HOSPICE ADVOCATES TAKE THEIR CASE TO CAPITOL HILL

Nearly 250 hospice advocates gathered on Capitol Hill recently to support the Personalize Your Care Act of 2016, the Rural Access to Hospice Act, and the Care Planning Act. The gathering was the annual Advocacy Intensive of the Hospice Action Network and the National Hospice and Palliative Care Organization.

This year’s theme for the Advocacy Intensive was “Advocacy in Your Backyard.” During the two-day conference, attendees learned “best practices for advocating for hospice and how to connect directly with their members of Congress on Capitol Hill and back in their home districts.” Attendees scheduled meetings with over 300 Capitol Hill offices. Advocates provided lawmakers with information about three policy issues that could affect the hospice community:

- **Personalize Your Care Act of 2016 [HR 5555]**, which allows individuals with chronic and advanced illness to receive both conventional, curative treatments along with hospice and palliative care services.

- **Rural Access to Hospice Act [S 2786]**, which addresses statutory barriers that restrict some patients’ primary care physician from becoming their attending physician during hospice care.

- **Care Planning Act [S 1549]**, which creates a new Medicare benefit for care planning services offered by a hospice-like interdisciplinary team.

HOSPICES URGED TO ENGAGE IN LEGISLATIVE ACTION

NAHC recently called hospices to legislative action, and the Corridor Group issued a summary of the NAHC position. Congress will recess in August, and hospices are urged to use this time to connect with their leaders. Among the issues that hospice leaders are urged to encourage lawmakers to take action on are:

- Rescind or rework the face-to-face physician encounter requirement, and overturn claims denials related to this.
- Refuse the attempts to include hospice within the Medicare Advantage Benefit package.
- Empower PA’s to operate as attending physicians for hospice.
- Safeguard the Medicare Hospice Benefit.
- Deny any attempt to cut federal funding for Medicaid.


INSURERS LOOK TO PALLIATIVE CARE FOR QUALITY AND COST SOLUTIONS

Despite the seemingly relentless rise in health care premiums, there are limits to how much insurers can raise rates to cover the growing expenses of modern health care delivery. Insurance companies seek ways to limit their costs and provide health care plans at competitive rates. An article in Managed Care Magazine says that palliative care has emerged as a crucial opportunity to improve care while simultaneously cutting costs.

As America’s fastest growing medical specialty, with more than 6,500 physicians and 13,500 certified palliative care nurses, palliative care teams are now available in more than 80% of US hospitals that have more than 50 beds. Unlike hospice care, says the article, which is limited to terminally ill patients who have forgone curative treatments, palliative medicine can provide benefits alongside curative care.

The need for palliative care has never been greater says the article. “Roughly 46 million Americans have both a serious illness and some functional dependency, meaning they rely on a caregiver to help with one or more daily activities such as bathing, dressing, or eating.” These are people who benefit most from a robust palliative care emphasis in our medical system. “Without it, these patients can experience unmanageable pain and symptom crises, resulting in 911 calls, emergency department visits, and repeated hospitalizations.”

Multiple studies have shown that palliative care offers an additional layer of support that provides for both heightened quality of care, as well as lower costs. This has drawn the attention of the managed care industry. Health providers such as Aetna, Highmark, Cambia Health Solutions, and others, have
experienced superior results when combining palliative care with curative medicine. For example, Aetna’s Compassionate Care Program “resulted in an 81% decrease in inpatient days, and a net savings of $12,000 per participating member.” Encouraged by these results, other health plans are developing similar programs.

Despite insurer’s vested interest in lowering costs, it would be a mistake to view palliative care as merely a cost-saving measure, because there are other benefits to the patient. **In fact, palliative care has been demonstrated not only to lower costs, but to improve quality of care as well.** Seriously ill patients receiving home-based palliative care have reported significant increases in satisfaction and quality of care. Studies have indicated that home-based palliative care reduces emergency room visits, which are normally an unwelcome and traumatic experience, and also reduces hospital readmissions. One study reported a 60% reduction in total hospital days for patients receiving home-based palliative care.

Contrary to the popular image of palliative care as a death sentence, **effective palliative treatments have been shown to prolong patient survival.** One study found that lung cancer patients who received palliative care survived an average of 2.7 months longer than those who only received high-quality cancer treatments. It is also significant that the palliative care recipients had lower care costs than the control group – despite the fact that the control group generally died earlier!

