Improving End-of-Life Care in Vermont--One Hospice Referral at a Time

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Objectives

- Distinguish Medicare Certified Hospice from Hospice Volunteer Services
- Differentiate criteria for community based palliative care versus hospice
- Debunk myths about hospice
- Define benefits to survival, family satisfaction and the bereaved associated with hospice
- Present national, regional and state Medicare data about hospice utilization

Medicare Certified Hospice: A one slide history

- St. Christopher's Hospice was established in England by Dame Cicely Saunders in 1967.

- Saunders came to the U.S. in the 1970s to teach at Yale; the Connecticut Hospice was opened in 1974.

- Established as Medicare benefit in 1982; made permanent in 1986.

But how do I know if it's hospice?

Medicare Certified	Non-Medicare Volunteer Hospice
• Nursing and therapy • Assistive (personal care) • Medical social work • Pastoral care • Physician visit/consultation • Bereavement Support	• Loving care at the end of life • Community education • Bereavement services

BAYADA® Hospice

vnas of Vermont

Brattleboro Area Hospice
Loving Care for the Dying and Bereaved

Hospice
VOLUNTEER SERVICES
Serving Addison County, Vermont Since 1983

Community-Based Palliative Care

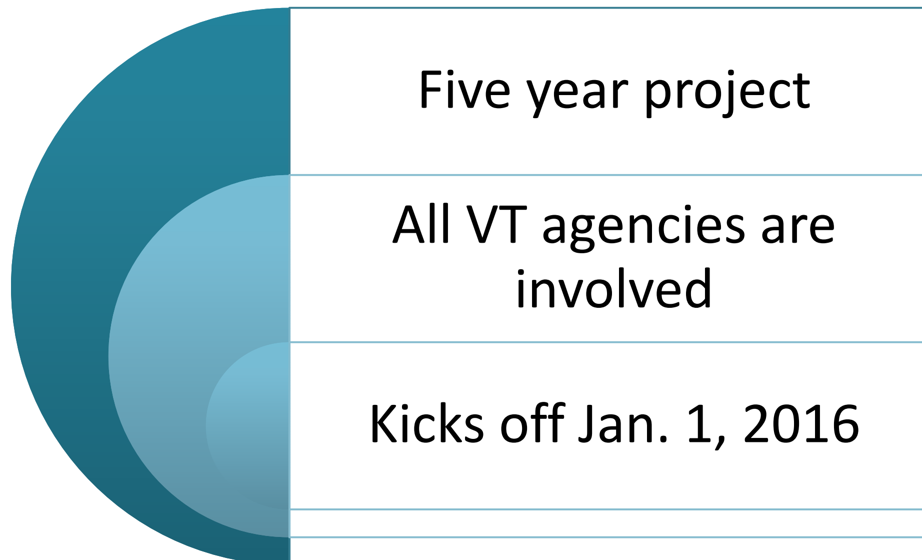
vs. Hospice Enrollment

Patient does not have to be homebound

Questions? Call your local hospice provider

Medicare Care Choices Model

Medicare will provide a new option for Medicare beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The purpose is for CMS to evaluate whether providing hospice services can improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures.



Hospice Myths vs. Truths

Medications will be stopped or not paid for

✓ Medications related to the patient's terminal prognosis will be continued and paid for

Patient will lose the MD who knows them best

✓ Patient chooses MD that drives the hospice POC

Referring MD worries that if survival is greater than six months, they will be "in trouble"

✓ Burden of proof for continuation of hospice care lies with the hospice MD

Hospice MD hastens death

✓ Studies show patients often live longer when enrolled in hospice sooner

Discharged if they live longer than six months

✓ Hospice MD must review hospice eligibility every two weeks or when there is a change in condition

