



# Hospice Care in Wyoming

Robert Monger, M.D., F.A.C.P.

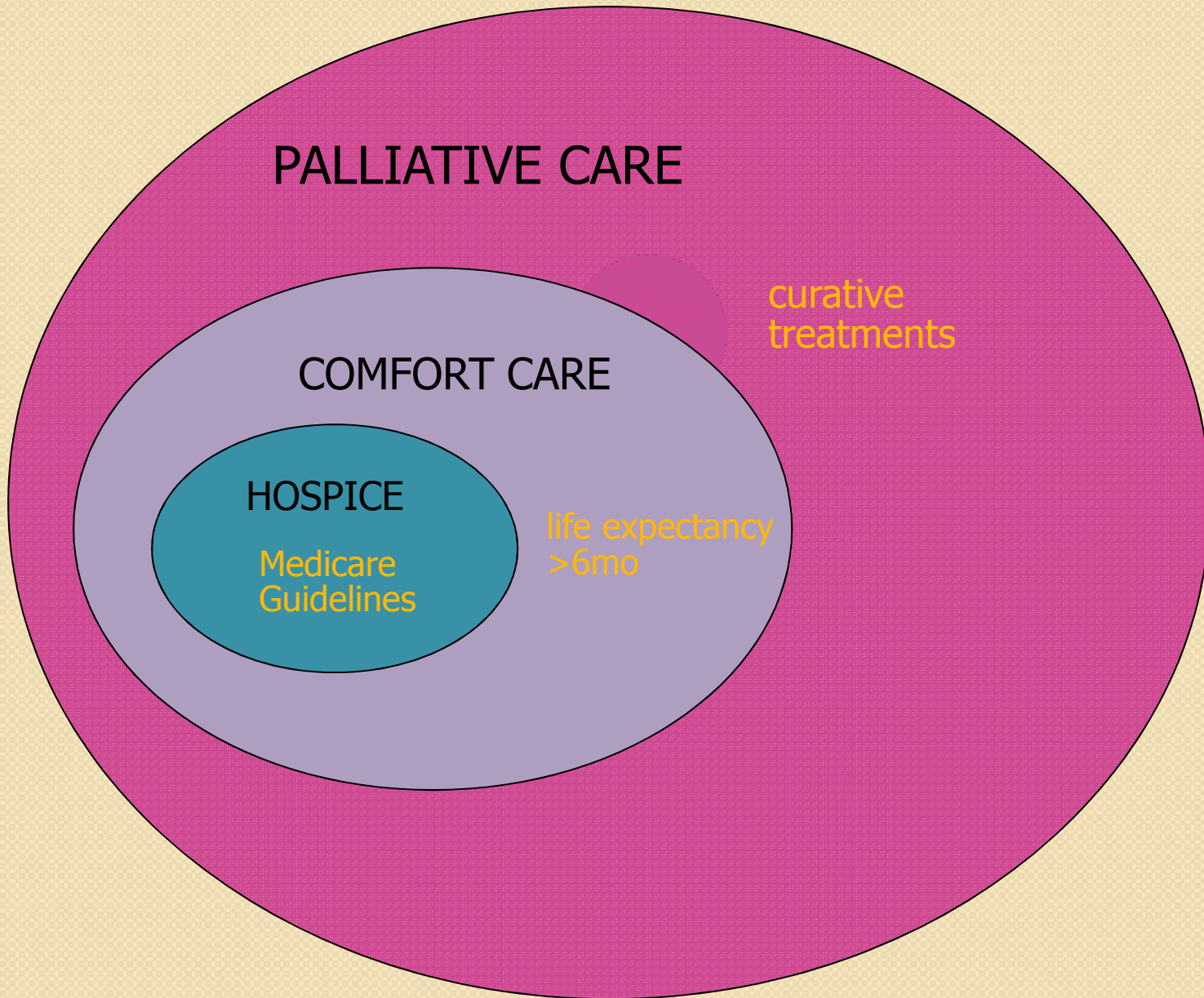
2014 Frontiers in Wyoming Medicine Conference

February 6<sup>th</sup>, 2014



# What is Hospice?

- Compassionate care for people facing a life-limiting illness or injury
- Team oriented approach: medical care as well as emotional and spiritual care
- Support is provided to the patient as well as to their families and loved ones
- Focus of hospice is on caring, not curing



PALLIATIVE CARE

curative  
treatments

COMFORT CARE

HOSPICE

life expectancy  
>6mo

Medicare  
Guidelines



# What is Hospice?

- Hospice services are available to patients of any age, religion, race, or illness.
- Typically family members serve as the primary caregivers with the support of the hospice team.
- Hospice care is covered under Medicare, Medicaid, HMOs, private insurance, etc.



# Hospice History: Europe

- Cicely Saunders began working with the terminally ill in the late 1940's
- She is generally credited with starting modern hospice care: she founded St. Christopher's Hospice (London) in 1967.
- Dr. Saunders key concept: treat the patient's "total pain" in a holistic way: physical, psychological, social, and spiritual.



