
HOSPICE NEWS NETWORK

Recent News On End-of-Life Care

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A Service of State Hospice Organizations

CMS ANNOUNCES MEDICARE CHOICE MODEL AWARDS

On July 20, CMS announced the hospices that may implement “a new model that empowers beneficiaries, their families, and clinicians by providing them with greater flexibility in deciding between hospice care and curative treatment when faced with life limiting illness.” Patients in these programs will be eligible to receive hospice care, and they will also be able to receive curative care.

In its release, CMS says, “The Medicare Care Choice Model is designed to evaluate whether eligible Medicare and dually eligible beneficiaries would elect to receive supportive care services typically provided by hospice if they could also continue to receive curative services and whether providing both palliative and curative care concurrently impacts quality of care, as well as patient and family satisfaction.”

By being a part of the model, programs agree to not receive the usual per diem for providing care. Rather, providers will receive \$200 to \$400 per patient per month to provide hospice care. Other providers of care will then bill Medicare for their own services. This includes a wide variety of services such as DME, drugs, supplies, and short-term inpatient services.

Though CMS originally planned to chose at least 30 Medicare-certified hospices to join the model program, they received overwhelming interest in the project. Now CMS has offered the model to over 140 providers and has changed the demonstration period from three to five years. “This will enable up to 150,000 eligible Medicare and dually eligible beneficiaries to participate.”

The model is available to only patients with “advanced cancer, chronic obstructive pulmonary disease (COPD), congestive heart failure, and HIV/AIDS who are otherwise eligible for hospice.” Half of the hospices that participate will be randomly assigned to begin the new model on January 1, 2016, and the rest will start on January 1, 2018. The CMS release includes a complete list of hospices that may take part in the demonstration. Patients’ participation in the model is optional.

Dr. Jennifer Temel is clinical director of thoracic oncology at Massachusetts General Hospital. She notes that the care decisions are getting increasingly difficult for cancer patients as new treatments emerge. “I think we need more of a gray zone where patients can get the benefits of hospice care but still receive chemotherapy to help them live longer.” Dr. Patrick Conway, the principle deputy administrator and chief medical officer at CMS, says, ““If it’s successful, and

we think it will be, it's a strong evidence base to potentially scale it to the entire Medicare population.”

Senator Ron Wyden (D-OR) issued a press release cheering the launch of the project.

“Today’s announcement marks a significant turning point in hospice care. Electing to enroll in hospice does not have to be a crossroads for millions of Americans and their families. It’s past time to get smart when it comes to health care at the end of life, and I’m hopeful the success of Care Choices will pave the way for greater access to this kind of care for more Americans.”

(CMS, 7/20, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-20.html>; *The United States Senate Committee on Finance*, 7/20, <http://www.finance.senate.gov/newsroom/ranking/release/?id=f7c84db4-a899-4774-8211-c51551e4bd1c>; *Forbes*, 7/21, <http://www.forbes.com/sites/howardgleckman/2015/07/21/a-new-way-to-get-hospice-services-without-giving-up-aggressive-treatment/>; *The Market Business*, 7/23, <http://www.themarketbusiness.com/2015-07-23-hospice-care-and-treatment-medicare-to-attempt-a-blend>)

HUFFINGTON POST CITES MEDPAC DATA IN CRITIQUING HOSPICE FINANCIAL PROFITS

Huffington Post published “**The Business of Dying Has Never Been More Lucrative,**” authored by Ben Hallman and Nicky Forster. Most of the data for the article comes from a June 2015 MedPAC report on health care spending in Medicare. They also cite a 2014 *Huffington Post* investigation. The authors say, “The new data is likely to give new ammunition to critics of the current payment system, which MedPAC and others have said incentivizes hospices to cherry pick the healthiest patients in order to boost gains.”

Though most hospices were nonprofit 15 years ago, say the authors, about two-thirds of hospices are now for-profits and are often “large, national chains.” The article shows charts and graphs, and cites data from the MedPac report titled “Hospice Care Spending and the Medicare Program.”

Among the authors claims are the following items. For-profit hospices have the highest profit margin, at 15.4%, of any health care provider group. Non-profit hospices have profit rates are 3.7%. They say, “Hospice growth is a function of aggressive marketing strategies—and in some cases, blatantly illegal recruiting tactics—pursued by for-profit providers.” Federal prosecutors, say the authors, have filed “dozens of lawsuits.” The lawsuits cite billing fraud that is allegedly because hospice “enrolled patients who didn’t quality and signed them up for extra-expensive levels of care.” Further, says the article, some families feel pressured into signing on for hospice care, without completely understanding what they are doing. The authors say that, though there have been efforts to uncover fraud, the hospices that break Medicare rules “are almost never punished.”

