
HOSPICE NEWS NETWORK

Recent News on End-of-Life Care

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CMS RELEASES 2017 HOSPICE PAYMENT AND POLICY CHANGES

CMS has released “Final Fiscal Year 2017 Payment and Policy Changes for the Medicare Hospice Benefit (CMS-1652-F).” The proposed rule was issued in April 2016 and open for comments. The final rule, says CMS, provides “a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing for the FY 2017 Hospice Payment Rate Update.”

According to CMS, **“This final rule updates the hospice wage index, payment rates, and cap amount for FY 2017. In addition, this rule finalizes changes to the hospice quality reporting program, including the addition of two new quality measures. The final rule also describes a potential future enhanced data collection instrument, as well as plans to publicly display quality measures and other hospice data beginning in calendar year (CY) 2017.”**

A key component of the final rule is a 2.1% increase of the hospital market basket payment rate. CMS also announced a change in the cap year, saying that the new cap year will be from October 1, 2016, through September 30, 2017. The cap amount will change to \$28,404.99.

One new quality measure focuses on “Hospice Visits When Death is Imminent.” This measure will quantify visits that “hospice staff make to patients and caregivers during the last three and seven days of life.” **The second measure, “Hospice and Palliative Care Composite Process Measure, will assess the percentage of hospice patients who received care processes consistent with guidelines.** This measure will be based on the seven that are currently being submitted under the Hospice QRP (Pain Screening, Pain Assessment, Dyspnea Screening, Dyspnea Treatment, Patients Treated with an Opioid who are given a Bowel Regimen, Treatment Preferences, and Beliefs/Values Addressed (if desired by patient).”

“The final rule also describes a potential future enhanced data collection instrument as well as plans to publicly display quality measures and other hospice data beginning in the middle of 2017, and includes information regarding the Medicare Care Choices Model (MCCM).” The current Hospice Item Set (HIS) will be enhanced to become a “comprehensive patient assessment instrument, rather than the current chart abstraction tool.” **CMS also said that they expect a “2.1 percent (\$350 million” increase in Medicare payments for FY2017.”** And, says the final rule, “The overall economic impact of this final rule is estimated to be \$350 million in increased payments to hospices during FY 2017.”

The final rule will be published in *The Federal Register* on August 5, and takes effect on October 1. **The final rule pre-publication is available now at the first link below.** (*CMS Final Rule*, 7/29, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-18221.pdf>; *CMS*, 7/29, <https://www.cms.gov/Center/Provider-Type/Hospice-Center.html>; <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-18221.pdf>)

COPING STRATEGIES OF PATIENTS WITH CANCER IMPACT END-OF-LIFE QUALITY

Patients employ a variety of coping strategies after receiving a terminal cancer diagnosis. **According to a new study published in the journal *Cancer*, certain types of coping are far more likely to produce positive outcomes for patients than others. Those who leaned on strategies based in emotional support and acceptance experienced more positive end-of-life experiences, while those who turned to denial and self-blame had a more difficult time.**

The study evaluated outcomes based on the self-reported quality of life (QOL) and mood of patients, correlated with the coping strategies they employed. It “examined associations between coping strategies, QOL, and mood in 350 patients who were part of a randomized trial of palliative care. Assessments were made within 8 weeks of receiving a diagnosis of incurable lung or gastrointestinal cancer.”

Most patients reported that emotional support and acceptance were their major strategies for coping with the diagnosis of terminal cancer. But “a concerning proportion” reported using self-blame and denial as their primary coping tools. **“The use of acceptance coping strategies correlated with lower anxiety and depression scores, whereas denial and self-blame coping strategies were associated with higher anxiety and depression scores.”**

Authors of the study hope that by better understanding what coping strategies patients use – and what outcomes they typically produce – clinicians will be in a better position to support patients during treatment. Specifically, physicians can offer greater psychological and supportive care services, as well as encouraging the use of more positively adaptive coping strategies.