# Hospice History: U.S.

- Cicely Saunders was a visiting faculty at Yale University in the 1960's
- 1969: "on Death and Dying" by Elizabeth Kubler-Ross published.
- 1972: Kubler-Ross testified at a U.S. Senate Hearing: "We live in a very particular death-denying society...we can give families and patients the spiritual, emotional and financial help to facilitate the final care at home".



# Hospice History: U.S.

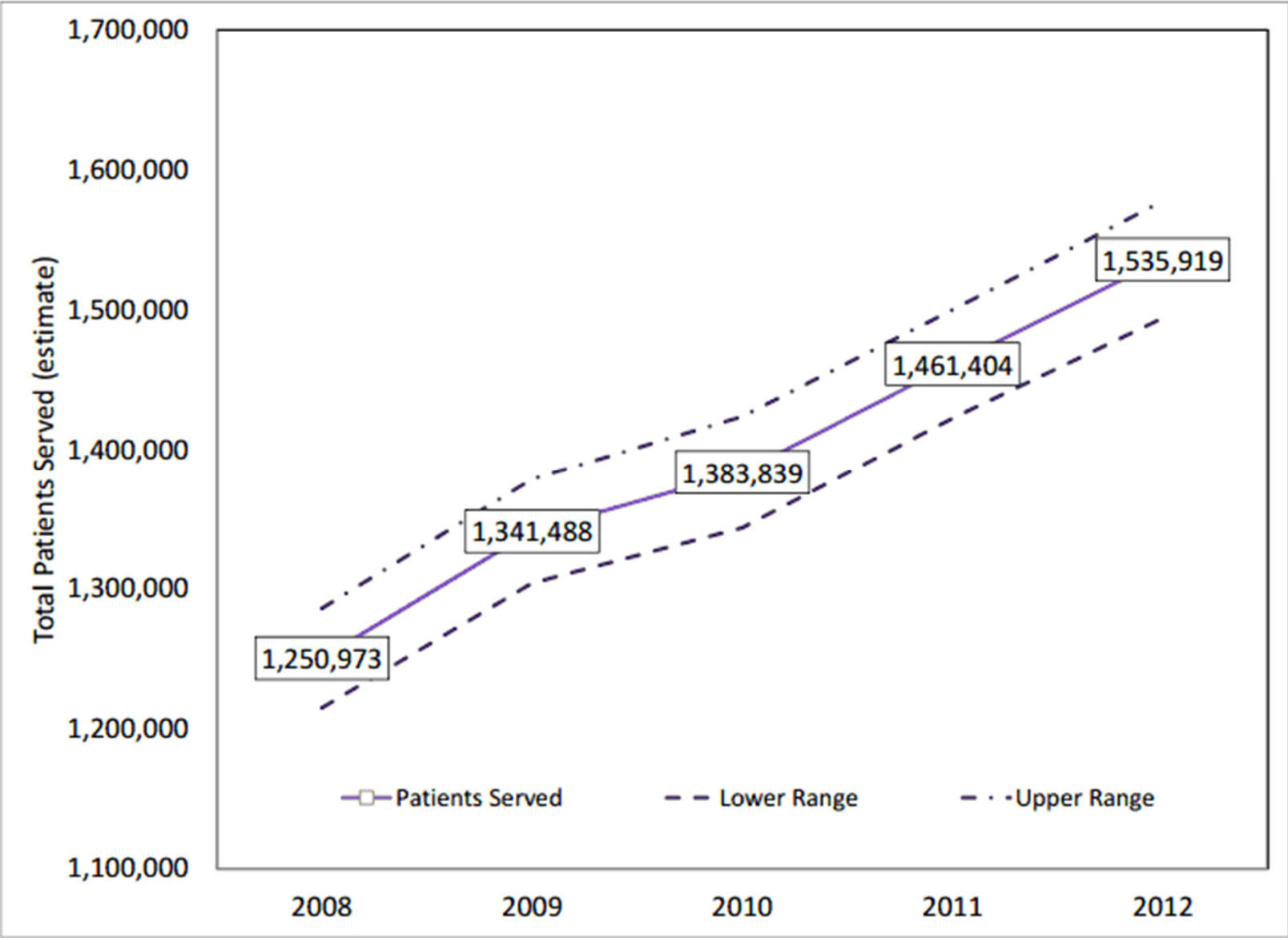
- 1974: The Connecticut Hospice in Branford Connecticut is founded.
- 1974: First federal legislation to provide federal funds for hospice programs is introduced (but defeated).
- 1982: Medicare hospice benefit is enacted.
- 1984: JCAHO initiates hospice accreditation.