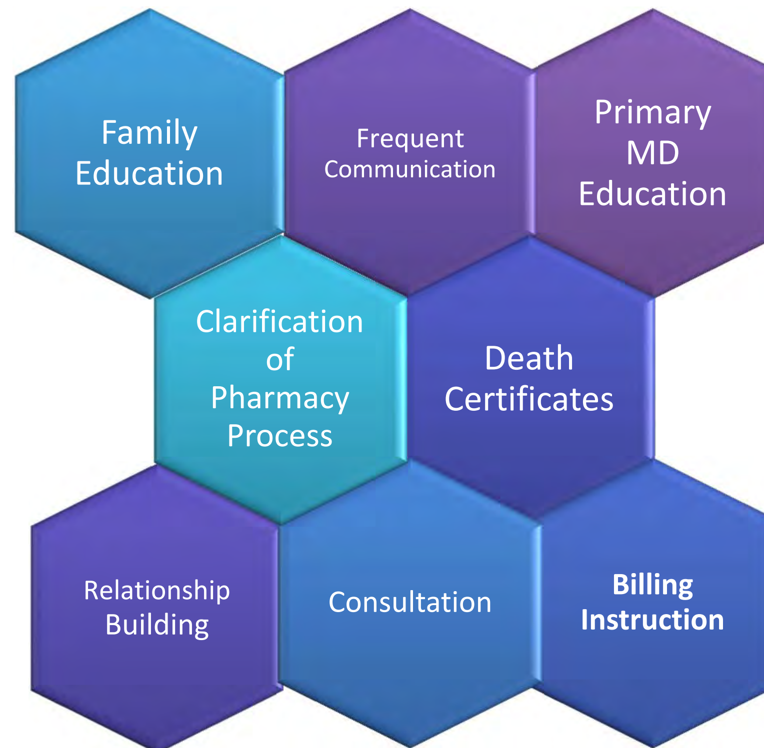
Hospice is only provided at the patient's home

✓ Hospice can be provided in skilled nursing facilities, assisted living facilities or anywhere a patient lives

General Inpatient (GIP)

The highest, most intensive level of care billable under Medicare-certified hospice. It is short-term, inpatient care or services provided through a Medicare-certified hospital or long term care facility to provide pain control and symptom management ***that cannot be accomplished in another setting***.

Collaboration



Comparing Hospice & Non-Hospice Survival

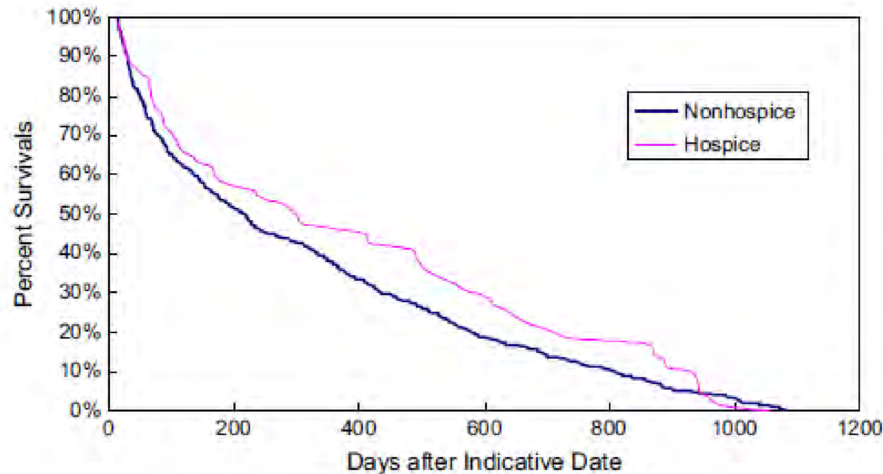


Fig. 1. Survival curve for patients with CHF.

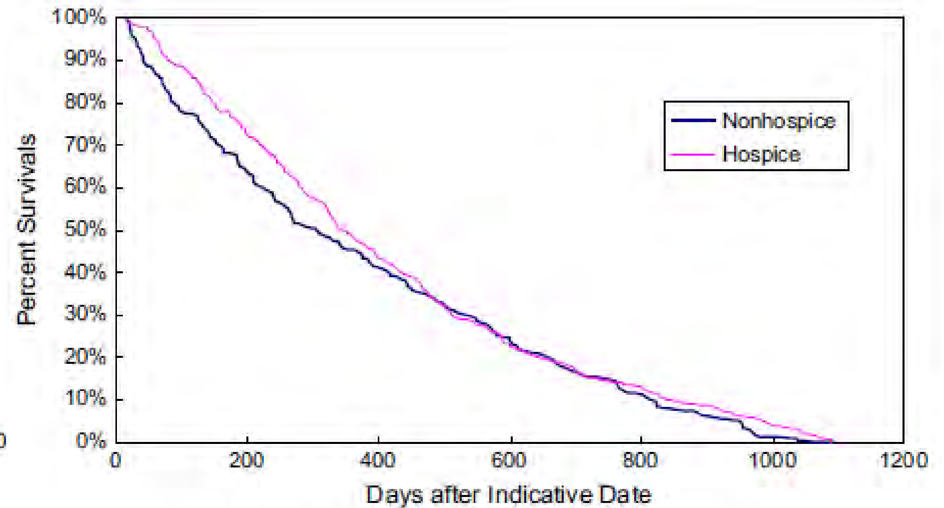


Fig. 2. Survival curve for patients with colon cancer.