Ultimately, the study indicates, there may indeed be “correct answers” in terms of coping choices – at least from the perspective of quality of life and general outlook at the end of life. For the sake of psychological and spiritual health, clinicians may consider how to promote these positive coping mechanisms, and to discourage their more destructive counterparts. (*Medscape*, 7/25, www.medscape.com/viewarticle/866563; *Cancer*, 7/1, onlinelibrary.wiley.com/doi/10.1002/cncr.30025/abstract;jsessionid=891DD9B8276CCC1B6E0E7A412D67BB0E.f04t04)

GERIATRIC EMERGENCY ROOMS EMERGE AS ALTERNATIVE FOR ELDER CARE

What comes to mind when you hear the words “emergency room”? Loud beeping from

machines, rushing nurses, and moans from patients needing urgent care. **Often, however, it is a place for elderly patients requiring urgent care.** “It’s like a war zone,” says physician assistant Emmy Cassagnol. “When it gets packed, it’s overwhelming. Our sickest patients are often our geriatric patients, and they get lost in the shuffle.” **But now, at Mt. Sinai Hospital, there is an alternative to the hectic traditional ER. A smaller, quieter, geriatric ER is designed specifically with the needs of elderly patients in mind.**

Packed emergency rooms can be challenging for anyone, but they’re often particularly perilous for older patients, who frequently enter the hospital with multiple chronic conditions, in addition to the presenting life-threatening crisis that brought them in. “Who is going to suffer the most from these crowded conditions?” asked Ula Hwang about the average ER. Hwang is associate professor in the emergency medicine and geriatrics departments at the Mount Sinai School of Medicine. “It is going to be the older adult... the poor older patient with dementia lying in the stretcher with a brewing infection that is forgotten about because it’s crazy, chaotic and crowded.”

Geriatric emergency rooms are a response to the realization that older patients have special needs that simply aren’t being met by traditional emergency rooms. Many elderly patients who come to the ER end up getting subjected to needless tests that stress their already weakened systems. They tend to have longer stays, and their diagnoses are less accurate than those of younger patients. Geriatric emergency rooms focus on the specific characteristics of elderly patients, and are able to provide better outcomes overall.

Geriatric ERs also have the potential to lower health costs, by avoiding unnecessary treatments and mistreatments that can lead to further poor health and complications. **Geriatric ERs are geared towards doing the important discernment of who would be best served in the hospital, and who would do better with outpatient treatment or in-home care.** “Emergency departments are the perfect places to make changes that could help control spending, because they are gateways between home and costly hospitalizations.”

This new form of emergency treatment is growing quickly as hospitals try to keep up with the boom in elderly patients who have complex conditions and are seeking care in traditional ER settings. The geriatric ER varies widely from hospital to hospital. In some, it is merely a special section of the traditional emergency room, while at other hospitals it is a semi-independent facility all to itself, with specially trained staff. “The first geriatric ER opened in New Jersey in 2008, and now there are more than 100 such units nationwide. Several others are being planned, including in California, North Carolina, Connecticut and Texas.” Geriatric emergency rooms are also being spurred by parts of the Affordable Care Act, because hospitals are sanctioned if they have many patients returning to the hospital too soon after treatment.

This form of elder care has the potential to become even more important over time, as the need for specialized care grows. The number of elderly patients treated in emergency rooms has increased from 15.9 million in 2001 to about 20.4 million patients in 2011, according to the most recent national hospital survey conducted by the Centers for Disease Control and Prevention. These numbers are expected to continue growing for the foreseeable future. (*CNN*, 7/27, www.cnn.com/2016/06/27/health/geriatric-emergency-rooms/index.html)

HOSPICE AND END-OF-LIFE NOTES

* **People** magazine featured a story about “The INN Between, a unique hospice in Salt Lake City that is providing terminally ill homeless people with peace of mind. “Society has turned its back on these people... We spend more time and money on homeless pets living at animal sanctuaries than we do on people living on the streets. They’re not homeless people, they’re abandoned people. At their end of their lives, they deserve a little peace of mind.” (*People*, 7/27, www.people.com/article/the-inn-between-hospice-for-homeless-people-utah; *The INN Between*, <http://www.theinnbetweenslc.org/>)

