

Quality of Life Matters®

End-of-life care news & clinical findings for physicians

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Hospice Care Linked to Longer Patient Survival

Findings Help Dispel 'Myth' of Hastened Death with Hospice

A recent study has found that terminally ill hospice patients with certain diseases live a significantly longer period of time than do their nonhospice counterparts. Indeed, across all patient groups studied, those enrolled in hospice lived a mean of 29 days longer than those who did not choose hospice.

“This study provides important information to dispel the myth that hospice hastens death and suggests that hospice is related with the longer length of survival by days or months in certain terminally ill patients,” write the authors of a report published in the *Journal of Pain and Symptom Management*.

“This extra time might be particularly important to patients and their families, as it may allow some people to use the end

of life as a time of resolution and closure.”

Researchers conducted a retrospective cohort study of 4493 terminally ill patients with congestive heart failure (CHF) or cancer of the lung, pancreas, colon, prostate, or breast. The statistically representative sample was drawn from Medicare records of patients who died within three years of entering the terminal stage of the disease.

Key Findings Include:

- Overall, the **mean survival was 29 days longer for hospice patients** than for nonhospice patients.
- The largest difference in survival between the hospice and nonhospice cohort was found among patients with **CHF** (402 vs 321 days, $P = 0.05$).

“There is a growing body of evidence to counter the argument that the use of opioid and sedative medication for symptom relief hastens death.”

— Connor et al,
Journal of Pain and Symptom Management

- Survival time was also significantly longer for hospice patients with **lung cancer** (279 vs 240 days, $P < 0.0001$) and **pancreatic cancer** (210 vs 189 days, $P = 0.01$), and approached statistical significance for the hospice cohort with **colon cancer** (414 vs 381 days, $P = 0.08$).

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New ICU Guidelines Address Crucial Role of Families, Recommend Hospice Referral

The first set of clinical practice guidelines to define standards for incorporating families into the decision making process and the care of their loved ones in the intensive care unit (ICU) has been published in a recent issue of *Critical Care Medicine*, the official journal of the Society of Critical Care Medicine.

“[W]e must acknowledge the important role that family members and other health care surrogates play in patient care and embrace their participation,” writes the task force for the American College

of Critical Care Medicine. Up to now, note the authors, ICU technology and training have caused family participation to be limited and the psychosocial needs of patients to be overlooked.

Recommendations concerning ICU palliative care include:

- Provide information about and offer referral to hospice as appropriate.
- Assess family understanding of the illness and its consequences and the

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Hospice Care Linked to Longer Patient Survival

Increased Longevity

Factors contributing to increased longevity among hospice patients may include:

- Avoidance of the risks of overtreatment among patients who are already in a weakened condition
- Improved monitoring and treatment provided by a coordinated interdisciplinary team
- Use of medications allowed under the Medicare hospice benefit, but not necessarily covered by Medicare Part D or other insurance programs
- Psychosocial support provided to patients and families, which may increase patients' sense of well being and desire to live, and decrease the feeling of being a burden to their families

— Connor et al,
Journal of Pain and Symptom Management

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- Across groups, **no significant association of hospice enrollment with shorter survival times was found.**

“Of note, the largest difference in survival between the hospice and nonhospice cohort was for the CHF patients, where relatively few patients chose hospice care,” point out the authors.

“Our findings are important in helping to dispel the myth that hospice care hastens a patient’s death,” write the authors. **“This myth may stem in part from the fact that hospice professionals not uncommonly admit patients who are in very poor shape and near death. Indeed, many patients continue to be referred late for hospice or palliative care.”**

The perceived association of hastened death with the use of opioid and sedative medications to alleviate symptoms

has also contributed to this myth, point out the authors, noting that “a growing body of literature has amassed to counter this association.”

“There is a perception among some health care providers that symptom relief in hospice, especially the use of opioids and sedatives, could cause patients to die sooner than they would otherwise,” says lead author Stephen R. Connor, PhD, vice president of the National Hospice and Palliative Care Organization.