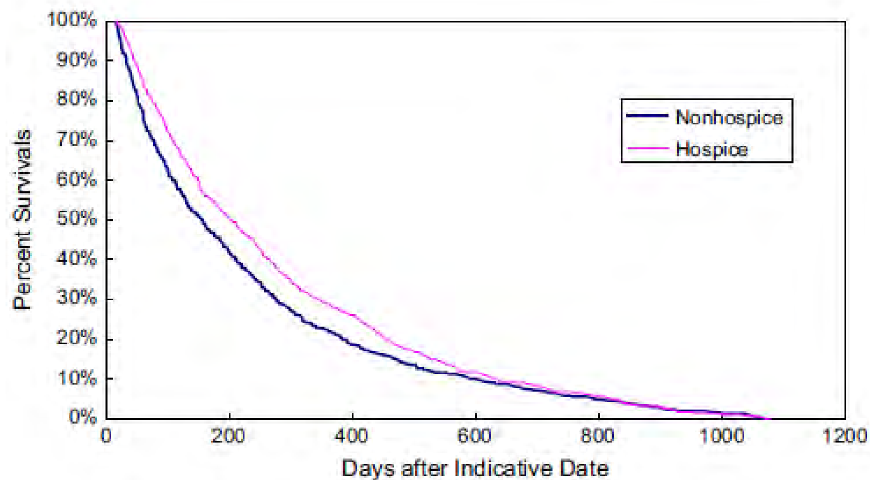


Fig. 3. Survival curve for patients with lung cancer.

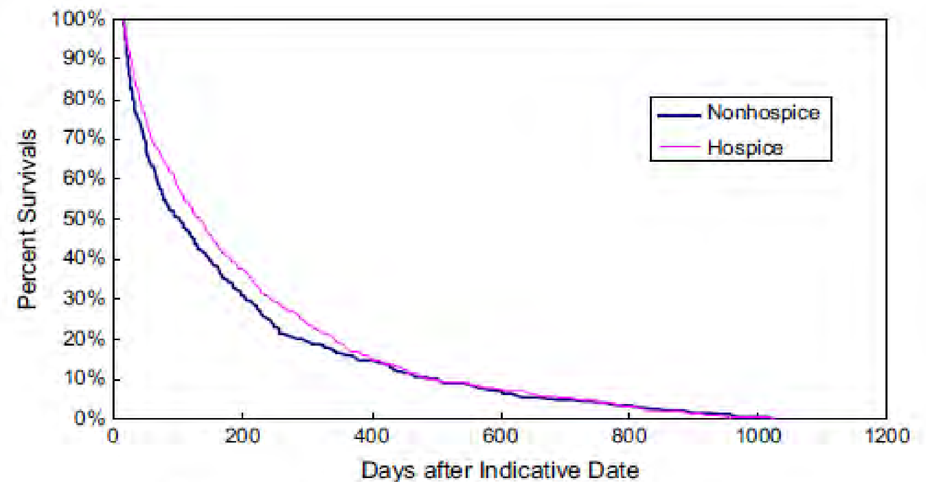


Fig. 4. Survival curve for patients with pancreatic cancer.

Connor 2007

Does Hospice Improve Quality of Care for Persons Dying from Dementia?

Nearly one in five decedents who died without hospice services reported a need for additional help in treatment of dyspnea

Outcome	Non-Hospice (n = 278)	Hospice (n = 208)	Hospice, Too Late (n = 33)	Adjusted Odds Ratio (95% Confidence Interval)*
Overall problem score, mean (range 0–8)†	1.2	0.74	2.7	0.49 (0.33–0.74)
Components of the problem score, % with component				
Unmet need for management of pain	11.7	7.0	28.6	0.51 (0.18–1.45)
Unmet need for management of dyspnea	19.1	6.1	31.3	0.22 (0.10–0.54)
Patient was always treated with respect	81.6	79.9	57.6	1.00 (0.62–1.57)
Family wanted more information on what to expect while patient was dying	22.5	11.1	48.5	0.41 (0.23–0.70)
Family wanted more information regarding how pain was managed	16.9	8.1	31.8	0.54 (0.29–1.00)
Family wanted more information on what to do at time of death	25.1	11.8	51.5	0.34 (0.23–0.53)
Family wanted more help regarding spiritual and religious concerns	10.6	7.3	21.2	0.64 (0.37–1.10)
Family wanted more emotional support regarding their grief before patient's death	22.7	14.0	43.8	0.50 (0.36–0.70)
Rating of quality of care, mean‡	31.6	34.3	25.4	2.30 (1.69–3.13)
Provided medical care that respected medical wishes, %	8.2	8.8	7.2	1.94 (1.48–2.57)
Symptoms were controlled to desired level, %	8.2	8.7	6.6	1.54 (1.10–2.15)
Emotional support provided to patient and family, %	7.4	8.1	5.5	2.00 (1.36–2.83)
Communicate with family about medical condition, %	7.7	8.5	5.8	2.30 (1.59–3.34)
Peacefulness of dying (1 = very much at peace, 10 = very much not at peace)	1.8	1.1	2.4	0.51 (0.35–0.74)
Quality of dying (1 = a very poor death, 10 = a very good death)	8.4	8.9	7.5	1.68 (1.11–2.56)