How are managed care organizations using these findings? Different health plans are finding unique ways of expanding access to palliative care to their most high-risk beneficiaries. “Members with serious illness can be provided with specially trained care management resources, delivered over the phone or in person. Plans can expand coverage and benefits policies to include full-fledged palliative care team support and home-based primary and palliative care. Support tools to build member awareness of palliative care and its benefits can support these efforts. Practical services such as transport or meal delivery can also be included. Furthermore, plans can design their provider networks to help direct members to specialty palliative care when it’s needed and require that hospitals, home health agencies, and primary care providers in a network obtain certifications in palliative care.” (Managed Care Magazine, 7/2016, www.managedcaremag.com/archives/2016/7/palliative-care-improves-quality-care-lowers-costs)

**HOSPICE NOTES**

* Hospice chaplains are a supportive presence for terminally ill individuals and their families. “Hospice cares for body, mind and spirit,” said Chaplain Matt Matevelis, spiritual supervisor at Nathan Adelson Hospice. “Hospice is a philosophy of care. We are there for spiritual support and emotional support before and after the death. And for some we are just a companion who is willing to listen.” (Review Journal, 7/14, www.reviewjournal.com/life/hospice-chaplains-listen-support-rather-preach)

* Grief is a common experience to all who have felt loss, and it’s something that can be healed over time. Hospices and hospitals often offer group bereavement sessions to help. (San Diego Union-Tribune, 7/18, www.sandiegouniontribune.com/news/2016/jul/18/coping-grief-death-survivor-grieving-health/)

* Great Lakes Hospice is linking patients to the palliative care resources they need. “Not for the fainthearted, palliative care nurses defy habitual avoidance of difficult topics like death. Across this region, they are aided by the Great Lakes Hospice which originally had a cottage to support patients in a
home like environment but later sold it to assist patients cared for by the Community Palliative care service.” (Great Lakes Advocate, 7/20, www.greatlakesadvocate.com.au/story/4028085/help-is-a-friend-indeed/)

* George Smith reflects on the blessings of gratitude, and the role that hospice played in his father’s end-of-life. “Mom died in the hospital, and while the staff was great, the hospice unit was a truly wonderful place, making our experience with Dad so much better. I still think, often, of the extraordinary staff and volunteers there.” (CentralMaine.com, 7/20, www.centralmaine.com/2016/07/20/george-smith-the-blessings-of-gratitude/)

* “Dying is hard. Death doulas want to help make it easier,” appeared in The Washington Post. The article explores the role of death doulas, the training that is available for this work, and notes that several organizations now offer certification in the field. Highlighted within the article is hospice volunteer Craig Phillip’s. (The Washington Post, 7/22, https://www.washingtonpost.com/lifestyle/style/dying-is-hard-death-doulas-want-to-help-make-it-easier/2016/07/22/53d80f5c-24f7-11e6-8690-f14ca9de2972_story.html#comments)

* The New Yorker features the story of the daily work of a hospice nurse, “who treats the physical, psychological, and spiritual needs of people at the most vulnerable point of their lives.” The article, “A Tender Hand in the Presence of Death,” provides insights into the world of hospice nursing, the depth of patients’ experiences, and the end of life. (The New Yorker, 7/18, www.newyorker.com/magazine/2016/07/11/the-work-of-a-hospice-nurse)

* Can mindfulness help clinicians avoid burnout? The Palliative Care Network of Wisconsin believes that it can, and shares fast facts and concepts about mindfulness self-care strategies for clinicians. “Burnout is an alarming problem affecting clinicians throughout many fields, including hospice and palliative care. Research suggests that comprehensive mindfulness training may correlate with improvements in emotional exhaustion, depersonalization, and a sense of accomplishment.” (PCNW, 7/2016, www.mypcnow.org/blank-4)

**PALLIATIVE CARE NOTES**

* The National Comprehensive Cancer Network hosted a roundtable on palliative care at their recent Annual Conference. “The panel explored some of the barriers to integrating palliative care as well as strategies for overcoming these obstacles to ensure that patients have the opportunity to benefit from the valuable yet often unheralded services provided by palliative care specialists.” (JNCCN, 7/2016, www.jnccn.org/content/14/5S/634.abstract?sid=aa44bb02-e7be-4872-b83c-4aff3923c671)

* The Palliative Care Network of Wisconsin has come out in opposition to partial or slow codes in CPR/DNAR. “Evidence suggests there is a near-certainty of death within days when partial codes are performed. Partial or slow codes can expose patients to substantial risk of suffering, can increase family suffering, and cause clinician moral distress. Lastly, performing partial or slow codes, that is, deliberately performing a medical procedure with no intended benefit, undermines clinician professionalism.” (PCNW, 7/14, www.mypcnow.org/single-post/2016/07/14/PCNOW-Position-Statement-Partial-Codes)
END-OF-LIFE AND OTHER NOTES


