CHANGES IN MEDICARE WILL IMPACT END-OF-LIFE CARE

“Evaluating A New Era In Medicare Hospice And End-Of-Life Policy,” by Donald Taylor, Nrupen Bhaysar, Matthey Harker, and Cordt Kassner, is printed in Health Affairs. The article focuses on three significant changes in Medicare’s payment system for end-of-life care. “A key task,” says the article, “will be providing evidence-based assessments of these and subsequent policy changes.” The authors share their ideas about questions that can guide evaluation in each of the three areas of change.

One reform implements a new two-tiered system of payment rates for hospice services. The first 60 days of a patient’s care will be billed at a higher rate. The hope is that this will encourage hospice providers to help patients enroll sooner and increase the average stay in hospice from the current eighteen days. This change also recognizes the intensity of care that occurs in the early days of hospice. This new structure may also slightly discourage very long (over 180 days) stays in hospice.

Also for hospices, retrospective Service Intensity Add-On payments will be added to help cover the costs for the additional care that often happens in the last week of a person’s life. Both of these changes should increase payments to hospice providers significantly in 2016. However, these two increases together may put hospices near or over the Medicare payment cap and result in them having to return money to the federal government.

Questions for evaluating these changes include: “Will the payment changes (i.e., higher rates for shorter stays) lead to an increase in the length of use at the shorter end of the spectrum, while decreasing it at the longer end?” Do the changes impact quality of hospice care? Are overall Medicare costs for hospice care? Do visits intensify during the last week of life?

Another change in Medicare payments will mean that advance care planning conversations between physicians, patients and their families will now be covered. Previously such discussions had only been paid for during the “Welcome to Medicare” visit. This increase in coverage will hopefully lead to more frequent discussions between healthcare providers and patients about end-of-life concerns. Knowing patient’s desires, and meeting their wishes, is the hope of this change.
Questions to evaluate this change include: Do the discussion impact the kind of care patients choose to receive? Do the conversations result in increased and earlier admissions to hospice? Are referrals to palliative care improved?

Finally, the Medicare Care Choices Model (MCCM) demonstration under the auspices of the Center for Medicare and Medicaid Innovation (CMMI) in the Center for Medicare and Medicaid Services (CMS) will allow patients in this pilot program to receive simultaneous hospice care and curative treatment. Providers will receive a monthly fee for this service.

Exploring this change in the care paradigm has been something that providers and patients have been seeking for a long time and may reduce costs. “A recent study found that around four in 10 Medicare beneficiaries with cancer would be willing to forgo some medical care in return for the flexibility of concurrent palliative care, and an evaluation of concurrent hospice in a non-elderly population showed improved quality of life and reduced costs.” However it is uncertain what kind of care exactly will be provided under this model. Hospices have to make it financially viable for them, which may mean reduced or different kinds of care, including remote and video visits in some areas.

Questions for evaluating the demonstration projects include: How is patient quality of life affected? How many patients elect the hospice benefit? How many patients leave the program?

According to the article, “Medicare policy focused on end-of-life care is entering a period of change that is likely to be ongoing. A key task will be providing evidence-based assessments of these and subsequent policy changes.”

In evaluating the outcomes, the government, Medicare and hospices must agree on what kind of evidence is “good enough” to show effective care and to inform evidence based policy-making. There also needs to be a good group comparison between beneficiaries who take advantage of the new advance care planning and those who do not. (Health Affairs, 12/22, healthaffairs.org/blog/2015/12/22/evaluating-a-new-era-in-medicare-hospice-and-end-of-life-policy/)

**COMFORT CARE CAN BE PART OF HOSPITAL DEATH**

Palliative care can be used to relieve distressing symptoms people often experience as they near death in the hospital. Healthcare providers outside the field of palliative care, according to an article in *The New England Journal of Medicine*, should know about what kinds of comfort care can be offered to make the dying less distressed and more at ease. This is particularly important as almost 30% of deaths in American happen in hospitals, with an average terminal stay of almost eight days.

The most important focus of comfort care is that it reflects the wishes of the patient and their family. Patient’s plans of care should have a clear connection to their values and goals. Healthcare providers should also be aware of the patient’s need for spiritual and psychological support during this time. The whole plan of care should be reviewed in detail with the patient,
The authors of the article in NEJM also offer detailed descriptions of the symptoms the dying might experience and a variety of ways they might be addressed to make them more comfortable. This includes things such as pain, breathlessness, cough, dry mouth and digestive issues. (The New England Journal of Medicine, 12/24, http://www.nejm.org/doi/full/10.1056/NEJMra1411746#t=article)

HOSPICE NOTES

* Two hospice workers have been arrested in Florida for stealing jewelry and other valuables from patients’ homes over a period of several years. (Osprey Observer, 12/28, www.ospreyobserver.com/2015/12/woman-arrested-for-stealing-jewelry-from-hospice-patients/)