“This study provides important information to suggest that hospice is related to the longer — not shorter — length of survival by days or months in many patients.”

Source: “Comparing Hospice and Nonhospice Patient Survival among Patients Who Die within a Three-Year Window,” Journal of Pain and Symptom Management; March 2007; 33(3):238-246. Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K; National Hospice and Palliative Care Organization, Alexandria, Virginia; and Milliman, Inc., New York, New York.

New ICU Guidelines Address Crucial Role of Families, Recommend Hospice Referral

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family’s ability to cope with same.

- Educate the family about the signs and symptoms of approaching death.
- Ensure availability of bereavement services and follow-up care.
- Include training in the elements of palliative care as a formal component of critical care education.

“Including and embracing the family as an integral part of the multiple-professional ICU team are essential for the timely restoration of health or optimization of the

dying process for critically ill patients,” the authors state. “Support for the psychological and spiritual health of the family is an essential component of patient-centered care for the critically ill.”

Other topics addressed by the guidelines include:

- Decision making
- Family coping
- Cultural support of the family
- Spiritual/religious support
- Family visitation
- Family environment of care

- Family presence on rounds
- Family presence at resuscitation
- Staff stress related to family interactions

The guidelines can be accessed online at www.learnicu.org.

Source: “Clinical Practice Guidelines for Support of the Family in the Patient-Centered Intensive Care Unit: American College of Critical Care Medicine Task Force 2004-2005,” Critical Care Medicine; February 2007; 35(2):605-622. Davidson JE, Powers K, Hedayat KM, et al; American College of Critical Care Medicine Task Force 2004-2005, Society of Critical Care Medicine.

Physicians Urged to Integrate Palliative Care and Hospice into Heart Failure Care

Heart failure (HF) is the leading cause of hospital admission and readmission in this country, and the only cardiac-related diagnosis that continues to rise in prevalence; deaths from HF have doubled over the past 15 years. The palliative approach to care for patients with advanced HF, although often “challenging to implement,” is gaining widespread support and should be integrated sooner into the care of patients with this disease.

That is according to Brad Stuart, MD, senior medical director of Sutter VNA and Hospice, Emeryville, CA, in a review of palliative and hospice care for patients with advanced HF, which was published in the *Journal of Palliative Medicine*.

“Palliative care should be integrated with advances in heart failure care to optimize treatment of high-risk patients while discouraging overuse of procedures and devices, and to help patients and families cope with an uncertain future,” writes Stuart, who is also principal investigator for Sutter’s Advanced Illness Management program.

Stuart provides a discussion of the pathogenesis, staging, assessment, prognosis determination, and treatment of HF, offering approaches to advance care planning, managing infusions and implanted defibrillators, and determining hospice eligibility.

Tables include the New York Heart Association (NYHA) functional classification system for heart failure and its “complement,” the staging system of the American College of Cardiology/American Heart Association 2005 Guideline Update, which “for the first time provides Class I recommendations for hospice and palliative care for patients with advanced HF,” comments Stuart, “signifying that these approaches are beneficial, useful, and effective.”

Although end-stage heart disease is now the second most common diagnosis upon

hospice admission, it accounts for only 12% of enrollees, points out Stuart, while cancer diagnosis accounts for 46%. Yet 27% of all deaths in the nation in 2004 were caused by heart disease, compared with 23% caused by cancer.

Asserting that “calculated prognosis... should not be the major criterion for hospice referral,” Stuart proposes a set of guidelines adapted from the National Hospice and Palliative Care Organization and others for determining hospice eligibility in HF patients with systolic failure. [See sidebar, below.]

“Uncertain prognosis should not be a barrier to enrollment,” states Stuart. **“Patients may stay on hospice for longer**

than six months as long as clinical decline can be documented. Those who stabilize or improve over several months may be discharged, then reenrolled in hospice if their condition worsens.”

