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Recent News On End-of-Life Care

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OIG INVESTIGATION REVEALS SERIOUS DEFICIENCIES IN HOSPICE ELECTION STATEMENTS AND CERTIFICATIONS OF TERMINAL ILLNESS

OIG issued a report titled “**Hospices Should Improve Their Election Statements And Certifications Of Terminal Illness.**” The purpose of the Medicare hospice benefit, notes the report, is to help terminally ill individuals live their last days, weeks, and months of life to the fullest, and to provide support to families and caregivers. As part of ensuring that hospice is reaching its full potential in providing benefits to dying Americans and their families, CMS requires that the beneficiary signs an election statement. Additionally, says the OIG report, the benefit also requires “a physician to certify the beneficiary as terminally ill.”

Combined, these two requirements safeguard hospice care and those who participate in it, ensuring both patient understanding of hospice itself, and that physician oversight is present in reaching a terminal diagnosis. Nevertheless, officials at the Office of the Inspector General have previously raised concerns saying, “**Some election statements used by hospices are misleading and ... physicians are sometimes not involved in care planning and may rarely see beneficiaries.**” Additionally, OIG has investigated and is investigating hundreds of cases of fraudulent claims for patients who were not eligible for hospice care.

In this context, OIG investigators were disturbed to find widespread irregularities in both the handling of patient election statements and physician certification. **Ultimately, they found that more than one third of hospice patients sampled used election statements that were missing required information, or had other vulnerabilities.** Notably, faulty election statements did not always mention (as required) the strictly palliative nature of hospice care, nothing that the patient would be waiving curative treatment if they chose to enroll in hospice.

Additionally, says the report, “**We identified concerns with election statements in more than one third of hospice GIP stays and, in 14 percent of stays, the physician did not meet requirements when certifying.**” Furthermore, **around 14% of patients in the study did not receive a narrative statement from the physician who certified them as having six months or less to live.** This appeared to indicate limited involvement on the part of the physician in ascertaining that the patient was indeed eligible for hospice care.

As a result of these findings, the OIG has released a set of four recommendations for CMS. Three of the recommendations were accepted, and a fourth was neither accepted nor rejected.

1) Develop and disseminate model text for the election statement. “The model text should clearly identify the benefit as Medicare, as we found numerous instances in which the election statement does not. Medicare can have different rules than other payers, so it is important for beneficiaries to know that Medicare, as opposed to other payers, is covering their care. This is a fundamental program integrity safeguard.” *Accepted by CMS.*

2) Instruct surveyors to strengthen their review of election statements and certifications of terminal illness. “Surveyors should determine whether election statements contain all the required information and that this information is accurate. If not, surveyors should cite deficiencies. Likewise, surveyors should strengthen their review of certifications of terminal illness to ensure that certifying physicians are meeting the requirements.” *Accepted by CMS.*

3) Educate hospices about election statements and certifications of terminal illness. “CMS should educate all hospices but should particularly focus on the hospices we found to have election statements that lacked required information or had other vulnerabilities and on the hospices that had certifications for which the physician did not meet requirements.” *Accepted by CMS.*

4) Provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care. “This guidance should explicitly address (1) whether remaining days of the election period are lost and (2) when, after revocation or discharge, a new election period can begin for beneficiaries who are eligible. Hospices should have a clear understanding of the effects of revocation and discharge so that they can consistently implement policies and accurately inform beneficiaries.” *Neither accepted nor rejected by CMS.*

Washington Post writer Peter Whoriskey addressed these concerns in an article titled “How tens of thousands of patients who weren’t actually dying wound up on hospice care.” Whoriskey cites Jody Nudelman, who worked on the report, as saying the trend is “‘alarming.’”

Whoriskey cites a 2014 *Washington Post* series of articles that addressed these issues. In closing, Whoriskey says, “**The new findings by the government inspectors are part of a larger body of work by the government that, in the inspectors words, reveals ‘numerous vulnerabilities’ and raises serious questions ‘as to whether Medicare is paying appropriately for hospice.’**”

A number of other news sources have included coverage of the OIG report and a few are included below. (*OIG*, 9/15, oig.hhs.gov/oei/reports/oei-02-10-00492.asp; *Washington Post*, 9/15, www.washingtonpost.com/news/wonk/wp/2016/09/15/how-tens-of-thousands-of-patients-who-werent-actually-dying-wound-up-on-hospice-care/; *McKnights*, 9/15, <http://www.mcknights.com/news/oig-hospices-need-to-better-certify-terminally-ill-patients-to-avert-fraud/article/522980/>; *Fiscal Times*, 9/18, <http://www.thefiscaltimes.com/2016/09/18/Report-Uncovers-Widespread-Medicare-Fraud-Hospice-Care>; *Healthcare Dive*, 9/16, <http://www.healthcaredive.com/news/oig-providers-offer-limited-proof-patients-need-hospice-care/426469/>)

WHAT DOES IT FEEL LIKE TO DIE?