* “Federal health officials have given a green light to a hospice provider’s proposal to make supplemental payments to skilled nursing facilities for dual eligible patients,” says an article in *McKnights*. “The payment arrangement, proposed by an unnamed nonprofit hospice provider, would have the hospice pay nursing facilities directly for hospice patients eligible for both Medicare and Medicaid, in addition to payments the facility receives from a state managed care organization.” This action would ensure, says the article, “The nursing facilities would receive the same amount of payment they would have if a patient had not elected hospice care, the provider said. The arrangement would also take away incentives for facilities to provide a lower level of care to hospice patients, or discourage patients from electing hospice.” In its advisory opinion, says the *McKnights* article, the OIG “said the proposal was acceptable even though the arrangement could potentially violate anti-kickback laws.” The advisory opinion also clearly states that it applies only to the requestor of the opinion, and is not applicable to others. (*McKnights*, 7/28, [https://oig.hhs.gov/fraud/docs/advisoryopinions/2016/AdvOpn16-08.pdf](http://www.mcknights.com/news/hospice-can-pay-snfs-for-dual-eligibles-feds-say/article/512570/?DCMP=EMC-MCK_Daily&spMailingID=15067203&spUserID=NDI1OTM3MTEwNDES1&spJobID=822073375&spReportId=ODIyMDczMzc1S0; OIG, 7/20, <a href=))

* **Facing death is challenging. “Death doulas” are here to help with the transition.** “The work of a death doula... is primarily about presence. He is there to ease the passage from this world to the next. And he knows that the most valuable thing he can offer anyone taking that most solitary of journeys is his company. So he sits, silently wishing them peace and comfort.” (*Washington Post*, 7/22, www.washingtonpost.com/lifestyle/style/dying-is-hard-death-doulas-want-to-help-make-it-easier/2016/07/22/53d80f5c-24f7-11e6-8690-f14ca9de2972_story.html)

* **Are you ready to have “the talk” with your parents?** Of respondents to a recent survey, 54% reported that they would rather talk with their children about sex than have a conversation with their parents about end-of-life care. And almost a third don’t know what their parents’ wishes are for the end of life. (*Huffington Post*, 7/26, www.huffingtonpost.com/jody-gastfriend/senior-care_b_11057736.htmlDocument2)

* **Some employers are stepping up support for working caregivers.** “A new cloud-based technology platform promises to [provide support to working caregivers] by reducing the costs and complexity of caregiving for families and employers. Boston startup torchlight, known for supporting caregivers with children of special needs, recently launched a new digital service that will aid adults caring for their elder loved ones.” (*Benefit News*, 7/24, <http://www.benefitnews.com/news/how-and-why-some-employers-are-stepping-up-support-for-working-caregivers?feed=00000152-18a4-d58e-ad5a-99fc032b0000>)

* **A Democratic Party delegate in Massachusetts left hospice care in order to attend the Democratic National Convention.** For 63-year-old Etta Goodstein, politics are a way of life. (*WBUR*, 7/25, www.wbur.org/politicker/2016/07/25/clinton-delegate-dncDocument2)

* **14-year-old Jerika Bolen had a prom for herself before planning to enter hospice.** Jerika has decided to go off the ventilator that keeps her alive. Her story has been covered widely in national media. (*Huffington Post*, 7/25, http://www.huffingtonpost.ca/2016/07/25/jerika-bolen-prom_n_11182800.html; *Inside Edition*, 7/25, <http://www.insideedition.com/headlines/17711-girl-14-with-incurable-disease-has-final-dance-as-prom-queen-before-she-plans-toDocument2>)

* **An article in *Upworthy* explores the etiquette of posting on social media when someone has died.** Taya Dunn Johnson explains what she calls the “hierarchy of grief.” “While I can in no way speak for the entire planet, I certainly feel qualified to propose some suggestions — or, dare I say, rules — for social media grieving.” Her suggestions focus on being sensitive about timing of posts and being sure that close family and friends have had a chance to be notified. (*Upworthy*, 7/20, <http://www.upworthy.com/please-read-this-before-you-post-another-rip-on-social-mediaDocument2>)

* **Colorado’s HopeWest hospice has received new grant funding.** “HopeWest has been awarded a \$300,000 grant from the Colorado Health Foundation to develop a comprehensive advanced care planning initiative with the goal of increasing the number of Coloradoans who are actively engaged in their health by 4,000 people over the course of two years.” (*eHospice*, 7/26, www.ehospice.com/usa/ArticleView/tabid/10708/ArticleId/20056/language/en-GB/View.aspxDocument2)

* **How should nurses handle conversations with patients who want assisted suicide?** “It is important to recognize that, despite best efforts and optimal palliative care, patients may still desire and persist in their requests for assisted death. It is thus essential that nurses understand their own positions on end-of-life decision making and recognize appropriate resources to best optimize patient care.” (*Journal of Hospice & Palliative Nursing*, 6/2016, journals.lww.com/jhpn/Abstract/2016/06000/When_a_Patient_Discusses_Assisted_Dying__Nursing.3.aspx)

