topic that everyone needs to talk about. The most important thing, he says, is that doctors need to remind their patients that these conversations are open-ended and that they should continue to talk about end-of-life care as their health changes. (*Medscape Multispecialty*, 04/26, www.medscape.com/viewarticle/862186)

* **A study published in *Neurology* found that “less than half of stroke patients who were hospitalized and died within 30 days had their preferences for lifesaving measures recorded.”** Those who had a severe stroke were more likely to have their preferences documented. Most who did went through the process within five days of their death. (*Reuters*, 04/21, www.reuters.com/article/us-health-stroke-care-preferences-idUSKCN0XI2M3)

* **An article in *California Healthline* is titled “Aid-in Dying: Not So Easy.”** The article reminds readers that California law on physician-assisted dying, which goes into effect on June

9, has “a long list of administrative hurdles that both patients and their doctors must clear.” The author explains several details in the law. No patient, physician, or healthcare facility is required to participate in the program. A patient can reverse the decision at any time. The medications are expensive and may not be covered by the patient’s insurance policy. The article includes numerous links to resources. (*California Healthline*, 4/29, <http://californiahealthline.org/news/aid-in-dying-not-so-easy/>)

* Haider Javed Warraich, MD, is a fellow in cardiology at Duke University Medical Center. **Warraich has written a book, to be released in early 2017, titled “Modern Death – How Medicine Changed the End of Life.”** Warraich writes in *New York Times* about the need for change in the way the medical system deals with death and dying. As a new father, he reflects on the joy of caring for children. But how we treat older persons is very different. “Not only do we siphon off old people to live outside of our immediate circles, but images of what the end looks like are scant, uncelebrated and frequently morbid,” says Warraich. “There is a significant disparity of empathy toward children versus the elderly. Children’s shortcomings turn into viral YouTube videos, while those of the elderly are often derided and ridiculed by the very people charged with taking care of them.” (*New York Times*, 4/29, http://well.blogs.nytimes.com/2016/04/29/a-life-lesson-in-my-baby-daughters-eyes/?_r=0)

PALLIATIVE CARE NOTES

* **Dr. Kenneth Lin, writing on *KevinMD*, says that the National Pain Strategy, and all the other federal work to address the opioid crisis, may fail because they do not address the question of why so many Americans are experiencing chronic pain.** Lin presents evidence that high levels of income insecurity increase the likelihood of chronic pain and lower pain tolerance. He encourages doctors to ask about patients’ financial stress so that they can better treat chronic pain. Lin says, “Well-intentioned government efforts to stem the tide of opioid overdoses may flounder without explicitly addressing the social determinants of pain.” (*KevinMD*, 04/21, www.kevinmd.com/blog/2016/04/is-the-governments-national-pain-strategy-doomed-to-fail.html)

* **Colleen Barry, professor at the Johns Hopkins Bloomberg School of Public Health, argues that legalizing medical marijuana decreases opioid overdoses.** Drawing from death certificate data, she says, “The annual rate of opioid overdose deaths decreased substantially - by 25 percent on average - following the passage of medical marijuana laws, compared to states that still had bans.” She cautions that the causal relation between these two things is not clear, and that the research was done before the spike in opioid and heroin use. Nevertheless, she finds the research promising. (*The New York Times*, 04/26, www.nytimes.com/roomfordebate/2016/04/26/is-marijuana-a-gateway-drug/overdoses-fell-with-medical-marijuana-legalization)

* **Bishop Richard Pates in Des Moines, Iowa, has announced that he supports the legalization of medical marijuana in the state.** In a letter to *The Des Moines Register*, Pates says, “I believe now is the time to help suffering Iowans and their families get access to this medicine.” (*The Des Moines Register*, 04/25, www.desmoinesregister.com/story/news/politics/2016/04/25/catholic-bishop-lends-support-

OTHER NOTES

* **The new book, “Unraveled: Prescriptions to Repair a Broken Health Care System,” is authored by physicians William B. Weeks and James N. Weinstein.** They examine “the health care experience through the eyes of patients and families, and prescribe practical, effective remedies for a dysfunctional system.” They offer “simple steps that patients can take now to ensure that their care is effective, efficient, and satisfying, and that they have the information necessary to make the best health care decisions for themselves and their families.” (*VTDigger*, 04/26, vtdigger.org/2016/04/26/dartmouth-hitchcock-authors-unravel-the-problem-of-modern-health-care-delivery/)

* **Cancer survivor Martha Garcia writes that patients need to be their own advocates for the care they want.** She says patients should question their physicians thoroughly, and remember, “No question is too dumb, and there are never too many to ask.” She encourages patients to trust their gut and “if something doesn’t feel right, seek another opinion and hope that your doctor assists in the process.” (*QConline*, 04/26, www.qconline.com/life/be-your-own-health-care-advocate---do/article_2dc33f35-7a5a-5a2e-8056-8c2d1f51a7ff.html)

* **Colorado is considering a universal health-care proposal.** The ColoradoCare plan would eliminate deductibles and allow patients to choose any healthcare provider or specialist. According to an article in *The Seattle Times*, “Insurance groups, chambers of commerce and conservatives have lined up in opposition.” (*The Seattle Times*, 4/28, <http://www.seattletimes.com/nation-world/colorado-considers-universal-health-care-proposal/>)

* “Made out of 100% biodegradable material, the Bios Urn is a self-contained unit that allows you to place your loved one’s ashes into it and plant a tree in the soil.” (*Ripleys*, 4/12, <http://www.ripleys.com/blog/bios-urn/>)

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