

# You stay involved in your patient's care with Coastal Hospice

You are an important member of the hospice team. You can consult with a Coastal Hospice physician to develop the best individualized plan of care for each patient.

- You continue to bill for visits your patients make to your office.
- The Coastal Hospice physician is available to handle nights and weekends, if you prefer.
- Coastal Hospice physicians can serve as attending if you and the patient choose.

## Referral hotlines

*Monday - Friday 8 am-5 pm*      410-742-7878  
*After hours, weekends, holidays*      877-839-0497



*Coastal Hospice*  
& *Palliative Care*

# A physician's guide to end-of-life conversations with patients

Discussing end-of-life issues with patients and their families is not an easy conversation to have, but it's an important one. Most patients want to know the truth about their medical condition and how much time they have to live. At a time when everything seems to be out of control, knowledge can be power. Patients who know what to expect can make better decisions about the future and feel in control of their destiny.

Yet, these conversations are very difficult for the physician. How will the patient or family react? Will the talk become too emotional? Will the patient blame the doctor for "failing" to make him well? Will you know the right words to use?

While each physician will develop his or her own way of having these conversations, we offer here some pointers on how to begin. With practice, discussing end-of-life issues will become easier, and the physician will see a stronger bond develop with the patient.

The staff at Coastal Hospice can help with practical advice and emotional support for all parties.

1. Choose the right time and setting. Having a conversation in private and allowing enough time for it can be difficult to achieve, but worth the effort. The patient and family will need time to absorb the news. They will also have questions about what comes next.

2. Share information directly and simply without using a lot of medical jargon or technical terms. Make it as easy as possible for everyone to understand the situation, yet be gentle with the news.

3. Listen for the patient's and family's response and emotions, and don't do all the talking. They may lead the conversation down an unexpected path. They may already be prepared for the news or totally surprised, so being flexible is key.

4. Show understanding and empathy. It's okay to take off your clinical hat. A hand on a shoulder or squeeze of a hand can do wonders. Let them know you understand their reaction.

5. Talk about end-of-life care goals early and before a crisis occurs. Encourage the patient to discuss their end-of-life decisions with their family before they decline to a point of severe infirmity. It's harder to make rational decisions under stress.

6. Let them know their options for the future clearly and simply.

7. Show support after the conversation. Patients and caregivers need to absorb the reality of their situation. Coastal Hospice staff can help you.

8. Remember you are part of a team of Coastal Hospice staff including nurses, social workers and chaplains who can assist throughout the conversation and help with care and decisions afterwards.

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# Hospice care: Did you know?

*Coastal Hospice evaluates every case individually and would consider the following interventions for symptom management and comfort:*

- 1. PEG tubes, J tubes and NG tubes**
  - a. A normal part of hospice care for nutrition. (We don't recommend initiating artificial nutrition, but support it once it is in place.)
  - b. NG tubes are sometimes used for gastric suction.
- 2. Oropharangeal suctioning**
  - a. Can be set up at home, if necessary, as can liquid oxygen to deliver high liter flows.
  - b. C-PAP and Bi-PAP are accommodated.
- 3. IV fluids/TPN**
  - a. Provided at home and our inpatient unit.
  - b. Provided for comfort, usually at a low rate.
  - c. We prefer to use a modified TPN solution that is D10 500cc and 20% intralipids 500cc to run over 12 hrs. This formulation does not require daily labs.
- 4. Radiation**
  - a. May be covered depending on the goal of treatment and number of treatments (aggressive treatment or symptom management).
  - b. A single fraction of radiation can be as beneficial to a patient as multiple treatments.
  - c. One or two treatments may be authorized, but usually not a full regimen.
- 5. Chemotherapy**
  - a. May be covered depending on the goal of treatment and benefit/burden ratio (aggressive treatment or symptom management).
  - b. Depending on the agent and the side effect profile, limited intervention may be covered if approved by the hospice Medical Director.
- 6. Transfusions**
  - a. To manage symptoms: weakness, SOB, etc.
  - b. We typically do not draw routine labs or transfuse because of blood counts.
  - c. We will continue for symptom relief and improvement in quality of life as long as patient is benefitting and can tolerate well.
- 7. Physical therapy**
  - a. Our Physical Therapist evaluates patient, provides plan of care and makes follow-up visits to monitor patient's progress.
  - b. Physical Therapist teaches family and patient the exercises. Nurse and aide can help the patient perform the exercises.
- 8. IV antibiotics**