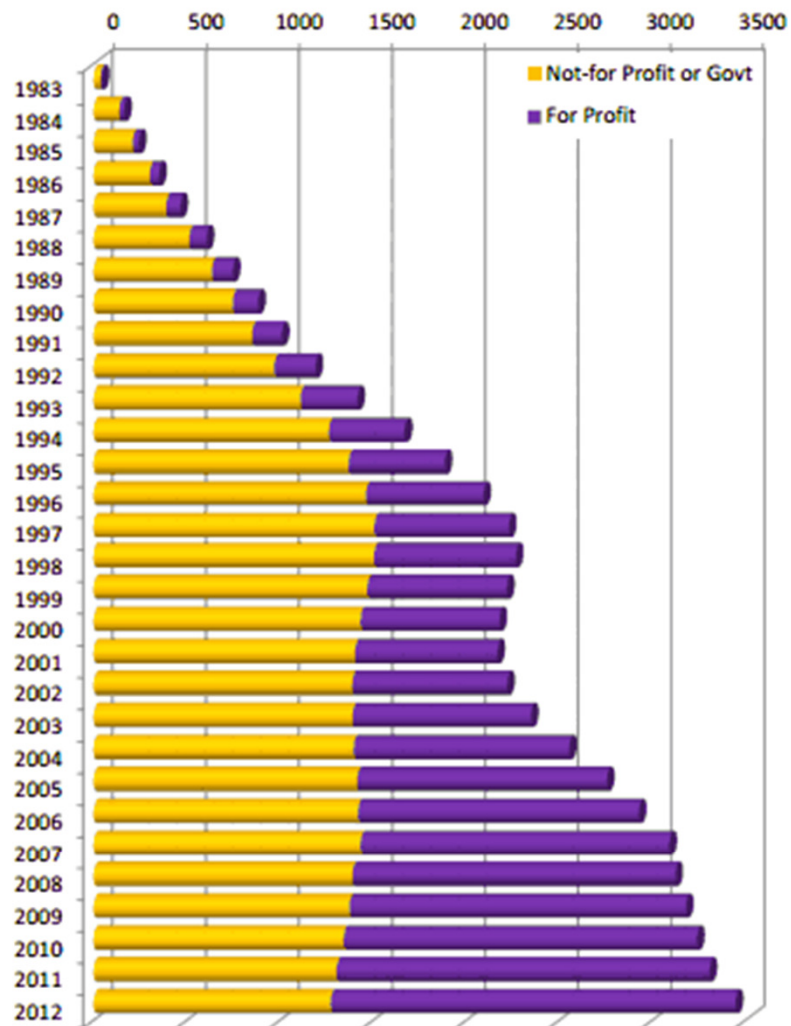
# Hospice Growth

- 1990: 76,500 Patients
- 2012: 1,535,000 Patients
- NHPCO estimated that 44.6% of all deaths in the U.S. were under hospice care in 2011.
  
- First U.S. Hospice opened in 1974
- 2012: 5,560 hospices (63% are For-Profit)





### Medicare Certified Hospice Providers



# Who Were the Hospice Patients in 2012?

- <24 years old: 0.4%
- 25-34: 0.4%
- 35-64: 15.7%
- 65-74: 16.3%
- 75-84: 27.7%
- 85+: 40.5%



## Who Were the Hospice Patients in 2012?

- 56% Female, 44% male
- Patient Race: 81% White/Caucasian, 8.6 % Black/African American, 0.3% American Indian or Alaskan Native
- Patient Ethnicity: Non-Hispanic/Latino origin: 93%, Hispanic/Latino Origin: 6.9%



## Location of Hospice Patients at Death in 2012:

- 41.5% Private Residence
- 27.4% Hospice Inpatient Facility
- 17.2% Nursing Home
- 7.3% Other Residential Facility
- 6.6% Acute Care Hospital



## Hospice Payer Mix 2012: Percentage of patient care days

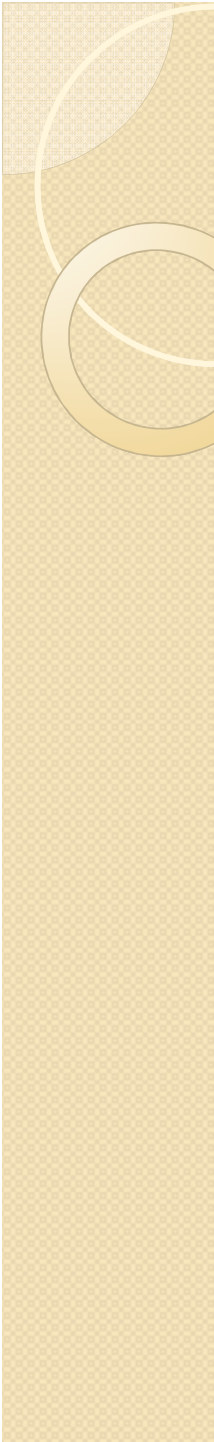
- Medicare: 89% (83% of patients)
  - \$13.8 Billion in 2011
- Private Insurance: 4.4% (7.6% of patients)
- Medicaid: 4.3% (5.5% of patients)
- Charity Care: 0.8% (1.2% of patients)
- Self Pay/Other: 1.5% (2.1% of patients)