Standard medical treatment of HF is palliative as well as disease-modifying, notes Stuart. “Using a flexible blend of disease-modifying and symptom-relieving measures that evolves as disease advances, clinicians can help ease the transition for seriously ill patients and their families from life-prolonging treatment toward comfort-focused care.”

Source: “Palliative Care and Hospice in Advanced Heart Failure,” Journal of Palliative Medicine; February 2007; 10(1):210-228. Stuart B; Sutter VNA and Hospice, Emeryville, California.

Guidelines for Hospice Eligibility in Heart Failure

Patients should show evidence of all of the following:

1. Illness severity

- Documentation of severe left ventricular dysfunction; left ventricular ejection fraction, 20% or less
- NYHA Class IV symptoms despite optimal treatment

2. Recent clinical progression, including any of the following:

- Two or more hospital admissions or emergency department visits for HF within six months
- New dependence in activities of daily living
- Renal, hepatic, or central nervous system dysfunction without reversible cause

3. Evaluation for advanced therapeutic options

- Many elderly patients with comorbidities may be hospice-appropriate without being considered for these options. Hospice enrollment is reasonable for younger patients who have been considered and have been found ineligible, refused them, or developed recurrent HF symptoms after undergoing them.

4. Preference for comfort care over life-sustaining treatment

- Comprehensive advance care planning, which includes discussion of disease process, prognosis, treatment goals, and advance directives
- Patient/family knowledge and acceptance of life-limiting prognosis
- Preference for treatment goals directed toward relief of symptoms rather than modification of underlying disease
- Preference to avoid hospitalization, except for inpatient palliative or hospice care

— Stuart, *Journal of Palliative Medicine*

Despite the Burdens, Informal Caregivers of Dying Patients Value Their Roles

Nearly three quarters (72.3%) of chronically disabled adults receive help from family caregivers or friends while living at home in their last year of life, a team of researchers from the Johns Hopkins School of Health, Baltimore, has found. Yet their caregivers report a higher rate of perceived rewards than of burdens associated with providing this help.

“Despite the intensity and challenges related to providing assistance, more than two thirds of end-of-life caregivers reported that they derived personal rewards from their helping role,” write the authors of the report published in the *Archives of Internal Medicine*.

The team analyzed interview responses of 1149 primary informal caregivers providing end-of-life care help to a nationally representative sample of chronically disabled older adults living in the community. Caregivers to those in their last year of life tended to be female (75.1%),

and averaged 63.6 years of age. Results were not analyzed for the presence of hospice care.

Findings regarding caregivers’ attitudes include:

- **CHALLENGES:** 53.5% of participants reported providing assistance when they did not feel well, 44.8% had their sleep interrupted to provide help, and 36.8% were not able to leave their care recipient at home alone.
- **BURDENS:** Informal caregivers experienced emotional stress (28.9%), physical strain (18.4%), and financial hardship (14%).
- **REWARDS:** 76% of caregivers reported feeling useful and needed; 70.2% said that helping made them feel good about themselves; and 69.4% reported that it enabled them to appreciate life more.

Informal caregivers provided a mean of 43 hours of help weekly, with 84.4% helping daily with such tasks as: shopping and

transportation (85.3%); household chores (82.8%); personal care and nursing (64.8%); finances (52.3%); administration of medicine (50.9%); and indoor mobility (38.6%).

“Findings from this study have practical implications for physicians and other health care professionals,” comment the authors. **“That nearly three quarters of chronically disabled older adults in the last year of life received help from an informal caregiver underscores the relevance of family to end-of-life patient care, and the potential benefit of productive collaborative relationships between physicians, patients, and families.”**

Source: “End-of-Life Care: Findings from a National Survey of Informal Caregivers,” Archives of Internal Medicine; January 8(1), 2007; 167:40-46. Wolff JL, Dy SM, Frick KD, Kasper JD; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Health, Baltimore.