Can be provided for comfort and symptom management.
- 9. Code status**
  - a. Patients can be a full code and still have hospice. We will educate patient and family about the disease progression, and, with support and knowledge, they may make a different choice as the patient declines. If not, they will call 911.
  - b. Hospice cannot follow in the ICU.
- 10. Creative staffing**
  - a. Routine home care can include daily hospice aides and nursing care if the situation calls for it. In addition, social workers, chaplains, volunteers, and the patient's community of friends are engaged to provide additional daily visitation.
  - b. We have regularly managed patients living alone, and, if symptoms are out of control, they can be admitted to our inpatient unit.
- 11. Grant funds for needed extras**

We have generous grant funds to provide things outside the hospice benefit such as:

  - a. Wheel chair ramp rentals
  - b. Pest extermination (for house and/or pets)
  - c. LifeLine monitors
  - d. Baby monitors
  - e. Lock boxes
    - 1) for front door when someone can't always answer
    - 2) for medication management
  - f. A night of in-home respite care.

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# Hospice patient's rights

“A hospice patient has the right to be informed of his or her rights, and the hospice must protect and encourage these rights.”

~ *Hospice Medicare Conditions of Participation (CRF 418.52, Subpart C, 418.52)*

## What are Hospice Patient Rights?

A list of rights guaranteed to all hospice patients including what a hospice must provide to a person who is receiving hospice care.

## Where can I find Hospice Patient Rights?

The Medicare Conditions of Participation are issued as regulations set by the federal government agency, the Centers for Medicare and Medicaid Services. Hospices must follow these regulations, which include a section on patient rights.

## What do Hospice Patient Rights include?

Each hospice patient has the right to:

- Be treated with respect.
- Receive quality end-of-life care.
- Receive spoken and written notice of his or her rights and responsibilities in a manner they understand during the assessment meeting with hospice staff.
- Receive information on advance directives including a living will and healthcare surrogate.
- Voice concerns and not be discriminated against for doing so.
- Receive pain management and symptom control.
- Be involved in developing his or her hospice plan of care.
- Refuse care or treatment.

- Choose his or her attending physician.
- Have a confidential medical record.
- Be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse.
- Receive information about the services covered under the Hospice Benefit.
- Receive information about the services that the hospice will provide and any limitations on those services.

## What do Hospice Patient Rights mean to hospice providers??

- The hospice must inform each patient of his or her rights during the admission verbally and in writing.
- The hospice must talk about and provide written information about the organization's policies and advance directives, including a description of state law.
- The hospice must prove they have the reviewed the hospice patient's rights by asking for the patient's or caregiver's signature.

*Coastal Hospice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.*

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The National Hospice and Palliative Care Organization (NHPCO) is the largest membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 3,800 hospice programs that care for the vast majority of hospice patients in the US. NHPCO is committed to improving end-of-life care and expanding access to hospice so that individuals and families facing serious illness, death, and grief will experience the best care that humankind can offer.

The Hospice Action Network, an NHPCO affiliate and national hospice advocacy organization, is dedicated to preserving and expanding access to hospice care in America. Our mission is to advocate, with one voice, for policies that ensure the best care for patients and families facing the end of life.