* ***The Journal of Palliative Medicine* features “A Survey of Home Hospice Staff Knowledge of Suicide Risk Factors, Evaluation, and Management.”** The article notes the variety that exists among hospice care providers in terms of knowledge and understanding of suicide. CNAs particularly need more training since they work most closely with patients. “Curriculum development efforts should focus on this group, and future research studies should examine the outcomes and determine whether the number of patients identified to be at risk for suicide increases after the educational intervention.” (*JPM*, 6/23, online.liebertpub.com/doi/abs/10.1089/jpm.2016.0127)

PALLIATIVE CARE AND OTHER NOTES

* **“Palliative care is not just for hospice patients,” but often times the two are conflated.** Jennfier Boen seeks to sort out the confusion. Palliative care referrals often come too late,

because of associations with death and dying. (*Next Avenue*, 7/20, www.nextavenue.org/confusion-palliative-vs-hospice-care/)

* **CMS has released the Overall Hospital Quality Star Rating on Hospice Compare.** “The Overall Hospital Quality Star Rating is designed to help individuals, their family members, and caregivers compare hospitals in an easily understandable way.” Learn more at CMS.gov. (*CMS*, 7/27, www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-27.html)

* **How can we leverage newly released hospital comparison data to improve palliative care?** “While the headlines are certainly going to focus on the number of well-known hospitals that received poor overall ratings... the real news for palliative care providers is the opportunity to present ‘the case’ for palliative care.” *The KB Group’s* blog provides ideas for how to best take advantage of this opportunity. (*The KB Group*, 7/27, <http://www.the-kb-group.com/#!/Leveraging-New-Hospital-Compare-Data-for-Palliative-Care/o1vab/5798ec6c0cf233f0ee88f123Document2>)

* **“There is a special bond between fellow cancer patients and survivors that is the deepest bond outside of a nuclear family that I have ever seen.”** Dr. Tom Marsilje is a 20-year oncology drug discovery scientist with “currently incurable” stage IV colon cancer. In an article for *Philadelphia Enquirer*, Marsilje reflects on what it means to be a part of this very special “club” of cancer patients and survivors. (*Philadelphia Enquirer*, 7/26, www.philly.com/philly/blogs/diagnosis-cancer/Band-of-brothers-and-sisters.htmlDocument2)

* **“The best answer for grief is to let it happen,” says local Ashland, Oregon, author Jack Wiens.** In his new book, *‘Tending Our Grief,’* Wiens says, “Grieving people need to be allowed to grieve fully, rant, rave, cry or go off by themselves. Grieving people will ride a long series of emotional waves, often feeling they’re going crazy, which is all very normal.” (*Daily Tidings*, 7/29, www.dailytidings.com/article/20160729/NEWS/160729814)

* **Caring for high-need, high-cost patients is an urgent priority, say Dr. David Blumenthal and co-authors in a perspective piece published in *The New England Journal of Medicine.*** “Improving the performance of America’s health system will require improving care for the patients who use it most: people with multiple chronic conditions that are often complicated by patients’ limited ability to care for themselves independently and by their complex social needs. Focusing on this population makes sense for humanitarian, demographic, and financial reasons.” **The Coalition to Transform Advanced Care (C-TAC) immediately responded with a letter to NEJM, applauding the review’s “urgent call to action as it validates our mission and reinforces our efforts to help some of the most vulnerable within this population.”** (*NEJM*, 7/27, www.nejm.org/doi/full/10.1056/NEJMp1608511Document2; *C-TAP Member Alert*, 7/29, <http://www.thectac.org/2016/07/c-tac-response-72816-new-england-journal-medicine-nejm-perspective-caring-high-need-high-cost-patients-urgent-priority/>)

* **For the first time, US rates for cremation have surpassed traditional burial rates.** Cremations rose from 10% in 1980 to almost 49%, last year, with traditional burials at 45%. One of the reasons, says an article in *Time* magazine, is that fewer Americans remain in the same location for the duration of their lives. The National Funeral Home Directors Association expects cremation to rise to 70% by 2030. (*Time*, 8/1, <http://time.com/4425172/cremation-outpaces->

burial-u-s/?xid=newsletter-brief)

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