Homeless People Voice Unique End-of-Life Care Concerns

Compassion and Respect from Providers Are Highly Valued

In the first in-depth exploration of a homeless population and their attitudes towards end-of-life care, a team of researchers has found that the **most often cited barrier to good end-of-life care was health care professionals’ attitudes towards the homeless. Respondents felt they were not treated with compassion or respect, although not all comments were negative, and “compassionate providers were described gratefully.”**

The team analyzed the interview responses of 53 homeless persons (female, 35%; mean age, 47 years) recruited from six social service agencies in Minneapolis

and St. Paul, MN. The study findings were published in a recent issue of the *Journal of General Internal Medicine*.

“A major finding is the importance of advance care planning and documentation for this isolated population,” the authors note. “According to participants, documents serve different functions among a population that is anonymous, voiceless, or lacks obvious surrogate decision makers.”

Respondents suggested ways to improve end-of-life care for homeless or overlooked populations. These include: health care provider and patient education; documentation to preserve autonomy; and

special programs and facilities for dying or seriously ill homeless people who have only shelters to go to when released from the hospital.

“These findings have implications not only for homeless persons, but for others who are poor and disenfranchised,” the authors note.

Source: “Dying on the Streets: Homeless Persons’ Concerns and Desires about End-of-Life Care,” Journal of General Internal Medicine; April 2007; 22(4):435-441. Song J, Bartels DM, Ratner ER, Alderton L, Hudson B, Ahluwalia JS; Center for Bioethics; Medical School; and Academic Health Center, University of Minnesota, Minneapolis.

Limiting 'Irrational Use' of Tube Feeding Could Improve Quality of Life in Advanced Dementia Patients

Despite a “near-complete lack” of evidence showing any benefit from the use of enteral tube feeding in nursing home patients with advanced dementia, the utilization of this invasive procedure nationally continues to be high. System-wide incentives — independent of real medical indications — drive the overuse of nonbeneficial tube feeding, according to an article published in the *Journal of the American Medical Directors Association*.

“Tube feeding is generally ineffective for nursing home residents with advanced dementia,” write Thomas E. Finucane, MD, and colleagues at the Johns Hopkins Bayview Medical Center, Baltimore. **“Underlying the widespread use of this marginally effective therapy is a basic misunderstanding about malnutrition and aspiration pneumonia.”**

The impulse in the face of an elder, demented patient or loved one who is eating little and losing weight is to provide nutrition, and weight loss is often a presumed sign of nursing home neglect. But advanced cachexia can closely mimic starvation; research is under way to distinguish wasting illness from inadequate nutrient intake, the authors note. Meanwhile, “administering protein and calories does not prevent the adverse clinical outcomes imputed to malnutrition.”

According to Scientific Evidence, Tube Feeding:

- Does not improve survival or functional status
 - Does not prevent pressure ulcers and other infections
 - Does not reduce the risk of aspiration pneumonia
- “With respect to aspiration pneumonia, tube feeding cannot protect the airway

from either oral secretions or regurgitated gastric contents, prime causes of the syndrome,” state the authors, “and in fact no published data suggest that tube feeding reduces the risk of aspiration pneumonia.”

Nevertheless, financial incentives for nursing homes, hospitals, and gastroenterologists favor tube feeding, and “hundreds of thousands” of demented patients have received feeding tubes over the past 20 years. The authors outline recommendations for changing these incentives for feeding tube use in the care of nursing home residents with advanced dementia.

“Reimbursement schemes require significant modification to limit the irrational use of tube feeding,” the authors write. “Nursing home regulations based more securely on scientific evidence would likely reduce nonbeneficial tube feeding, as would evidence-based tort reform.”