The new regulatory proposal for hospice payment structure for 2016 calls for paying providers less for patients after 60 days of hospice care. The authors call the change, “A step in the right direction, but a small one.” (*Huffington Post*, 7/24, http://www.huffingtonpost.com/entry/hospice-report_55b1307ee4b0a9b94853fc7a; MedPAC,

AUTHOR SAYS “CLOSURE” IS A MYTH

Stephen J. Forman, MD, director of the Hematologic Malignancies and Stem Cell Transplantation Institute, wrote an article for City of Hope’s *Breakthroughs*. Like most of us, he says, he knows what life is like for survivors after death of a loved one. “It is a time when emotions run high and deep, and as time passes from the moment of loss, we often hear how important it is for those who have most directly experienced the void to gain closure in order to move on with their own lives.” Closure, says Forman, is a way of “tidying up, fearing that the memory of that person or a well-meaning comment may provoke unintended pain or undo what time is said to heal.” The truth, says Forman, is that closure is a myth.

From both his personal and professional experiences, he has learned that “going on with life is not the same as gaining closure.” Memories, recollections, sights, sounds, places, dates, continue to make the “wound of loss,” which is “indelible.” We don’t forget, or fail to recall, those we have loved. **“Grief changes the experience of loss,” says Forman, “but does not close or eliminate it, and is not intended to do so.”**

Forman notes the many ways that culture and religions individuals, families and groups build traditions to memorialize those who have died. These are not created to give closure, he says, “but rather they are about the fullness in each of our lives that came from our family, loved ones, friends and those whose lives were touched by that person's presence in our own lives.”

Forman says he often writes family members of loved ones who were under his care, but he writes and sends these letters months later after most bereaved people are “left along with their own feeling and thoughts.” He closes by recalling a woman whose husband died many years ago. After talking with her, she said, “I think of him almost every day.” (*Breakthroughs*, 7/22, <http://breakthroughs.cityofhope.org/myth-of-closure-stephen-j-forman>)

HOSPICE NOTES

*** Writing for *Medscape*, author Peter McMnamin, PhD, examines the state of end-of-life care for Medicare beneficiaries.** He considers the effect the baby-boom generation will have on death rates, and asks, “Who Will Take Care of the New Beneficiaries?” And, he asks, “What New Models of Care Might Be Used?” He says, “The general increase in deaths may make it feasible to create new healthcare organizations to attend to the needs of the dying.” McMnamin notes that doulas and midwives are already assisting those who are dying. He also imagines emerging “healthcare organizations that would facilitate end-of-life care coordination for many patients who will approach the end of life with multiple chronic conditions.” **As he imagines this future of end-of-life care, he says, “Whether such organizations would emerge from the hospice industry or from fair-sized primary care practices with experience in chronic care management is unclear.”** (*Medscape*, 7/24, <http://www.medscape.com/viewarticle/848325>)

* **Media attention is focused on Bobbi Kristina Brown, who is in hospice care.** *WebProNews* spoke with Jon Radulovic, NHPCO. Radulovic’s comments focus on clarifying the work of hospice and explaining how hospice works. Bobbi Kristina Brown died on 7/25. (*WebProNews*, 7/19, <http://www.webpronews.com/bobbi-kristina-brown-not-dead-hospice-professional-ways-in-on-end-of-life-process-2015-07>; *CNN*, 7/26, <http://www.cnn.com/2015/07/26/us/bobbi-kristina-brown-dies/>)

* **Don Taylor, Associate Professor of Public Policy of Duke University**, wrote a blog post about the CMS hospice concurrent care demonstration. He presents “a few thoughts” about the model, and gives kudos to CMS for this innovation. (*freeforall*, 7/22, <https://donaldhtaylorjr.wordpress.com/>)

* **Theresa Brown, a hospice nurse and author, has an opinion piece in *The New York Times* titled “Choosing How We Die.”** Brown reflects on the history, value and importance of patient choice in end-of-life care. The CMS proposal to reimburse for conversations with patients about their end-of-life care choices, she says, “has the potential to give the sickest among us the ability to say, ‘This is what I want!’ at the most vulnerable point in their lives. (*The New York Times*, 7/24, <http://www.nytimes.com/2015/07/24/opinion/choosing-how-we-die.html>)

* **Residents in assisted living facilities may receive hospice care nearer the end of their lives that people who receive hospice at home.** They also may be “less likely to receive opiate painkillers,” and “less likely to die in an inpatient hospice unit. These results are part of a study lead by Dr. David Casarett and colleagues and reported in the *Journal of American Geriatrics Society*. Some of the additional findings are that residents of assisted living are much less likely to die in hospitals as home hospice patients, and receive less pain medication. (*Reuters*, 7/23, <http://www.reuters.com/article/2015/07/23/us-health-hospice-assisted-living-idUSKCN0PX2FC20150723>)