### The Medicare Hospice Benefit, 1990–2010.\*

Variable	1990	2000	2010
Number of hospice users	76,500	513,000	1,159,000
Percent of patients who died while covered by Medicare who had used hospice	5.5	22.9	44.0
Length of hospice stay (days)			
Mean	67	54	86
Median	25	17	18
Percent of hospice users with noncancer diagnoses	16	49	69
Number of Medicare-certified hospice agencies	806†	2318	3555
Percent of hospice agencies that are for-profit	14.5†	32.6	53.9
Total hospice spending (\$)	309 million	2.9 billion	13 billion

\* Except where noted, data for 1990 are from the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, and data for 2000 and 2010 are from the Medicare Payment Advisory Commission. Dollars are not adjusted for inflation.

† The listed value is from the National Hospice and Palliative Care Organization.



## 2012 Percentage of Hospice Admissions by Primary Diagnosis:

- 36.9% Cancer
- 63.1% Non-Cancer Diagnoses:
  - Debility: 14%
  - Dementia: 13%
  - Heart Disease: 11%
  - Lung Disease: 8%





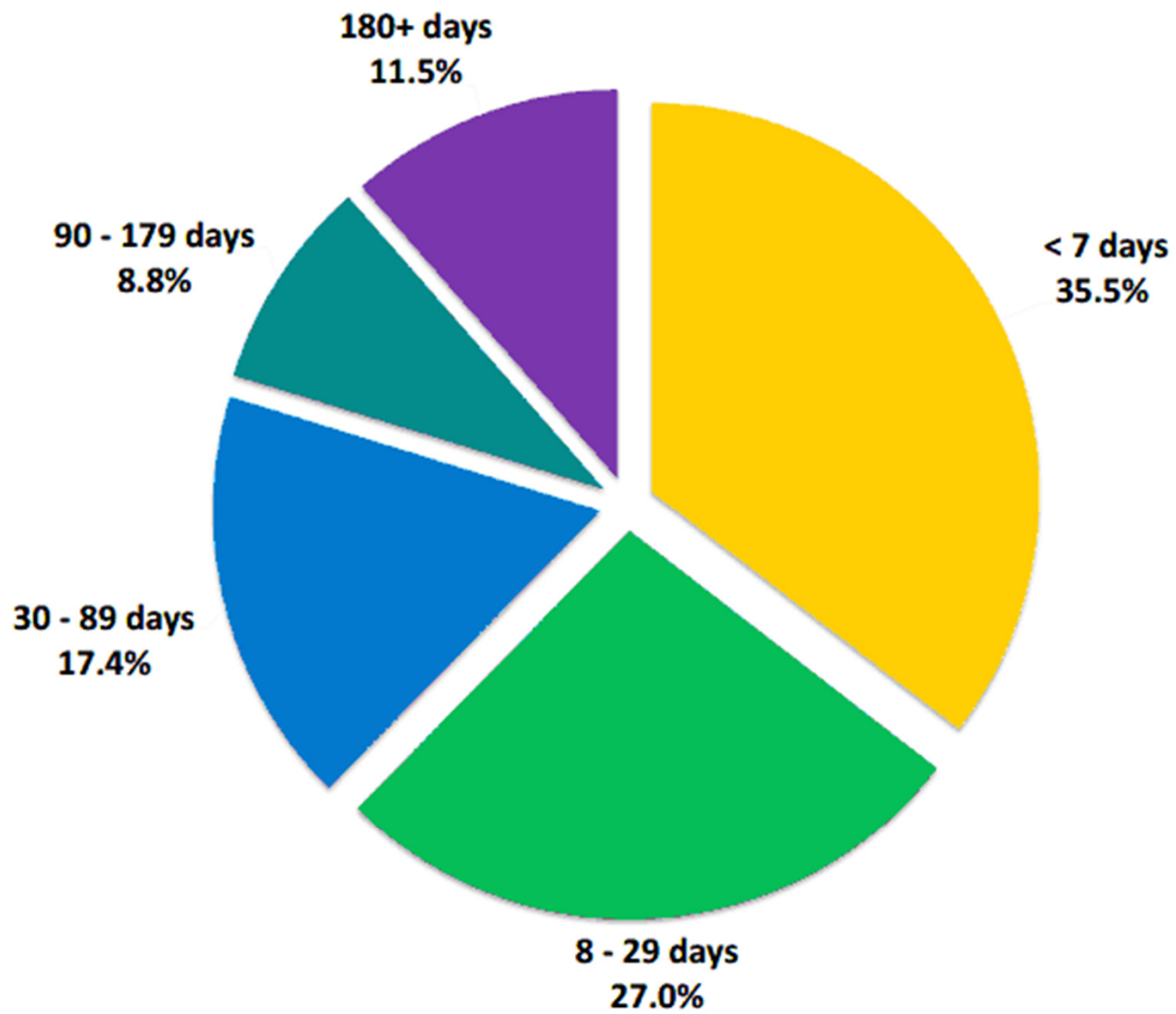
## 2012 Length of Service:

- Median Length of service: 19 days
- Average Length of Service: 72 days

Over the past several years the median length of service has declined while the average length of service has increased.