* Susan Dolan responds to the question “Doesn’t hospice really kill people?” in an article for Huffington Post. She explains that patients’ experiences and wishes drive the kind and amount of pain relief hospice provides for the dying. Some people choose stronger drugs in order to be out of pain, while others will choose to experience some pain in order to be more alert. Death, she argues, doesn’t have to hurt. (Huffington Post, 12/27, www.huffingtonpost.com/susan-r-dolan/hospice-care_b_8846910.html)

* “Receipt of hospice care concurrently with chemotherapy or radiation therapy has increased among veterans dying from cancer without reduction in receipt of cancer therapy, according to a recent study published online ahead of print in Cancer.” Unlike Medicare, the Veterans Administration does not require patients to stop treatment before they enter hospice care. Between 2006 and 2012, those receiving concurrent care increased from 16% to 25%. (Cancer Therapy Advisor, 12/16, www.cancertherapyadvisor.com/general-oncology/veteran-cancer-concurrent-hospice-chemotherapy-radiation-treatment-risk/article/460068/)

* A new survey released by Hospital & Healthcare Compensation Service and the National Association for Home Care & Hospice reports that the average number of hospice patients that nurses and home care aides visited each day increased in 2015. The turnover rate for hospice workers also increased. All of the hospices surveyed offered their employees health insurance. (Home Health Care News, 12/28, homehealthcarenews.com/2015/12/hospice-nurse-care-aide-productivity-rises-in-2015/)

END-OF-LIFE NOTES

*A new study published in JAMA Neurology says, “Hospital policies for determining brain death are surprisingly inconsistent.” Among hospitals, “many have failed to fully implement guidelines designed to minimize errors.” The American Academy of Neurology composed a detailed set of guidelines in 2010 which hospitals are encouraged to follow. David Greer, a neurologist at the Yale University School of
Medicine led the study. Greer says, “There are very few things in medicine that should be black and white, but this is certainly one of them. There really are no excuses at this point for hospitals not to be able to do this 100 percent of the time.” Bioethicists are concerned that uncertainty about whether a person is really dead will erode trust in hospitals and make people reluctant to donate organs. (NPR, 12/28, www.npr.org/sections/health-shots/2015/12/28/460940576/researchers-find-lapses-in-hospitals-policies-for-determining-brain-death)

* With doctors beginning to be paid by Medicare for advance care planning, there is concern over whether physicians are ready and properly trained for these often-difficult conversations. “It’s a huge problem,” says Dr. Susan Block, director of the Serious Illness Care Program at Ariadne Labs, a collaboration of Brigham and Women’s Hospital and the Harvard School of Public Health. “This particular kind of conversation is at the intersection of two topics that medical schools have by and large avoided — end-of-life care and communication.” Others do not take as bleak a view of the situation, but agree that more training is needed and that there is room for physicians to improve their care of patients who are make decisions about end of life care. (Next Avenue, 12/17, www.nextavenue.org/are-doctors-ready-to-talk-about-end-of-life-care/)

* Blue Cross Blue Shield, the largest health insurance provider in Massachusetts and many other states has announced that it will pay for customers to receive more end-of-life counseling. CEO Andrew Dreyfus recently lost several family members and says he was inspired by the conversations they and the family had with physicians, and by the gentle death each had. (WGBH, 12/28, wgbhnews.org/post/blue-cross-blue-shield-pay-more-end-life-counseling)

* The Kansas City Star talked with Miranda Lewis, Nancy Cruzan’s niece. Lewis reflects on the legacy of her aunt’s death and her family’s fight to stop medical invention and allow her to die. In 1990 the US Supreme Court ruled in Cruzan v. Director, Missouri Dept. of Health that “the 14th Amendment to the Constitution allowed people to refuse unwanted medical treatments ordered by states — in this case, Missouri — that would artificially extend life.” Now that several more members of the family have died, Lewis is thankful for the more open atmosphere in which end of life wishes and death with dignity are discussed. (The Kansas City Star, 12/26, www.kansascity.com/news/business/health-care/article51696025.html)

* Writing in Vox about the change in Medicare reimbursement for advance care planning, Sarah Kliff, Vox health writer, says, “The United States has — quietly and with little fanfare — begun to do something quite remarkable. We’ve started to have a more sane conversation about death.” Kliff notes the Medicare payments now available for patients to talk with doctors about end-of-life care and hopes that this change will mean that most patients will receive something closer to the kind of care they say they want. She also sees the physician assisted suicide laws in Oregon and California as positive steps in the right direction, giving patients more control over their deaths. (Vox, 12/16, http://www.vox.com/2015/12/16/10117442/advance-care-planning-debate-2015)