Recommendations Include:

- **Improved education of families, physicians, and staff.** “The false belief that tube feeding prolongs life can be overcome.”
- **Modification of reimbursement schemes.** “Improved reimbursement for bedside care [in nursing homes] is essential.” Payments for hand feeding and tube feeding should be equalized, and Medicare reimbursement for “skilled days” following tube placement should be eliminated.
- **Modernization and clarification of federal nursing home regulations.** These are currently “based on discredited ideas about nutrition and nutritional markers” such as monitoring albumin levels, which “remain normal during prolonged

“We are not suggesting that patients should not receive nutrition; we believe that a careful, motivated program to improve oral nutrient intake is essential from the human as well as the scientific point of view in caring for all frail, demented, institutionalized people.”

— Finucane, et al,
Journal of the American Medical Directors Association

starvation, and tube feeding does not raise albumin levels in demented nursing home residents.”

- **Quality improvement initiatives.** The quality improvement organizations of the Centers for Medicare and Medicaid Services could provide technical assistance, measure and publicly report feeding tube use, and consider prohibiting the practice as a condition of Medicare participation.
- **Rationalization of the tort system.** Although “good solutions remain elusive,” tort reform that is evidence-based could discourage initiation of tube feeding merely as a defensive measure against possible litigation from families with unrealistic expectations.

“Realigning incentives in these ways could, we believe, improve the quality of care, quality of life, and safety of these vulnerable individuals, likely with reduced costs of care,” the authors conclude.

Source: “*Tube Feeding in Dementia: How Incentives Undermine Health Care Quality and Patient Safety*,” *Journal of the American Medical Directors Association*; May 2007; 8(4):205-208. Finucane TE, Christmas C, Leff BA; Johns Hopkins Bayview Medical Center, Baltimore.

CLINICIAN RESOURCES

When and How to Discuss Hospice? Physicians Offered a Structured Strategy

Hospice offers dying patients a “unique set of benefits,” providing care that studies have found to be of high quality, with a high rate of patient and family satisfaction, according to palliative care experts writing in a recent issue of the *Annals of Internal Medicine*. Yet the median length of hospice stay remains at about two weeks. As well, many eligible patients never enter hospice, and 10% of those who do are not enrolled until the last 24 hours of life.

“[T]here is widespread agreement among experts in the field and physicians that more patients could enroll in hospice and many of those who enroll should do so sooner,” write David J. Casarett, MD, Philadelphia Veterans Affairs Medical Center, and Timothy E. Quill, MD, University of Rochester, NY.

Clinicians are not expected to address the systemic barriers to timely hospice referral — such as the way the Medicare hospice benefit is structured — but they can help patients to enroll sooner by knowing when and how to discuss hospice with patients and families, without depriving them of hope, maintain the authors.

PHYSICIANS CAN:

- Be alert for clinical characteristics associated with a life expectancy of six months, which are often easily ascertained. “The most valuable predictors of a limited life expectancy can be derived from available clinical and laboratory data and require no additional testing.” A table of factors associated with limited prognosis in four major diseases is included in the article.
- Frame the hospice discussion in terms of the patient’s goals and needs for care.
- Recommend hospice when it appears to be the best option, and arrange for an enrollment visit or informational visit with a hospice nurse.

A Structured Approach to Discussing Hospice

- **Ensure that appropriate family members are present** for the discussion. “Is there someone you rely on to help you make important decisions?” “Who in the family should be there with us when we discuss the results?”
- **Clarify the patient’s understanding** of the disease status and prognosis. “From what you know, would you expect your condition to get better, worse, or remain the same in the next month?” Asking patients to describe their current medical situation can help identify possible misunderstandings and states of denial.
- **Define the goals of care.** For some patients, a summarization can be used. “From what you’ve told me and the things we’ve discussed before, it seems that what’s most important to you is... Is that right?” For other patients, clarification of goals will be needed. “What are you hoping for most in the next few months?” “What do you fear most?”
- **Identify the needs for care.** Determine patient and family needs that can best be met by the multidimensional approach of hospice care. “It can be very difficult to care for a family member at home. Have you thought about what kinds of help you might need?” “Would it help if we could have your medications delivered to you?” “Would you find it reassuring to have regular home visits from a nurse?”
- **Summarize and link the goals and care needs.** “So, as I understand it, your main goal is to stay at home and spend as much time as you can with your family. To do that,

we will need to help you in several ways, for instance...”