35% of patients had a length of stay 7 days or less

11.5% of patients had a length of stay >180 days





# Hospice Eligibility: General

- Any Patient with Any Terminal Illness
- Prognosis of less than 6 months to live



# Medicare Hospice Benefit

- Funded through Part A Medicare
- Hospice benefit covered 100% at no cost to patient (as long as services are related to the terminal diagnosis)
- To initially qualify for hospice two physicians certify diagnosis (generally a hospice physician and the patient's attending physician)
- The patient doesn't necessarily need to be DNR or have a primary caregiver



# End of Life Planning: Resources

- National Healthcare Decisions Day: April 16<sup>th</sup>, 2014
- NHDD.org
  - Advance Directive Documents
  - Resources for Family Conversations
  - Legal Resources (American Bar Assn.)
  - Organ Donation Information



# How is hospice paid for?

- Per Diem: around \$150/day for routine care
- ALL services are covered under the per diem: medications, durable medical equipment, nursing (social work, etc.), bereavement services, etc.
- Hospices must ration care



# Choosing Hospice

- For patients to receive hospice services, they must opt out of regular Medicare coverage for medical care of their terminal diagnosis
- This means that the patients must choose between curative care and hospice care



## Choosing Hospice: “Limited Role for Disease-Modifying Treatment”

- Chemotherapy
- Radiation therapy
- Surgery
- Blood Transfusions
- Parenteral Hydration/TPN
- Enteral Feeding (Tube Feeds)
  
- “Late Referrals”





# Does Hospice Save Money?

Duke University Study (Taylor, et al., Soc Sci Med 2007 Oct;65 (7) 1466-78):

- Hospice reduces Medicare costs by an average of \$2309 per hospice patient
- Medicare costs would be reduced for 7 out of 10 hospice recipients if hospice were used for a longer period of time
- For cancer patients hospice use decreased Medicare costs up until 233 days of hospice care
- For non-cancer patients there were cost savings seen up until 154 days of hospice care



# Structure of Benefit

- Initially: two 90 day certification periods

Then: Unlimited 60 day periods as long as the patient continues to meet eligibility criteria

- Patients can transfer from one hospice to another, and can opt-out of hospice at any time and go back to regular Medicare coverage



# Hospice Eligibility

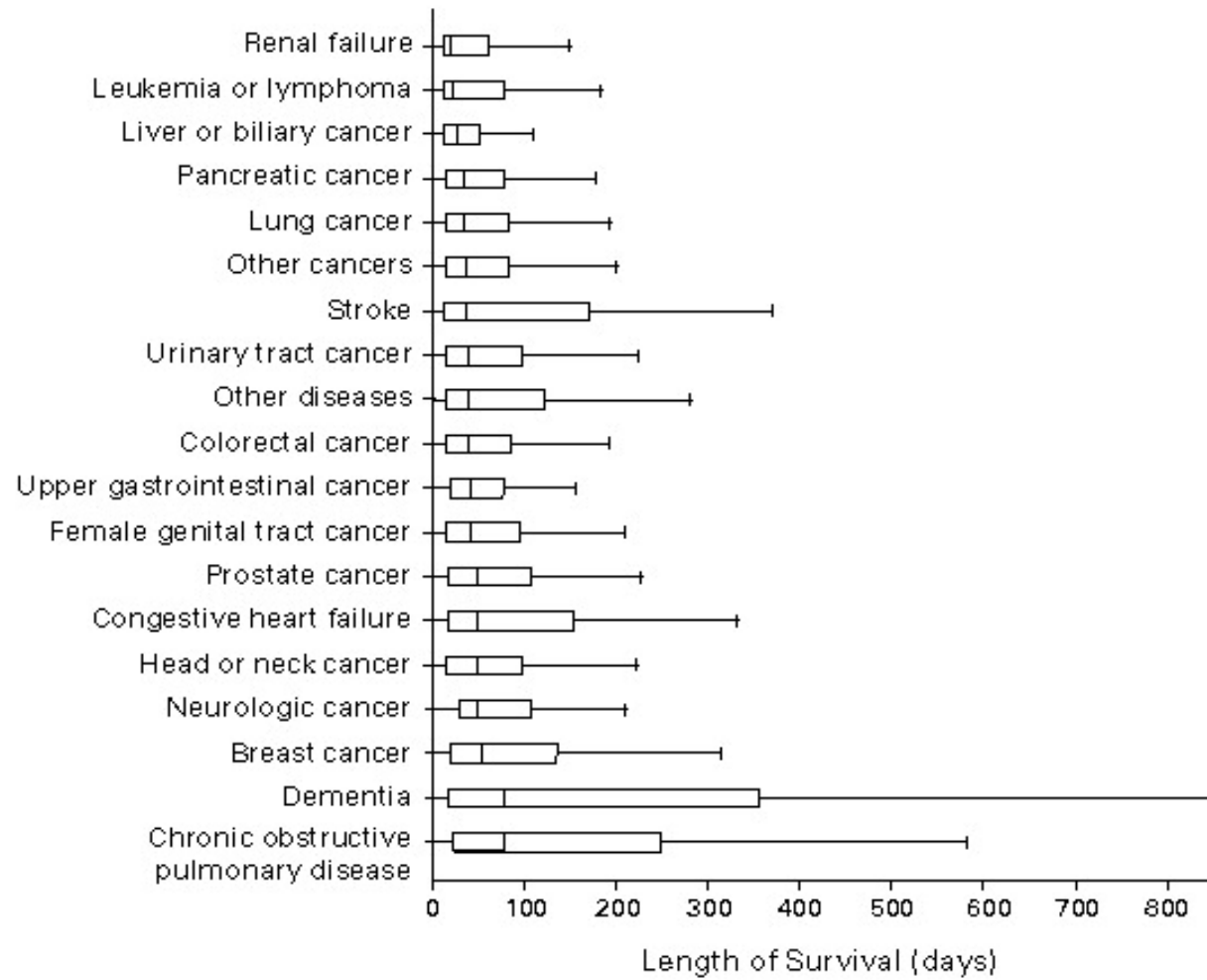
The patient needs to have a prognosis of 6 months or less if the disease runs its normal course