No one can tell us what it feels like to die, since none of us has actually done that yet. An article in *The Atlantic* magazine explores the experience in “What It Feels Like to Die” by Jennie Dear. What we know about the lived experience of the final moments of life has long been limited to what we could glean from the words, actions, and expressions of the actively dying. The final experience of death, however, has always been off-limits to us – short of actually dying ourselves.

James Hallenbeck, a palliative-care specialist at Stanford University, likes to compare dying to black holes. “We can see the effect of black holes, but it is extremely difficult, if not impossible, to look inside them. They exert an increasingly strong gravitational pull the closer one gets to them. As one passes the ‘event horizon,’ apparently the laws of physics begin to change.”

With advances in scientific knowledge and diagnostic technology, however, the medical community is beginning to peek beyond the horizon. Though still forced to observe from the outside, we are gaining an intriguing new look into the physiological process of dying, and what may be waiting for us when we get there.

Death used to be fast. Generally, people died over a relatively short period. But in the last century, the advance of medical knowledge and treatment has allowed humans far greater control over the end-of-life timeline. “Americans who have access to medical care often die gradually, of lingering diseases like most terminal cancers or complications from diabetes or dementia, rather than quickly from, say, a farm accident or the flu. According to the Centers for Disease Control’s most recent figures, Americans are most likely to die of heart disease, cancer, or chronic pulmonary lung disease.”

When death doesn’t come quickly, there is a fairly predictable order to the final days and hours of life. The human body shuts itself down in a certain sequence. “First hunger and then thirst are lost. Speech is lost next, followed by vision. The last senses to go are usually hearing and touch,” says Hallenbeck.

The level of pain involved with dying, on the other hand, is less predictable. Some types of death are inevitably painful, but many diseases associated with suffering – such as cancer – are often able to be addressed with modern palliative medicine. Assuming the pain meds are being administered properly, pain shouldn’t necessarily be overwhelming.

Of course, the actual experience of death remains a mystery for everyone who hasn’t tried it. **While we have our ideas of what the actively dying experience in those final hours, the truth is we can’t quite be sure.** “We generally believe that if your brain is really in a comatose kind of situation, or you’re not really responsive, that your perception—how you feel about things—may also be significantly decreased,” says David Hui, an oncologist and palliative-care specialist who researches the signs of approaching death. “You may or may not even be aware of what’s happening.”

On the other hand, other actively dying individuals have described an experience of reality that – far from comatose – is hyper-alert, present and aware. “A lot of cardiac-arrest survivors describe that during their unconscious period, they have this amazing experience in their brain,” says Jimo

Borjigin, a neuroscientist at the University of Michigan. “They see lights and then they describe the experience as ‘realer than real.’”

The article, with a subtitle of “Science is just beginning to understand the experience of life’s end,” is available online. Also available is a video, “What Happens Inside a Dying Mind?” displayed at the end of the article. (*The Atlantic*, 9/9, www.theatlantic.com/health/archive/2016/09/what-it-feels-like-to-die/499319/)

HOSPICE AND END-OF-LIFE NOTES

* **A Netflix documentary, “Extremis,” features heart-breaking end-of-life care decision-making at a hospital in Oakland, California.** “‘Extremis, which is Latin for at the point of death,’ follows doctors, patients and their loved ones in various end-of-life scenarios that play out at the intensive care unit at Oakland’s Highland Hospital.” The video trailer is online. (*KQED*, 9/13, ww2.kqed.org/stateofhealth/2016/09/13/netflix-documentary-features-heartbreaking-end-of-life-care-decisions-at-an-oakland-hospital/)

* **What does it mean for hospice professionals to meet each patient where they are emotionally?** “By listening, by observing, by asking the right questions at the right time, good hospice workers ... can recognize where patients and loved ones are in the process of preparing for end of life and can then take the right opportunity to help, support and educate.” (*Huffington Post*, 9/13, www.huffingtonpost.com/rosemary-baughn/meeting-people-where-they_1_b_11994152.html)