* Ojibwe writer Jim Northrup is dying, but he’s not afraid. “As he contemplates the end of his life, the Ojibwe writer, poet, performer, and basket maker is finding peace and satisfaction in the traditional life he’s led.” The article reflects on life’s meaning and facing the end of life. (*MPR*, 7/19, https://www.mprnews.org/story/2016/07/19/ojibwe-writer-jim-northrup-recalls-rich-life)

* A study has found that communication facilitators can help reduce long-term depression in family members of deceased loved ones. The researchers say, “Communication facilitators may be associated with decreased family depressive symptoms at 6 months, but we found no significant difference at 3 months or in anxiety or PTSD. The intervention reduced costs and length of stay, especially among decedents.” (*Journal of Respiratory and Critical Care Medicine*, 1/2016, www.atsjournals.org/doi/abs/10.1164/rccm.201505-0900OC#.V5JOqzsrKUI)

* Rich Mayfield reflects on the inevitability of death and the many ways that we often hide from acknowledging it. “One of the most common responses when people learn of my work in a skilled nursing facility is their passionate desire not to be put on life support. ‘I don’t want to be filled with tubes and hoses to be kept alive when it’s time for me to die.’ And yet we often live this life in precisely the opposite way; we try to keep alive situations and circumstances, policies and practices that should have been allowed to die natural deaths long ago.” (*Calavera Enterprise*, 7/19, www.calaverasenterprise.com/sierra_lodestar/article_1be0577c-4df0-11e6-b6dc-7743594c4a64.html)

ADVANCE CARE PLANNING NOTES

* How can physicians provide good end-of-life care when they’re too busy to have meaningful conversations with their patients? Dr. Tim Lahey reflects on the harried nature of his profession. He also shares why he believes that video training pioneered by Dr. Angelo Volandes could be part of the solution. (*WBUR*, 7/20, www.wbur.org/commonhealth/2016/07/20/end-of-life-time)

* A new guide is available to help doctors reduce racial disparities at the end of life. “While A REFLECTION,” the name of the guide, “can help providers discuss this sensitive topic with any patient, it is designed to increase their cultural humility to help acknowledge mistrust and fear about end-of-life decisions and move past these issues to ensure the patient receives the best care.” The article offers statistics on advance care planning and shares some details about A REFLECTION. (*Aging Today*, 7/7, asaging.org/blog/new-guide-can-help-doctors-reduce-racial-disparities-end-life-care)
* The Pain & Policy Studies Group (PPSG) has announced the release of a new online tool to explore opioid consumption data, as well as “global, regional, and national consumption data for fentanyl, hydromorphone, methadone, morphine, oxycodone, and pethidine.” The data is available on PPSG’s website/ (PPSG, 7/20, www.painpolicy.wisc.edu; https://ppsg-chart.medicine.wisc.edu/)

* CMS has proposed removing pain management questions from hospital’s value-based purchasing scores, but many advocates are calling foul, saying the move would hurt patients. CMS says their plan would reduce opioid prescriptions, which they believe are spurred by the current questions asked by physicians. But advocates contend that the questions should be retained until improved questions can be put in their place. (McKnight’s, 7/17, www.mcknights.com/news/healthcare-groups-urge-cms-to-keep-pain-questions-until-alternatives-are-developed/article/509924/)

**OTHER NOTES**

* Dr. Barry Simkin, DO, interviewed recently by Florida Today, shared about his efforts to change the culture of death and dying. Dr. Simkin “is blazing a trail in medicine by helping establish Health First Supportive Care to give personal options to seriously ill patients and their families during the hardest conversations.” (Florida Today, 7/19, www.floridatoday.com/story/life/wellness/2016/07/19/health-pro-changing-culture-dying-death/87260954/)

* Some health care providers in Vermont are suing the state, saying that Vermont’s health care agencies “are construing Vermont’s assisted suicide law as requiring them, regardless of their conscience or [Hippocratic] oath, to counsel patients on doctor-prescribed death as an option.” State agencies say that physicians are only required to refer patients to others for counseling, but some object that even referring for PAS counseling goes against their moral or ethical convictions. (Life News, 7/20, www.lifenews.com/2016/07/20/doctor-sue-vermont-forcing-them-to-promote-killing-their-patients-in-assisted-suicides/)

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