- How often is normal? 100% of the time, 51% of the time, or somewhere in between?
- Medicare has still not defined this, but it is the law



## Prognosis: The Future is Hard to Predict

- How do you predict prognosis?
- Disease-specific guidelines
- Karnofsky Performance Scale
- Vitas App (Free in the iTunes store)
  
- Some diseases are predictable, some are not

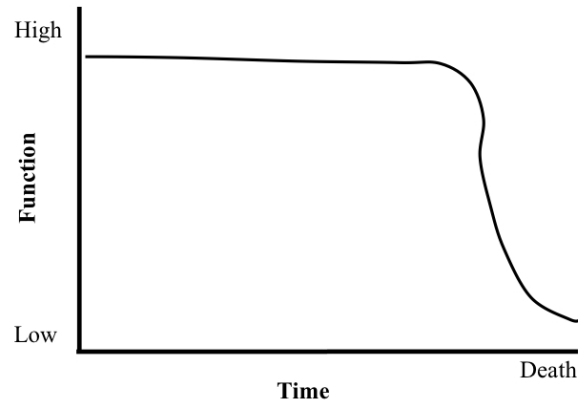


**Christakis NA, Escarce JJ. N Engl J Med 1996;335:172-178.**

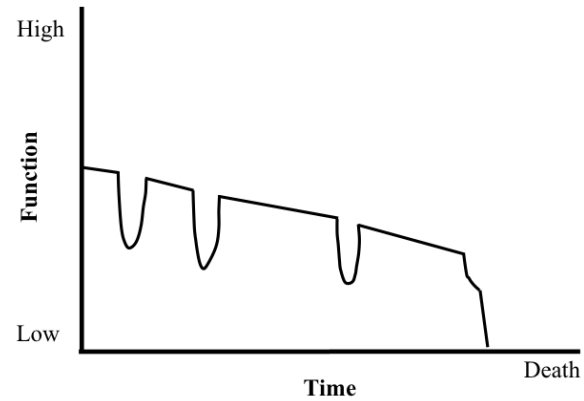
# IOM Report (1997)