People who received hospice services "at the right time" had lower problem scores than those who did not receive hospice services. (P <.001)

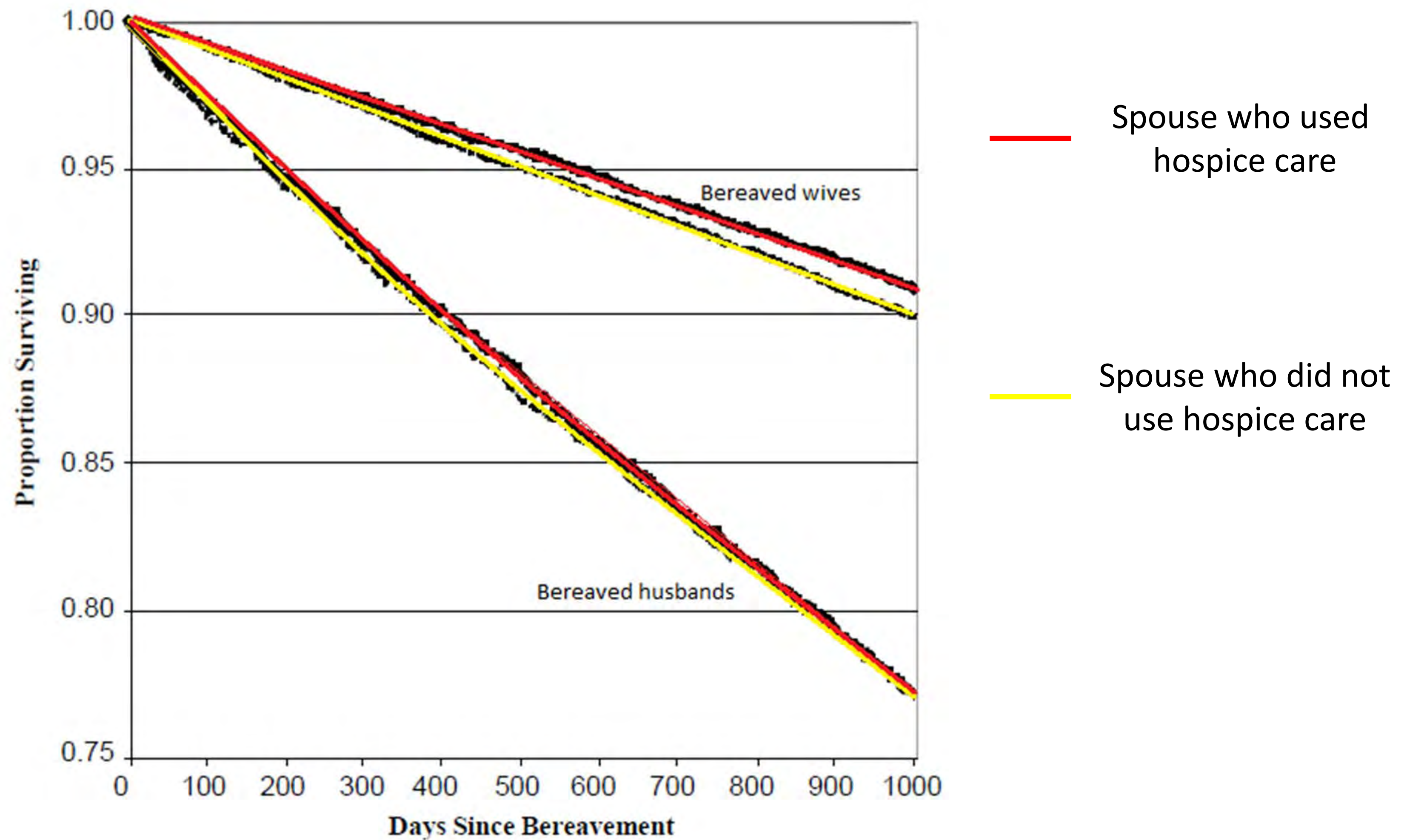
* Results compare persons receiving hospice at the right time with those who did not receive hospice after adjusting for state, age, sex, race, respondent relationship, and years of education.

† Overall problem score is based on 8 items that measure whether the family member had a concern with the quality of care or an unmet need.