We fight to ensure compassionate, high-quality care for all Americans facing a life-limiting illness by:

- Expanding an ongoing and influential presence on Capitol Hill,
- Mobilizing a growing network of Hospice Advocates throughout the nation,
- Empowering, through new and innovative techniques, an interactive community connecting the public with Hospice Advocacy, and
- Cultivating relationships with the media to highlight issues impacting end-of-life care.

# THE MEDICARE HOSPICE BENEFIT

The Medicare Hospice Benefit was established in 1983 to provide Medicare beneficiaries with access to high-quality end-of-life care. Considered the model for quality care for people facing a life-limiting illness, hospice is a patient-centered, cost-effective philosophy of care that utilizes an interdisciplinary team of healthcare professionals to provide compassionate care including expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Patients may receive care at their place of residence (including their private residence, nursing home, or residential facility), a hospice inpatient facility or an acute care hospital. 66% of patients choose hospice care where they reside.

**Table 1. Location of Hospice patients at Death**

Location of Death	2012	2011
Patient's Place of Residence	66.0%	66.4%
Private Residence	41.5%	41.6%
Nursing Home	17.2%	18.3%
Residential Facility	7.3%	6.6%
Hospice Inpatient Facility	27.4%	26.1%
Acute Care Hospital	6.6%	7.4%

**Figure 1. Interdisciplinary Team**



An interdisciplinary team of professionals is responsible for the care of each hospice patient.

Hospice focuses on caring, not curing. Under hospice, support is provided to the patient's loved ones as well.

## WHO RECEIVES HOSPICE CARE

A patient is eligible for hospice care if a physician determines that the patient has six months or less to live if the terminal illness runs its normal course. Patients must be re-assessed for eligibility at regular intervals, but there is no limit on the amount of time a patient can then spend under hospice care. In 2011, an estimated **1.65 million patients received services from hospice**. NHPCO estimates that 44.6% of all deaths in the U.S. were under the care of a hospice program.

**Figure 2. Hospice Utilization in the U.S. in 2011<sup>1,2</sup>**

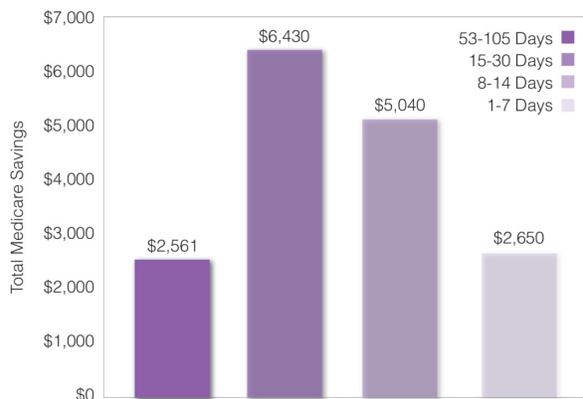


1. 2011, NHPCO National Data Set and/or NHPCO Member Database.  
 2. Hoyert DL, Xu J. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, vol 61 no6. National Center for Health Statistics, CDC, available online at: [http://www.cdc.gov/nchs/data/nvsr/61/nvsr61\\_06.pdf](http://www.cdc.gov/nchs/data/nvsr/61/nvsr61_06.pdf).

## HOSPICE RESULTS IN COST SAVINGS FOR MEDICARE

New research out of Mount Sinai's Icahn School of Medicine, published in the March 2013 issue of *Health Affairs*, found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries across a number of different lengths of services.

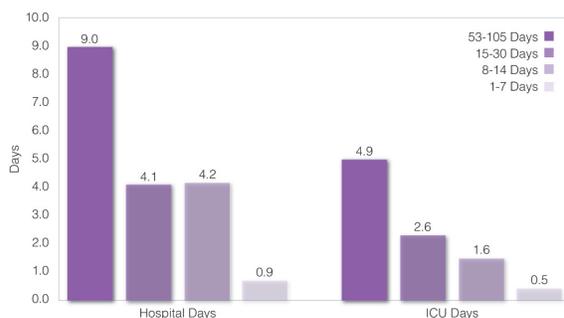
**Figure 3. Incremental Effect in Cost Between Hospice and Non-Hospice Groups<sup>3</sup>**



Among the key findings:

- Medicare costs for hospice patients were lower than non-hospice Medicare beneficiaries with similar diagnoses and patient profiles.
- Hospice enrollment is associated with fewer 30-day hospital readmissions and in-hospital deaths.
- Hospice enrollment is associated with significantly fewer hospital and ICU days.