- **Introduce hospice** as part of a coherent plan of care, in light of clinical circumstances, prognosis, and the goals and needs of the patient and family. “One of the best ways to give you the help that you will need to stay at home with your family is a program called hospice. Have you heard of it?” “Hospice can provide more services and support than most other home care programs.” “The hospice team has a lot of experience caring for seriously ill people at home.”
- **Respond to emotions and provide closure.** “You seemed surprised to learn how sick you are.” “I can see it’s not easy for you to talk about hospice.”
- **Empathize.** “I can imagine how hard this is for both of you; you care so much about one another.”
- **Explain hospice goals and reassure.** “Hospice doesn’t help people die sooner. Hospice helps people die naturally, in their own time.” “Hospice helps people live as well as they can for as long as they can.” “Hospice can help you and your family make the most of the time you have left.” “Hospice’s goal is to improve your quality of life as much as possible...”
- **Recommend hospice.** “I think that hospice would be your best choice right now, but of course, the final decision is yours.” “Hospice could be very helpful to you in the ways we’ve discussed, but I realize it’s a big decision. I’d like to arrange for a hospice nurse to visit you, so you can decide for yourself if hospice would be right for you.”

— Casarett and Quill. *Annals of Internal Medicine*

“Although there are clear benefits to timely hospice referral for many patients, the introduction of hospice is frequently perceived by patients and families as bad news,” write the authors. They suggest that physicians approach hospice discussions in a structured manner similar to that used for sharing “bad news.”

Source: “‘I’m Not Ready for Hospice:’ Strategies for Timely and Effective Hospice Discussions,” *Annals of Internal Medicine*; March 20, 2007; 146(6):443-449. Casarett DJ and Quill TE; Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, and University of Pennsylvania, Philadelphia; Center for Ethics, Humanities, and Palliative Care, University of Rochester Medical Center, Rochester, New York.

CLINICIAN RESOURCES

Pain Management and Opioid Addiction: Federal Agency Hosts Interdisciplinary Dialogue

Webcast: www.nida.nih.gov

For the first time in its 33-year history, the National Institute on Drug Abuse of the federal National Institutes of Health (NIH) invited researchers, clinical experts, and others to participate in a public discussion of the benefits and risks of opioid pain medication.

The two-day conference, “Pain, Opioids, and Addiction: An Urgent Problem for Doctors and Patients,” convened last March under the co-sponsorship of the NIH Pain Consortium and the American Medical Association. A Webcast of the meeting is available at www.nida.nih.gov. The stated goal of the conference was “to bring the power of science to inform practitioners how to most effectively and compassionately treat these [chronic, nonmalignant pain] conditions while minimizing the risk of abuse and addiction in these patients.”

Physicians were offered practical strategies for safe prescribing, structured monitoring, and regular assessment for the effectiveness of treatment and possible negative outcomes — all in the context of the imperative for aggressive pain management.