‡ Based on four items that ask the respondent to rate care between 0 (the worst care) and 10 (the best care). The four items are added to create a score between 0 and 40.

Teno 2013

Mortality Outcomes in Surviving Widowed Spouses



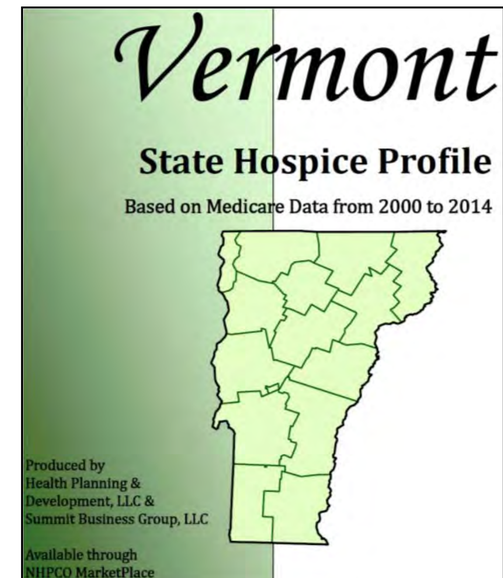
Christakis & Iwashyna 2003

Definitions

Hospice Penetration: $\frac{\text{(Total Hospice Patients)}}{\text{(Total Medicare Deaths)}}$

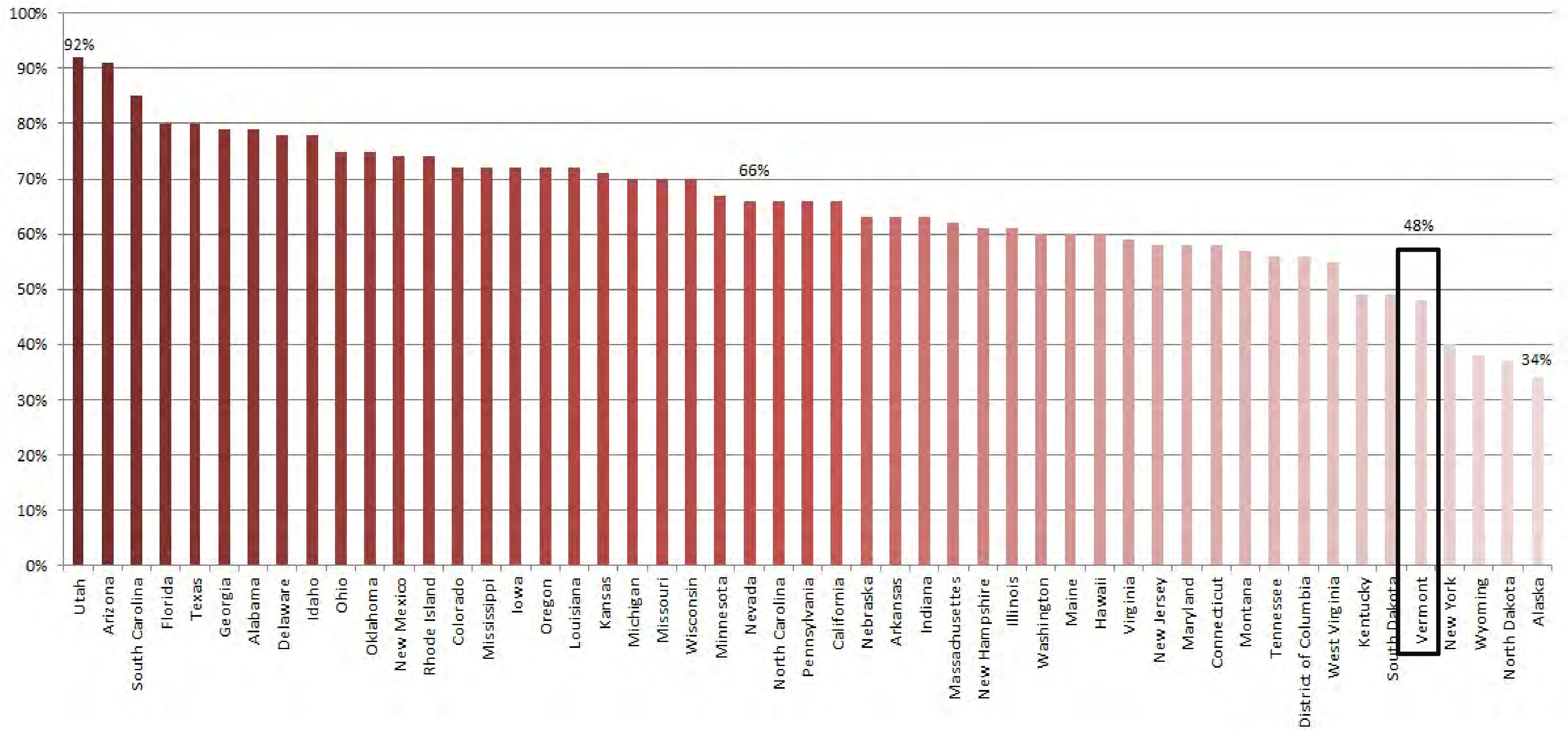
Median LOS is the median number of days patients spend in hospice in the year.