**Figure 4. Incremental Effect in Days Between Hospice and Non-Hospice Groups<sup>3</sup>**



A 2007 Duke University Study published in *Social Science & Medicine*, shows that hospice care in America reduces Medicare program expenditures during the last year of life by an average of \$2,309 per hospice patient.<sup>4</sup>

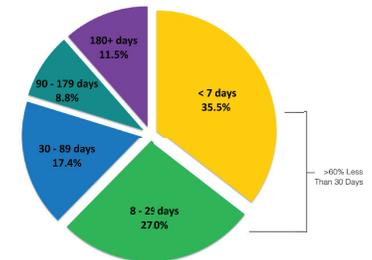
3. Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay," *Health Affairs* 2013; 32(3): 552-561.  
 4. Taylor DC, Osterman J, et al., "What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?" *Social Science & Medicine* 2007; (65): 1466-1478.

## LENGTH OF SERVICE

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay). LOS can be influenced by a number of factors including disease course, timing of referral, and access to care. **The median (50th percentile) LOS in 2012 was 18.7 days.** This means that half of hospice patients receive care for less than three weeks and half receive care for more than three weeks. **The average LOS is 72 days.**

Approximately 35.3% of hospice patients receive care for just seven days or less. 49.5% of patients die or are discharged within 14 days of admission.<sup>5</sup> Only 11.5% of patients remain under hospice care for longer than 180 days.

**Figure 5. Proportion of Patients by Length of Hospice Service<sup>6</sup>**



This high percentage of shorter LOS is consistent over the past several years.

## LEVELS OF CARE

Medicare pays hospice a flat, per-diem rate that covers all aspects of the patient's care, including all services delivered by the interdisciplinary team, drugs, medical equipment and supplies. 84.1% of hospice patients were covered by the Medicare Hospice Benefit in 2011, versus other payment sources.<sup>7</sup> While the number of beneficiaries using hospice has more than doubled since 2000, hospice comprises only 2 percent of total Medicare expenditures, the least of any direct patient service provider under the program.

Because patients require differing intensities of care during the course of their disease, the Medicare Hospice Benefit affords patients four levels of care to meet their needs: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. **95% of hospice care is provided at the routine home care level, which is reimbursed at approximately \$153 per day.**

**Table 2. Percentage of Patient Care Days by Level of Care**

Level of Care	2012	2011
Routine Home Care	95.0%	97.1%
General Inpatient Care	2.7%	2.2%
Continuous Care	0.5%	0.4%
Respite Care	0.3%	0.3%

5. 2012, NHPCO National Data Set and/or NHPCO Member Database.  
 6. Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay," *Health Affairs* 2013; 32(3): 552-561.  
 7. 2012, NHPCO National Data Set and/or NHPCO Member Database.

## MARGINS & MEDICARE EXPENDITURES

According to recent MedPAC data, the projected hospice margin for 2014 is 7.8%, or 6.1% once all statutorily mandated services are taken into consideration.<sup>8</sup> Note: This estimate does not include the 2% cut to reimbursements to Medicare providers as mandated by sequestration.

**Medicare spending on hospice rose to approximately \$15.1 billion in 2012<sup>9</sup>, which still comprises only about 2 percent of Medicare expenditures.** This growth in spending on hospice reflects several important factors, including greater awareness of hospice care, which has led to increased utilization of the Medicare Hospice Benefit. Additionally, hospices have grown as they are serving more patients with non-cancer terminal diagnoses such as heart disease, COPD and Alzheimer's.