For regular assessment of the effectiveness of pain treatment and presence of negative outcomes, Steven D. Passik, PhD, Memorial Sloan-Kettering Cancer Center, NYC, has co-developed and published a 4-domain (“the 4 As”) Pain Assessment and Documentation Tool. Physicians should assess:

Analgesia — for adequate pain relief

Activities of daily living — for improvement in patient functioning

Adverse events

Aberrant drug-related behaviors

Regular assessment gives physicians the opportunity to intervene and adjust their treatment regimens, said Nathaniel P. Katz, MD, Tufts University School of Medicine, Boston. For those 30% to 40% of patients who do not initially respond to opioids, said Katz, physicians can:

- Adjust the dosing regimen
- Add another analgesic
- Suggest physical therapy
- Obtain a psychological consultation
- Try a different opioid
- Try nonpharmacological therapies

Source: “Scientists Probe Ways to Curb Opioid Abuse without Hindering Pain Treatment,” *Journal of the American Medical Association*; May 9, 2007; 297(18):1965-1967. Kuehn BM. “A New Tool to Assess and Document Pain Outcomes in Chronic Pain Patients Receiving Opioid Therapy,” *Clinical Therapeutics*; April 2004; 26(4):552-561. Passik SD et al; *Symptom Management and Palliative Care Program, Markey Cancer Center, University of Kentucky, Lexington.*

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice and Palliative Medicine

www.eperc.mcw.edu

End of Life/Palliative Education Resource Center (EPERC)

www.epec.net

The EPEC Project (Education in Palliative and End-of-Life Care)

www.nhpco.org

National Hospice & Palliative Care Organization

www.caringinfo.org

National consumer engagement initiative to improve end-of-life care

www.promotingexcellence.org

Promoting Excellence in End-of-Life Care

www.hospicefoundation.org

Hospice Foundation of America

www.americanhospice.org

American Hospice Foundation

www.hpna.org

Hospice and Palliative Nurses Association

www.medicaring.org

Palliative Care Policy Center

www.abcd-caring.org

Americans for Better Care of the Dying

www.mcw.edu/pallmed/

Medical College of Wisconsin Palliative Care Center

www.painpolicy.wisc.edu/

University of Wisconsin Pain and Policy Studies Group

www.capcmssm.org

Center to Advance Palliative Care

www.stoppain.org

Pain Medicine & Palliative Care, Beth Israel Medical Center

FAQ's on the Medicare Hospice Benefit

1. Can I refer a patient to Hospice of VNS even though the patient has a Medicare HMO?

Yes! Patients who have elected a Medicare HMO may select the hospice of their choice. This is because Medicare Part A becomes the primary insurance for hospice even if the patient has been enrolled in a Medicare HMO.

2. What does the Medicare Hospice Benefit cover?

The Medicare Hospice Benefit was developed to encompass most of the needs of terminally ill patients, including medications related to the patient's terminal illness. Benefits include:

- Analgesics for pain control and other medications necessary to ensure the patient's comfort.
- Durable medical equipment such as electric hospital beds or oxygen and supplies related to the terminal diagnosis.
- All of the visits by the hospice interdisciplinary team – RN, SW, nurse's aide, chaplain, and volunteers, as well as dietary counseling and grief and loss counseling for the patient and family. PT, OT, ST and massage therapy, as directed by the hospice interdisciplinary team, are also covered.
- Short-term inpatient care for pain and symptom

control, as well as respite care.

3. What happens if I certify a patient's terminal illness as 6 months or less to live and they survive longer than the prognosis?

Physicians can recertify Hospice Benefit patients whose terminal illness runs a more gradual course than originally expected. Upon enrollment, beneficiaries receive two 90-day "periods of care," followed by an unlimited number of 60-day periods, provided their prognosis continues to meet eligibility requirements.

At **each** recertification, regardless of how long the patient has been enrolled in hospice, the physician is certifying that the prognosis is 6 months or less if the illness runs its expected course.

4. If the patient opts out of Hospice or is discharged from Hospice due to improvement or stability, can the patient reapply for the Hospice Benefit again?

Yes. There is unlimited, lifetime access to hospice care under the Medicare Hospice Benefit. As long as a patient meets the criteria for hospice care, it can be reelected if the patient chooses. This is true for Medicare, Medicaid, and most private insurances.

**Call 330-665-1455 or 800-335-1455
to make a referral to
Hospice of Visiting Nurse Service.**

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