Average LOS is: $\frac{\text{(Patient Days in County)}}{\text{(Patients Served in County)}}$



The information provided from the Hospice Market Atlas™ consists of aggregated data as reported by CMS in the annual Limited Data Sets for calendar years 2000 to 2014. The data within the Hospice Market Atlas ™ are limited to Medicare patients.

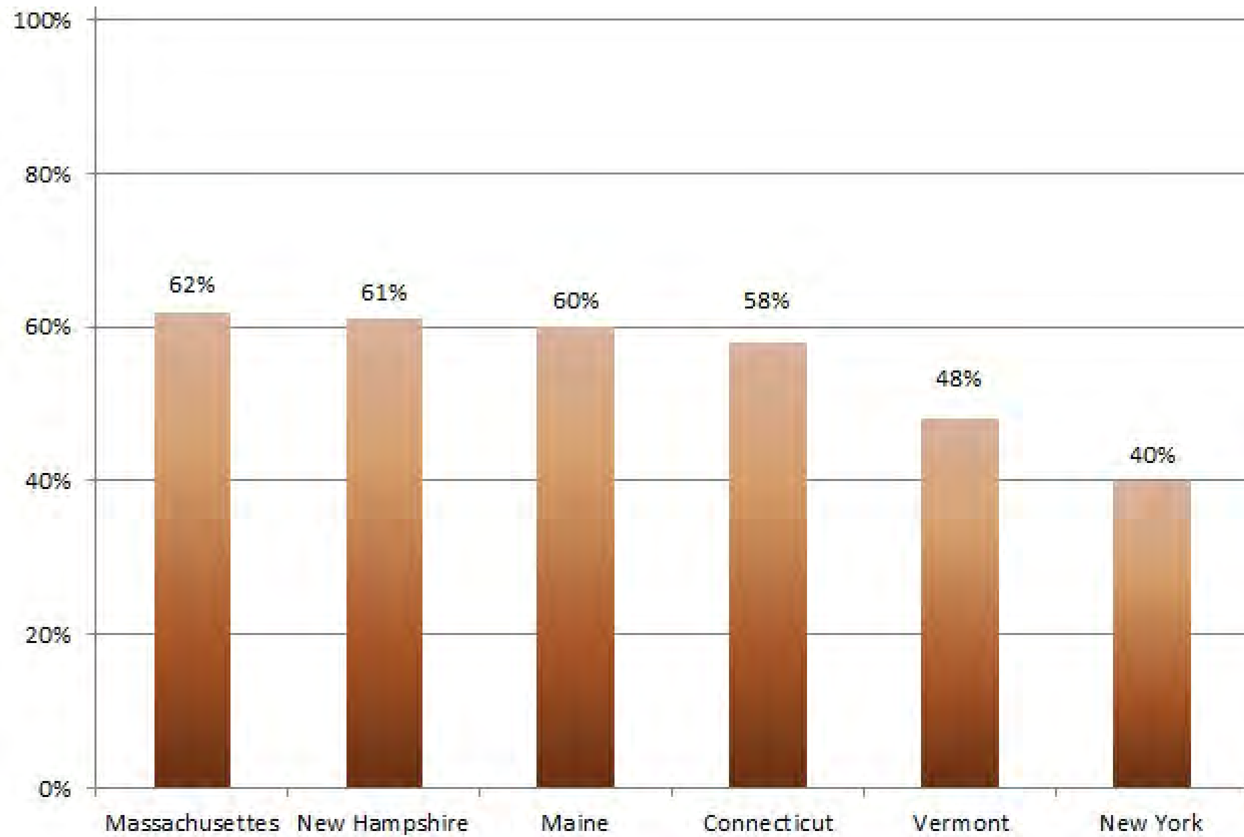
Hospice Penetration by State, 2014



2013 Hospice Penetration for State of VT: 44%

Based on Medicare Data from 2000 to 2014
Produced by Health Planning & Development, LLC
& Summit Business Group, LLC

Hospice Penetration in Vermont and Nearby States, 2014



Vermont

$$\frac{\text{(2,293 Hospice Patients)}}{\text{(4,774 Medicare Deaths)}} = 48\%$$