* In a nationwide survey of hematologic oncologists in the United States, published in JAMA Internal Medicine, “more than half report that end-of-life discussions with their patients occur too late, with many reporting that they wait until a patient’s death is imminent before discussing EOL issues.” Hematologic oncologists who work in tertiary care centers are more likely to report late EOL discussions than those who work in centers based the community. (Medscape Multispecialty, 12/21, www.medscape.com/viewarticle/856233)
* Writer Melinda Welsh writes in *The Los Angeles Times* about her experience of being told that she has terminal cancer and “a yearish” to live. She reflects on her priorities and decisions about how to spend her time. She reflects, “I sometimes worry about my ability to exit life with grace and humor. What if I’m bad at suffering? I admit I can fill up with fear, but what’s the point?” (*The Los Angeles Times*, 12/11, [www.latimes.com/opinion/op-ed/la-oe-welsh-time-i-have-left-20151213-story.html](http://www.latimes.com/opinion/op-ed/la-oe-welsh-time-i-have-left-20151213-story.html))

**PALLIATIVE CARE NOTES**

* At the American College of Rheumatology (ACR) annual meeting, John Markman, MD, a neurologist at the University of Rochester Medical Center, and Daniel Clauw, MD, a professor of anesthesiology, rheumatology, and psychiatry at the University of Michigan, debated whether or not opioid analgesic medications belong in the management of chronic, noncancer pain. Dr. Markman argued that, while the risks of misused and abuse need to be taken in to account, there are many patients for whom opioids are an effective tool in pain management. Dr. Clauw argued that while opioids work well for acute pain, they are not effective with chronic pain and have too high a risk of addiction. (*Medscape Multispeciality*, 12/10, [www.medscape.com/viewarticle/855602?nlid=93274_1521&src=wnl_edit_medp_wir&uac=68861EJ&sp on=17&implID=921866&faf=1])


* Addressing the debate on opioid use for chronic pain, Fred Kaeser writes in *Pain News Network* “Looking objectively at the situation, there needs to be humane action on both sides of this conundrum. Whatever the result of the CDC’s new prescribing guidelines, people in chronic pain must not be denied adequate access to opioids when absolutely needed, and yet some action needs to occur to reduce the outrageous rates of opioid addiction.” Kaeser points out that there are almost no studies on long term used of opioids. Part of the solution, he argues, is alternative pain management techniques such as medication, yoga and stretching. (*Pain News Network*, 12/27, [www.painnewsnetwork.org/stories/2015/12/26/give-and-take-needed-on-cdc-guidelines](http://www.painnewsnetwork.org/stories/2015/12/26/give-and-take-needed-on-cdc-guidelines))

* Representative Elizabeth A. Malia, who serves in the Massachusetts’s House, has introduced a bill designed to curb opioid abuse. It differs significantly from the bill introduced in the state by Governor Charlie Baker. The Massachusetts Medical Society has pushed back against the governor’s proposals, saying it places too strict of limitations on prescriptions of opioids. The new House bill addresses some of those concerns among others. A joint Senate and House committee is currently considering the new bill and it is expected to go to other committees before reaching the floor of the chamber. A vote could happen early 2016. (*The Boston Globe*, 12/29, [www.bostonglobe.com/metro/2015/12/28/house-opioid-bill-veers-significantly-from-baker-proposal/dKJrN7vP9pXHeuR7QyqsSJ/story.html](http://www.bostonglobe.com/metro/2015/12/28/house-opioid-bill-veers-significantly-from-baker-proposal/dKJrN7vP9pXHeuR7QyqsSJ/story.html))

* A study published in *Critical Care Nurse* enumerates the benefits of palliative care in an ICU setting. Palliative care, however, is often underutilized in ICUs. Barriers to palliative care in ICUs include

**OTHER NOTES**

* Last January a father concerned about his brain dead son caused a three-hour standoff with police when he came to the hospital drunk and armed with a gun to stop his son from being weaned off life support. George Pickering II said that he felt like things were moving too fast and that there was still life in his son. Despite the previous diagnosis, his son has since recovered from the stroke and coma. Pickering was released from jail this month after serving time for two counts of aggravated assault with a deadly weapon. (*Fox 13*, 12/22, fox13now.com/2015/12/22/father-brings-gun-to-hospital-to-buy-time-for-his-brain-dead-son/)

* For the fourteenth year in a row Americans have ranked nurses as the most trusted profession. Eighty-five percent of those surveyed said that nurses’ honesty and ethical standards were “high” or “very high.” (*PR Newswire*, 12/21, www.prnewswire.com/news-releases/nurses-rank-as-most-honest-ethical-profession-for-14th-straight-year-300195781.html?sf43387729=1)