* **Paul Ledford, President and CEO of the Florida Hospice and Palliative Care Organization, received the Florida Society of Association Executives “Executive of the Year for 2015.”** This is the most prestigious award the group bestows. The award honors “an association executive who has displayed the highest commitment to professional growth and pride and association management, and who professionalism and leadership are evident in both services to the association management profession and to the community” (*The Business Journals*, 7/22, http://www.bizjournals.com/prnewswire/press_releases/2015/07/22/DC63203)

* **Writing on *Pallimed*, Lizzy Miles, MA, MSW, LSW, writes about “The secrets of hospice patients.”** Miles is a hospice social worker and “best known for bringing the Death Café concept to the United State.” She talks about, and gives tips for, dealing with information that is given to hospice providers by hospice patients, and making decisions about how to handle information that is given in confidence. (*Pallimed*, 7/13, <http://www.pallimed.org/2015/07/the-secrets-of-hospice-patients.html>)

* **OPTUMHealth is offering a cost-free webinar on “Hospice and Palliative Care for Patients with Dementia.”** The September 18 webinar features Zaldy S. Tan, MD, MPH, Medical Director, UCLA Alzheimer’s and Dementia Care Program. Goals for the session include the explanation of how hospices help and support dementia patients nearing the end of life. Details and registration are online at the link provided. (*OPTUMHealth*,

<https://www.optumhealtheducation.com/palliative-care-hospice/hospice-palliative-care-dementia-live?sid=84692>)

* **Colorado State University’s Veteran Teaching Hospital says it is “the only teaching hospital in the country to offer pet hospice services.”** The service has been offered since 2004 and provides hospice care, at no charge and in the animal’s home. “The program is suited for pets with terminal illnesses, and the hospice team provides basic nursing services, quality-of-life assessments, end-of-life arrangements and emotional support. The role of the hospice is also to act as a bridge between clients and veterinarians.” (*The Rocky Mountain Collegian*, 7/8, <http://www.collegian.com/2015/07/csu-vet-teaching-hospital-offers-free-hospice-care/127114/>)

* In 2006, a case was filed against “Hospice Care of Kanas LLC and its parent company, Ft. Worth, Texas-based Voyager HospiceCare Inc. They are accused of submitting claims to the Medicare program for ineligible hospice services.” According to *The Whistle Blower Institute*, a settlement agreement has been reached for \$6,100,000. Of that, \$1.342 million will go to the whistleblower. (*The Whistleblower Institute*, 7/23, <http://whistleonfraud.com/article/61-million-settlement-reached-whistleblower-case-kansas-hospice-care-companies>)

ADVANCE CARE PLANNING NOTES

* **Congressman Representative Earl Blumenauer (D-OR) wrote an article sharing his support for “empowering patients and their families, by improving end-of-life care.”** The article, published in *Portland Tribune*, traces his personal leadership in improving care at life’s end. While he is glad to see the CMS proposal to reimburse physicians for end-of-life conversations, he says, “Our fight to improve end-of-life care is far from over.” Blumenauer calls for electronic medical records that replicate these conversations and ensure that they will “be interoperable and portable, following people wherever they go.” (*Portland Tribune*, 7/21, <http://portlandtribune.com/pt/10-opinion/267155-140657-my-view-protecting-your-wishes-for-end-of-life-care>)

* **A *Boston Globe* editorial supports the proposal to reimburse physicians for end-of-life conversations with patients.** Because they more commonly receive the kind of training to effectively have these conversations, says the editorial, “Medicare should also seriously consider including social workers and other psychiatric caregivers in the group of those covered.” This is “an important step forward for public policy in health care. It also signals a welcome shift to a more open attitude toward a subject most people would rather avoid” (*Boston Globe*, 1/20, <http://www.bostonglobe.com/opinion/editorials/2015/07/19/making-end-life-part-health-care/1USjMcW8H2aFshI1BZWQ8K/story.html#>)

* ***The New York Times* posted an editorial supporting Medicare’s proposal to pay for end-of-life conversations.** The paper says, “More patients may finally be able to talk to their doctors and gain more control over the care they receive in their final days.” (*The New York Times*, 7/25, http://www.nytimes.com/2015/07/26/opinion/sunday/helping-patients-and-doctors-talk-about-death.html?_r=0)

END-OF-LIFE AND OTHER NOTES

* **Oliver Sacks is professor of neurology at the New York University School of Medicine. Sacks, 82, is also terminally ill with metastatic cancer.** Sacks wrote an opinion published in *The New York Times*. As he lives this last part of his life, he reveals, he finds himself drawn back to the physical sciences that “provided my first enchantment as boy.” Sacks poignantly shares how this is meaningful to him, saying that, since a child, he has dealt with loss “by turning to the nonhuman.” (*The New York Times*, 7/24 online and 7/26 in print, <http://www.nytimes.com/2015/07/26/opinion/my-periodic-table.html?smid=fb-nytimes&smtyp=cur&r=0>)