Based on Medicare Data from 2000 to 2014
Produced by Health Planning & Development, LLC
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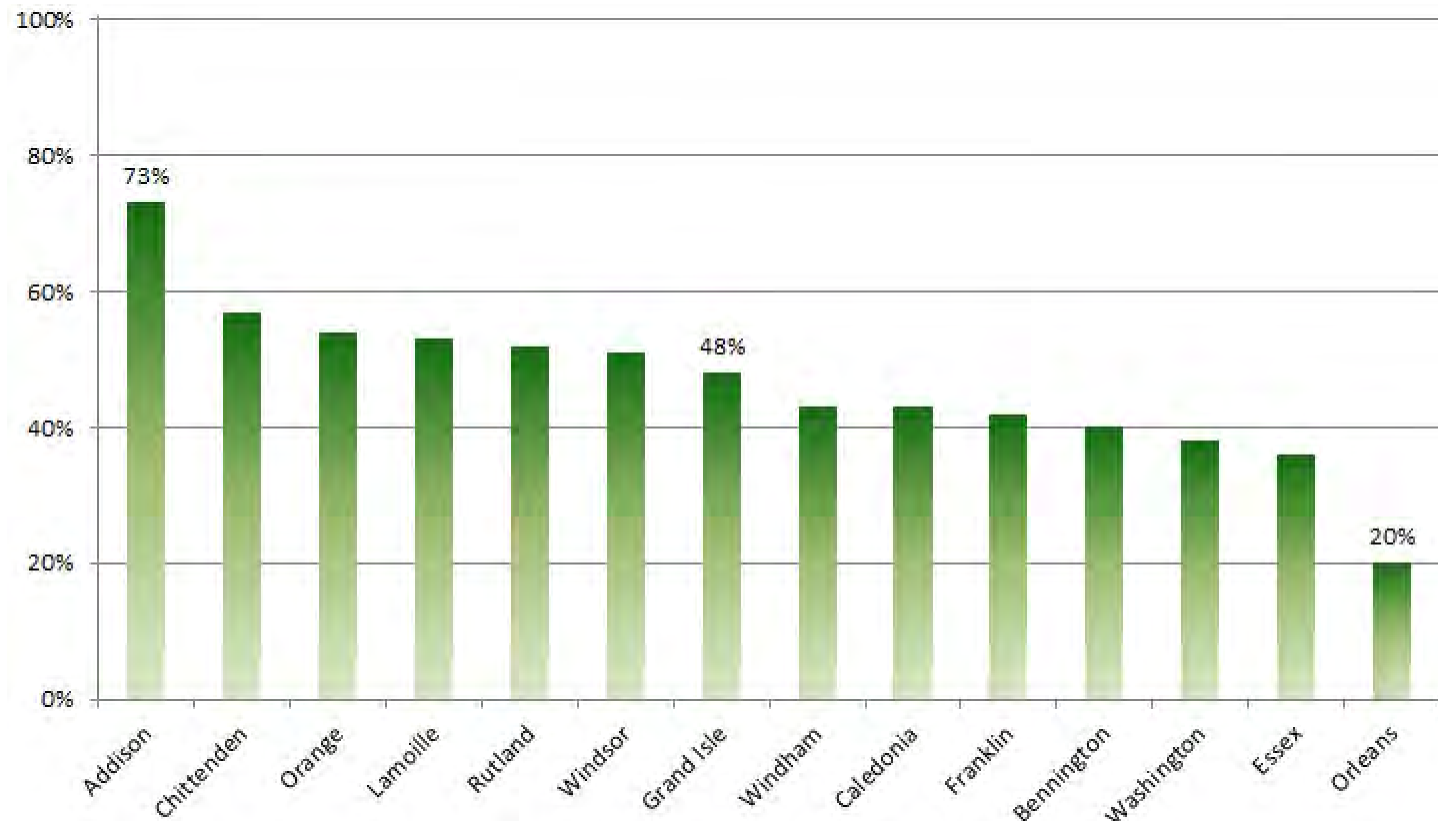
Hospice Penetration in Vermont by County, 2014



Addison County
(173 Hospice Patients) = 73%
(237 Medicare Deaths)

Grand Isle County
(20 Hospice Patients) = 48%
(42 Medicare Deaths)

Orleans County
(50 Hospice Patients) = 20%
(246 Medicare Deaths)