## Approaching Death: Improving Care at the End of Life

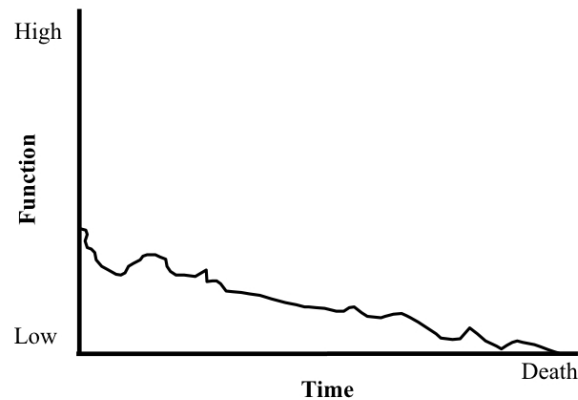
1. Short Period of Decline



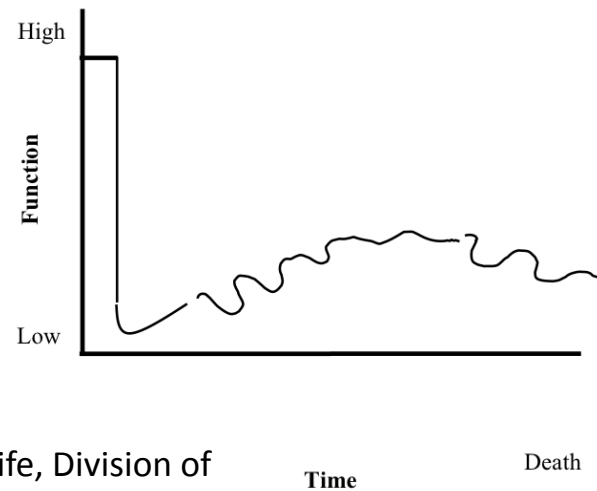
2. Chronic Illness with Exacerbations



3. Prolonged Dwindling



4. Sudden Neurological Impairment



Field M, Cassel C. Committee on Care at the End of Life, Division of Health Care Services, Institute of Medicine. Washington, D.C., 1997

## Medicare Hospice Eligibility Guidelines for Selected Diagnoses.\*

### **Alzheimer's disease**

Eligibility is based on Reisberg Functional Assessment Staging (FAST), stage 7 or greater. Stage 7 is defined by the following criteria:

- need for assistance with at least three activities of daily living
- increased frequency of incontinence of bowel and bladder
- ability to speak only six or fewer intelligible words in the course of an average day

In addition to the FAST criteria, the patient must have one of the following:

- a history of upper urinary tract infection, sepsis, or pneumonia within the past 12 months
- multiple stage III or IV decubitus ulcers within the past 12 months

If the patient meets neither of the two preceding criteria, the patient must show nutritional decline, as evidenced by one of the following:

- unintentional progressive weight loss of 10% of body weight over the past 6 months
- a serum albumin level of <2.5 g/dl

### **Pulmonary disease**

Eligibility is based on severe chronic lung disease, as defined by the following criteria:

- disabling dyspnea at rest and poor response to bronchodilators, resulting in decreased functional capacity
- disease progression reflected in increased emergency department or physician visits or by increased hospitalizations
- hypoxemia at rest — oxygen saturation  $\leq 88\%$  with patient breathing ambient air

### **Heart disease**

Eligibility is based on New York Heart Association classification of class IV, as defined by the following criterion:

- inability to carry out any physical activity without discomfort (documentation of an ejection fraction of <20% is helpful but not required)

In addition, the patient must be optimally treated with diuretics and vasodilators as tolerated in relation to blood pressure and renal function

If the criteria for class IV do not apply, eligibility can be based on one of the following:

- the patient has angina, which must be present at rest or resistant to standard nitrate therapy
- the patient is not a candidate for or declines invasive procedures

### **Debility (no one specific terminal diagnosis identified)**

Eligibility is based on the progression of disease, as documented by one of the following:

- recurrent or intractable infections, such as pneumonia, upper urinary tract infections, or sepsis
- progressive weight loss of >10% of body weight over the past 6 months
- dysphagia leading to recurrent aspiration or inadequate nutritional intake
- progressive deep decubitus ulcers

\* The guidelines do not represent hard-and-fast requirements. The presence of clinically significant coexisting conditions or rapid functional decline can substitute for some criteria. The guidelines may also vary with the Medicare fiscal intermediary. Information is from National Government Services ([www.ugsmedicare.com/providers/LMRP/documents/Hospice%20REVISED%2010-01-06.pdf](http://www.ugsmedicare.com/providers/LMRP/documents/Hospice%20REVISED%2010-01-06.pdf)) and is based on personal communication with James Cope, medical director of National Government Services.





# Hospice Services

- Comprehensive Care: medical care (including medications), nursing services, social work, pastoral care, durable medical equipment
- Respite care
- Bereavement care





# The Hospice Inter-Disciplinary Team

- Hospice Physician
- Registered Nurse
- Medical Social Worker
- Chaplain
- Pharmacist
- CNA
- Volunteers



## Hospice Volunteers:

- U.S. Hospice Movement was Founded by Volunteers
- Medicare Conditions of Participation requires that hospice volunteers provide at least 5% of total patient care hours
- NHPCO estimates that in 2012 there were 400,000 hospice volunteers in the U.S. who provided 19 million hours of service



# CRMC Hospice Volunteers

- Average about 80 active volunteers
- Average 12% of total patient care hours
- Provide 9,000-10,000 volunteer hours yearly
- Drive about 30,000 miles per year- not reimbursed for mileage
- Currently Range in age from 23-94



## CRMC Hospice Volunteers: Duties

Meals, Companionship, Personal Care, Therapy Dogs, Spiritual Care, Make Cookies, Play the Harp, Read to Patients, Front Desk Greeter, Tree of Remembrance, Office Work, Bear Making for Care Givers, Bereavement, Respite, Legacy Work, etc., etc.