* **The Traverse, Michigan, *Record Eagle*, writes about a local nonprofit that is offering services and workshops for end-of-life preparation.** Golden Intentions provides a variety of services, “from hosting end-of-life planning sessions and community workshops to facilitating end-of-life gatherings and special trips.” (*Record Eagle*, 9/11, www.record-eagle.com/news/business/nonprofit-offers-services-workshops-for-end-of-life-prep/article_c6177bbc-017f-5c96-9e88-4fdc4255d301.html)

* **Kokua Mau, Hawaii’s Hospice and Palliative Care Organization, has been awarded a two-year grant for “Improving Care and Support for those with Serious Illness” from the Stupski Family Fund of the Hawaii Community Foundation.** The \$466,800, 2-year grant will help Kokua Mau to coordinate a data project “to get a clearer picture on what is happening with advance care planning, advance directives and POLST across the state and share best practices and lessons learned.” (Kokua Mau, 9/14, *email*)

* **Who ultimately gets to decide about end-of-life care decisions?** Dr. David Hornick *et al* ask, “Should transfers to the emergency department occur when it is the stated wish of the patient not to be transferred and there is no obvious emergency indication?” (*Journal of Palliative Medicine*, 9/1, online.liebertpub.com/doi/full/10.1089/jpm.2016.0159)

* **The lag between a terminal diagnosis and the beginning of palliative treatment can be significant, finds a new study in the *Journal of Palliative Medicine*.** “There remains a gap between recommended timing of supportive services and real-world practice of care. Results

suggest that difficulties in prognosticating death are not fully responsible for underexposure to hospice.” (*JPM*, 9/1, online.liebertpub.com/doi/full/10.1089/jpm.2015.0514)

* **The *Chicago Tribune* reports on how hospice workers are helping to ease the end-of-life experience for family members.** “You're working with the patient to make sure he or she is comfortable and safe, and you're preparing the family for the inevitable.” (*Chicago Tribune*, 9/16, www.chicagotribune.com/business/careers/sns-201609091230--tms--careercarer-b20160911-20160911-story.html)

* **Cancer caregivers often face greater burdens and work longer hours.** “Informal caregivers for patients with cancer tended to report a higher burden and spent more hours per week caregiving than caregivers of patients with other illnesses, according to study results presented at the Palliative Care in Oncology Symposium.” (*Healio*, 9/7, www.healio.com/hematology-oncology/palliative-care/news/online/%7Ba4ccb00b-36a5-43b3-8fe1-36487349c5d3%7D/cancer-caregivers-often-face-great-burdens-work-long-hours)

* **A 16-pound Chihuahua is walking 375 miles for hospice. Hachi is a hospice therapy dog and will be walking with chaplain, Jeff Douglas.** For “25 days, 63-year-old Douglas and 5-year-old Hachi will be winding through wicked terrain on the American Discovery Trail. They will be promoting hospice care on their Facebook page.” (*KHOU*, 9/14, www.khou.com/news/local/animals/chihuahua-on-375-mile-journey-for-hospice/318188039; *ABC News*, 9/14, <http://abcnews.go.com/Lifestyle/tiny-therapy-dog-embarks-375-mile-hike-california/story?id=42082090>; *Facebook*, <https://www.facebook.com/connectorjeff>;))

* The owner of a Mississippi hospice has been ordered to pay \$5 million in restitution for Medicare and Medicaid fraud. A federal investigation revealed that the owner and the hospice “were knowingly enrolling non-hospice eligible Medicaid and Medicare recipients and then filing false hospice claims to Medicaid and Medicare for services that were not medically necessary or were not ever provided.” The woman was ordered “to serve 48 months in home confinement in lieu of imprisonment because of recurrent metastatic cancer, which requires substantial medical care.” (*Clarion-Ledger*, 9/15, www.clarionledger.com/story/news/2016/09/14/mississippi-hospice-owner-restitution/90373484/)

* **A VA panel from Arkansas had the full attention of members of Congress during a recent presentation on end-of-life care planning.** “When a congressional panel was looking for examples of innovative VA hospital system projects, they highlighted an Arkansas project that encourages veterans to talk about emergency and end-of-life health-care planning.” (*Arkansas Online*, 9/16, www.arkansasonline.com/news/2016/sep/08/state-va-project-keeps-panel-rapt-20160-1/)