* *NPR* posted “Intensive End-of-Life Care on the rise for Cancer Patients.” Though advance care planning has increased, so have intensive medical interventions. (*NPR*, 7/22, <http://www.npr.org/sections/health-shots/2015/07/22/425311737/intensive-end-of-life-care-on-the-rise-for-cancer-patients>)

* *Huffington Post* has posted a video titled “How To Have Difficult Conversations About Hospice Care.” The video was created because *HuffPost Live* “wanted to dig a little deeper to help you understand your care options, specifically about hospice.” The video includes presentation segments by Donald Schumacher, NHPCO’s President/CEO, and Sherwin Sheik, Carelix founder. (*Huffington Post*, 7/23, http://www.huffingtonpost.com/entry/hospice-care-end-of-life_55b0f831e4b0a9b94853ca3d)

* David J. Casarett, MD, is Associate Professor of Medicine, University of Pennsylvania Perelman School of Medicine Director of Hospice and Palliative Care, University of Pennsylvania Health System. Casarett’s “major research interest is understanding and improving the way that health systems care for patients near the end of life.” **In his new book, “Stoned: A Doctor’s Case for Medical Marijuana.” Casarett explores the use of medical marijuana and converts from seeing marijuana as a “joke” to believing there is a “case for marijuana’s medicinal use — as well as for more research into the drug’s long-term effects.”** He was recently interviewed on NPR, and a book review appeared in *Pantagraph*. (*Penn Department of Medical Ethics & Health Policy*, <http://medicalethics.med.upenn.edu/people/faculty/david-j-casarett>; *NPR*, 7/14, <http://www.npr.org/sections/health-shots/2015/07/14/422876973/when-weed-is-the-cure-a-doctors-case-for-medical-marijuana>; *Pantagraph*, 7/22, http://www.pantagraph.com/entertainment/books/book-review-stoned-a-doctor-s-case-for-medical-marijuana/article_68892be5-6ac6-5c68-9de0-1ad7e10a1b83.html)

* **“Marijuana is a Wonder Drug When It Comes to Dealing with the Horrors of Chemo,” appeared in *Newsweek*.** The article shares personal experiences from patients and physicians about the value of marijuana. It is cited as “the only anti-nausea medicine that increases appetite,” and a drug that “helps patients sleep and elevates their mood. The article cites a 2014 poll that found “82 percent of oncologists agreed that cannabis should be offered as a treatment option.” Other studies have found limited impact and some adverse effects. Comments from David Casarett, author of “Stoned,” are included in the article. (*Newsweek*, 7/22, <http://www.newsweek.com/2015/07/31/keep-toke-alive-356032.html>)

* **Christopher Layne, UCLA, Julie Kaplow, at University of Texas, and Robert Pynoos, UCLA, have worked together to create a new assessment tool to determine if children and youth are dealing with “maladaptive grief.”** The assessment tool is then used to create individual treatment plans for each child or young person. “‘What has been inspiring to us,’ said Kaplow, ‘is that children often react to the test by saying, ‘So other kids feel this way, too? I thought it was just me.’” (*Medical Express*, 7/22, <http://medicalxpress.com/news/2015-07-checklist-children-teens-bereavement-disorder.html>)

* **Abdul Gawande offered the keynote address to the American Hospital Association Leadership Summit in LA. A key message of his speech urged healthcare leaders to “rethink how care is delivered and organized.”** Gawande called for a paradigm shift to move out of the old system of providing services, such as “pills, and surgeries, and specialists.” Instead, he says, we need to move to a healthcare system that delivers outcomes. He spoke specifically to end-of-life care. People have priorities and preferences near the end of life, he says. The only way physicians can know these priorities is to ask the patients. **Finding out what patients want is key to good care.** CEOs can help to support systemic change. He gives an example of implementing a training system and monitoring how many physicians have these conversations with patients. Notice about the speech and a video interview after the presentation is available online. (*H&HN*, 7/24, <http://www.hhnmag.com/Daily/2015/July/atul-gawande-deliver-outcomes-video-summit-weinstock>)

* **A study published in *JAMA Oncology*, says *Healio*, reports that chemotherapy “did not improve quality of life near death for patients with end-stage cancer.”** In some patients, chemotherapy actually decreased the quality of life near life’s end. The study garnered significant media coverage. (*JAMA Oncology*, 7/23, <http://oncology.jamanetwork.com/article.aspx?articleid=2398177>; *Healio*, 7/24, <http://www.healio.com/hematology-oncology/palliative-care/news/online/%7Bd949312a-edd7-445a-a01a-bb356e51f5b8%7D/palliative-chemotherapy-fails-to-improve-quality-of-life-near-death>)

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