## TAX STATUS

Hospice agencies are organized into three tax status categories:

1. Not-for-profit (charitable organization subject to 501(c)3 tax provisions)
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality)

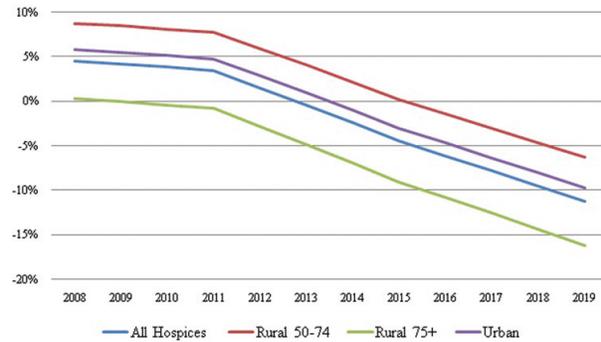
Based on NHPCO membership and survey data, 32% of providers hold not-for-profit tax status and 63% hold for-profit status. Government-owned programs, such as U.S. Department of Veterans Affairs medical centers and county-run hospices, comprise the smallest percentage of hospice providers at about 5%.<sup>10</sup>

## RECENT CHANGES: THE PRICE OF CARE

**Rate Cuts:** A 2009 CMS rule implemented a seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), a key element in the calculation of the Medicare hospice wage index. **Elimination of the BNAF will ultimately result in a permanent reduction in hospice reimbursement rates of approximately 4.2 percent.**

**The Affordable Care Act (ACA) further altered the Medicare hospice rate formula through the introduction of a "productivity adjustment factor," that will reduce annual hospice payments by an additional 11.8 percent over the next ten years.** Hospice is a highly labor-intensive model of care where productivity gains are not as achievable relative to other areas of our health care system. The Moran Company recently conducted an analysis of the impact of these two cuts on hospice margins over the next decade.

**Table 3. Moran Company Analysis - Estimated Median Profit Margins, 2008-2019 (All Hospices, Urban, and Rural Hospices)**



**Sequestration:** Sequestration reductions affect several areas of federal spending, including cuts to Medicare:

- Reductions of 2.0% each year in most Medicare spending, including hospice (total savings: \$123 billion)
- Reductions in premium support (resulting in increased beneficiary costs) for Medicare Part B and other spending changes (savings: \$31 billion)

**Table 4. Cumulative Rate Cuts Affecting Hospice**

Rate Cut	Amount	Timeline
Budget Neutrality Adjustment Factor	-4.2% overall	2011-2016
ACA Productivity Adjustment Factor	-11.8% overall	2013-2022
Sequestration	-2% per year	2013-2024

## RECENT CHANGES: REGULATORY REQUIREMENTS

Three Medicare hospice requirements around certification and recertification as well as medical review of patients have laid the regulatory groundwork to better ensure that hospice programs are serving only patients who are eligible and appropriate for hospice care. If given the proper time to be impactful and implemented correctly, these requirements should meet the goal of ensuring that appropriate and eligible patients are served by hospice, while also ensuring that hospice programs are able to provide the quality that patients and families desire at the end of life.

**Brief Physician Narrative:** Effective October 1, 2009, this Medicare requirement calls for the hospice certifying physician to provide a brief narrative statement to explain the clinical findings that support the certification and recertification of terminal illness. The intent is for the physician to record, in their own words, the reasons they believe each patient continues to be eligible for the Medicare Hospice Benefit in each benefit period.

**Face-to-Face Encounter:** Effective January 1, 2011, Medicare requires that after a hospice patient has completed the first two 90-day benefit periods, the patient must have a face-to-face visit with a hospice physician or nurse practitioner prior to being recertified for the third and any subsequent periods, in order to determine whether the patient continues to be eligible for hospice care.

8. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2014.  
 9. Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2014.  
 10. 1st Quarter 2012, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).