Based on Medicare Data from 2000 to 2014
Produced by Health Planning & Development, LLC
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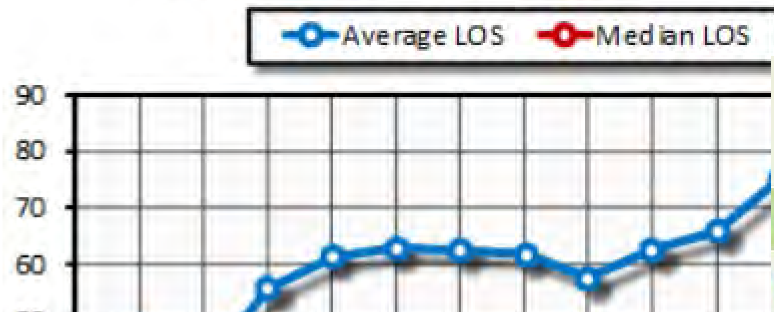
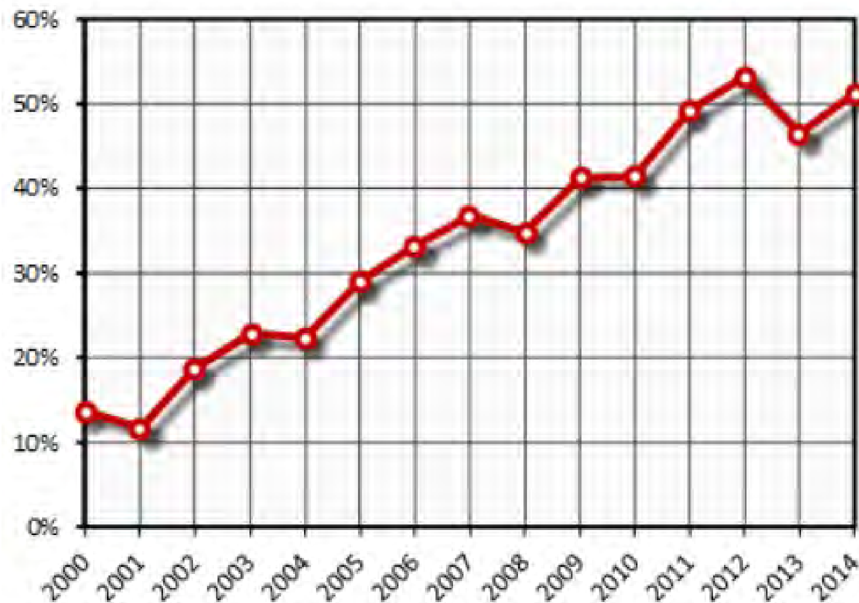
Medicare Hospice Utilization in Windsor County



Distribution of Hospice Census in Windsor County for 2014	
Home	61%
Nursing Home	18%
Assisted Living Facility	20%
Hospital	1%
Hospice Facility	0%
Other	0%
Total	100%



Based on Medicare Data from 2000 to 2014
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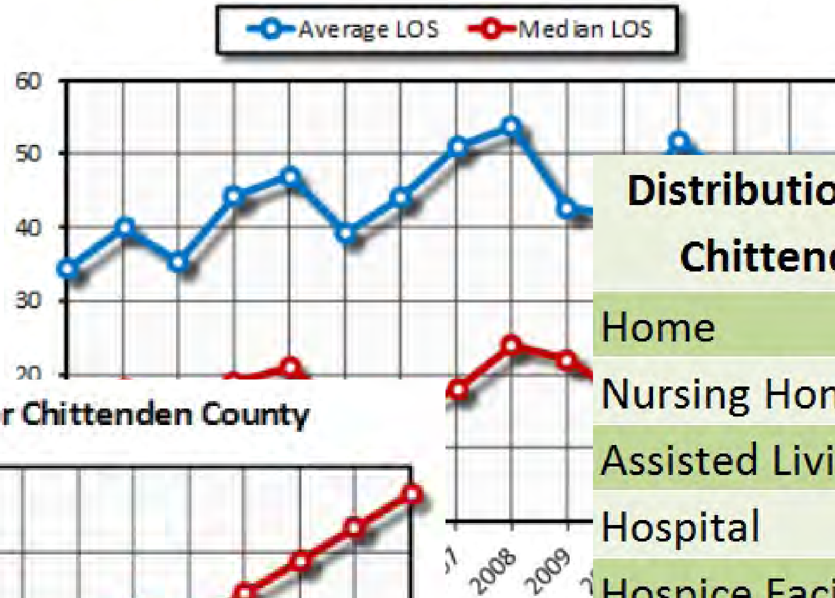
Medicare Hospice Utilization in Chittenden County



Distribution of Hospice Census in Chittenden County for 2014	
Home	62%
Nursing Home	15%
Assisted Living Facility	10%
Hospital	0%
Hospice Facility	9%
Other	5%
Total	100%

Based on Medicare Data from 2000 to 2014
Produced by Health Planning & Development, LLC
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Why is hospice utilization still so low in VT?

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