# The Role of the Hospice Physician

- Certify Prognosis
- Medical Care



# The Role of the Attending Physician

- Identify and Refer Patients
- Counseling patients
- Prognosis
- Medical Care

Does the attending physician get paid?



## When Should You Refer a Patient to Hospice?

- Whenever you think they are ready
- Whenever you think that they **MIGHT** have a prognosis of less than 6 months to live
- In Cheyenne in 2014 can also refer to Palliative Care



## Where are Hospice Patients Located In Cheyenne?

People generally prefer to be at home

- Most don't want to be in a hospital, ICU, nursing home, etc.
- But, some can't be at home





## The Davis Center- Cheyenne

Opened 2006

12 Cottages

Office space and meeting rooms



# CRMC Hospice Admissions

- 2007-08: 170 Davis, (Outpatient not tracked)
- 2008-09: 178 Davis, 173 Outpatient
- 2009-10: 215 Davis, 182 Outpatient
- 2010-11: 226 Davis, 105 Outpatient
- 2011-12: 170 Davis, 119 Outpatient
- 2012-2013: 155 Davis, 116 Outpatient



# Hospice in Wyoming

- Big towns vs. small towns: Cheyenne vs. Wheatland
- VERY low hospice utilization in Wyoming (Medicare data): in 2005 Wyoming ranked #48/50 states in hospice utilization (only Alaska and Hawaii lower)
- 2012: 18 Hospices in Wyoming
- Wyoming Hospice Organization?



# Hospice in Wyoming

- 62<sup>nd</sup> (2013) Wyoming Legislature passed a bill that allows Wyoming Medicaid to cover room and board expenses for hospice patients.
- Sponsored by Drew Perkins, R-Casper



# Medicare Hospice Utilization 2010

- National: 1.165 million patients, 81 million covered days
- Florida: 105,000 patients, 7.5 million covered days
- Colorado: 16,000 patients, 1.3 million covered days
- Wyoming: 1,054 patients, 57,000 covered days



# Hospice Becomes Mainstream

- AMA recognition in 2006 of AAHPM as official organization
- ABMS recognition 2006: Board Exams
- 2013: >50 fellowship programs, >125 fellowship positions; ACGME accredited



# The Future of Hospice: MedPac 2013 Report to Congress

- **Payment Reform:**
  - Currently hospices receive a flat daily rate for each hospice patient
  - Studies indicate that patients require more work/visits at the beginning and end of their hospice enrollment, less in the middle
  - So...long stays in hospice are more profitable
  - In 2011 >50% of Medicare spending for hospice went for patients with >180 days in hospice
  - Recommend: change payment structure



# The Future of Hospice: MedPac 2013 Report to Congress

- **Accountability**
  - In 2010 18% of hospice patients were discharged alive
  - Lots of reasons: patients change their mind, patients get better, “the hospice effect”
  - Little is known about these patients, IE what happens to them after discharge (in 2010 43% of those discharged were alive 1 year later)
  - Recommend: CMS review of all hospice stays >180 days





# The Future of Hospice: MedPac 2013 Report to Congress

- **Nursing Facilities**
  - Nursing Home room and board fees cover nursing aide services
  - Hospice Payments cover nursing aide services
  - Is this a duplicate payment?
  - Recommend: Consider reduced hospice payments for hospice patients who are nursing home residents



## The Future of Hospice: Chronic Care Clerkship

- University of Washington Medical School now requires a 4<sup>th</sup> year Chronic Care Clerkship rotation.
- Includes time spent working in hospice, palliative care, pain clinics, and geriatrics.
- Mandatory 4 week rotation for all WWAMI Students



## The Future of Hospice: Chronic Care Clerkship

- Cheyenne will be a Chronic Care Clerkship site starting summer 2014
- Will include rotations through hospice, palliative care, PACE program, LifeCare Center, Pain Clinic.
- Faculty to include Drs. Monger, Gruber, Stefka, Johnson, Winters (more?)



# Advantages of Hospice

- Comprehensive Care: symptom control, nursing, social work, respite, etc.
- Reduction of out-of-pocket expenses (everything covered at 100%, even meds)
- Bereavement Care



# Disadvantages of Hospice

- ▶ Must choose hospice care **INSTEAD** of curative care, leading to late referrals
- ▶ Hospices paid per diem, so sometimes under pressure to reduce medical care

So, the fundamentally excellent concept of hospice becomes an insurance problem



# Tips for Caring for Hospice Patients

1. Remember Decadron
2. Haldol not Benzos
3. Remember Senna
4. ABHR Gel
5. Turn off the Defibrillator
6. Don't have to be DNR or have a pay source
7. Epidural pain pump
8. Bereavement for Families
9. Consider Palliative Care Services
10. When in Doubt Ask for a Hospice Referral!