* **When OhioHealth hospital system began to use hospice care as a quality measure, the length of stay for hospice patients jumped from 19.7 days to 39.6 days within a year.** ““Hospice care is proven to be the best care at the end of life, but the key issue is how to reach all eligible patients,”” says Dr. Charles F. Von Gunten, vice president of medical affairs, hospice and palliative medicine at OhioHealth in Columbus. ““Since we know that it improves quality and lowers cost, then can we treat referral to hospice as a quality measure?”” (*Medscape*, 9/15, http://www.medscape.com/viewarticle/868831#vp_2)

*** Pope Francis visited Rome’s Villa Speranza Hospice, taking time to visit individually with each of the 30 residential patients.** A statement from the Vatican says, the Pope’s visit is a “‘concrete and tangible sign’ of how essential it is to give our attention ‘to those in the most vulnerable and precarious situations.’” (*Catholic News Agency*, 9/16, <http://www.catholicnewsagency.com/news/pope-visits-neonatal-unit-hospice-to-highlight-respect-for-life-39673/>)

PALLIATIVE CARE NOTES

*** Seventy-five percent of America’s hospitals still do not have full palliative care teams.** “Only 25% of the nation’s hospitals have a fully staffed paid palliative care team that meets Joint Commission guidelines, according to a study in *Health Affairs*.” (*Managed Care*, 9/2016, www.managedcaremag.com/dailynews/75-nation-s-hospitals-lack-palliative-care-teams)

*** Early use of palliative care is beneficial for patients with cancer, but the type of cancer matters.** A recent study finds that palliative care “can improve quality of life (QOL), mood, coping, and the frequency of end-of-life discussions for patients with newly diagnosed lung and gastrointestinal (GI) cancer.” However, outcomes of palliative care interventions differed markedly by cancer type. (*Medscape*, 9/14, www.medscape.com/viewarticle/868758)

*** What could be the role of marijuana in providing palliative care?** In an interview with *Health MJ*, Bernard Lee, a hospice and palliative care doctor in the greater New York City area, speaks about how medical marijuana might impact palliative care services. (*Health MJ*, 9/13, www.healthmj.com/cancer/marijuana-palliative-care-interview/)

*** Palliative care helps patients and their families, and it saves money, too.** “Researchers from Johns Hopkins Health System in Baltimore, Maryland, found that in addition to improving quality of care and patient satisfaction, the combined inpatient and consultation palliative care programs contributed to substantially lower charges and costs per day.” (*Medscape*, 9/12, www.medscape.com/viewarticle/868672)

OTHER NOTES

*** Alzheimer’s researchers have some good news they’d like to share.** “Some of the nation’s top Alzheimer’s researchers and clinicians helped dispel the mystery of the disease at an educational forum held . . . at the University of San Diego.” Videos, and updates about emerging good news, are available online. (*San Diego Union Tribune*, 9/16, www.sandiegouniontribune.com/business/biotech/sdut-alzheimer-doctors-researchers-dose-hope-2016sep10-htmlstory.html)

*** Health care providers, including hospices, have a tight timeline to prepare for new federal disaster-preparedness guidelines.** “An estimated 72,315 American health care providers and suppliers — from hospitals and nursing homes to dialysis facilities and care homes for those with intellectual disabilities — will have a little over a year to meet federal disaster preparedness requirements” that were recently released by the Centers for Medicare and

Medicaid Services. (*New York Times*, 9/10, www.nytimes.com/2016/09/10/us/medicare-requirements-disaster-readiness.html)

* **“A maker of deadly painkillers is bankrolling the opposition to legal marijuana in Arizona,” is an article that appears in *Washington Post*.** “The campaign against marijuana legalization in Arizona received a major infusion of cash last week from a synthetic cannabis drugmaker that has been investigated for alleged improper marketing of a highly addictive prescription painkiller, according to campaign finance reports.” (*Washington Post*, 9/9, www.washingtonpost.com/news/wonk/wp/2016/09/09/a-maker-of-deadly-painkillers-is-bankrolling-the-opposition-to-legal-marijuana-in-arizona/)

* **Recognizing that caregiving leave is important for others besides new parents, Deloitte announced it will provide 16 weeks of caregiving leave for employees – including caring for elderly parents.** An article in *Huffington Post* says, “This is a bold new step in the broader caregiving space inasmuch as it recognizes the changing family dynamics and the emerging needs of workers as they move through different life stages. (*Huffington Post*, 9/8, http://www.huffingtonpost.com/entry/deloitte-just-gave-its-workers-16-weeks-paid-leave-for-caregiving_us_57d17126e4b03d2d4598b151)

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