Hospice Medical Director Update and Exam Prep

Systems-Based Practice:
Eligibility, Certification, Face-to-Face, Narratives

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Disclosures

- Ronald J Crossno, MD has disclosed the following financial relationships:
  - is employed by Kindred Healthcare
- No off-label discussions

- Remember: this presentation is about Medicare
  - In most states, Medicaid rules follow Medicare rules, but not uncommonly, there are variances
  - Commercial insurers often model on Medicare rules, but often differ in substantial ways

Objectives

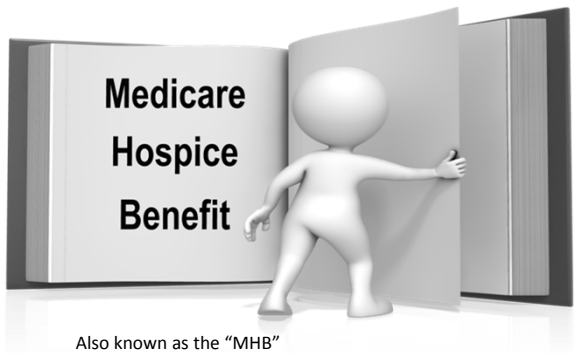
- Discuss aspects of the Medicare Hospice Benefit (MHB) that important for Hospice Medical Directors (HMD) to understand, including:
  - Hospice Conditions of Participation (COP)
  - Role & responsibilities of the HMD
- Identify key components that comprise the MHB certification process, including:
  - Certification in various benefit periods
  - Complying with face-to-face visit requirements
  - Composing optimal physician narratives

HMDCB content blueprint

- **Medical Knowledge:**
  - Formulate and certify prognosis for hospice patients by
    - Reviewing available clinical data (comorbid and secondary conditions, medical findings, disease progression, medications and treatment orders)
    - Understanding the patient's and family's expectations and goals for care

HMDCB content blueprint

- **Systems-Based Practice:**
  - Demonstrate knowledge of hospice regulation and reimbursement
  - Utilize local coverage determinations and understand limitations
  - Comply with Medicare/Medicaid Hospice Benefit (CoPs, requirements for certification, related/unrelated to terminal diagnosis, and levels of hospice care)



Also known as the "MHB"

Overview

- Discussion of regulatory aspects
  - "Quotation marks" indicate actual rule language
  - Will sometimes go out of regulation order so as to follow a general area under consideration
- Resources
  - Medicare Hospice Benefit regulations: CFR §418 online at: http://bit.ly/1SmCpW0 (current as of 12/27/2016)
  - CMS State Operations Manual – Guidance for Hospice online at: http://bit.ly/1SmCwRx (last update 10/9/2015)
  - Guidance from Medicare Administrative Contractors
  - Opinions from other CMS contracted reviewers

Why do you need this material?

- Some of this is admittedly (VERY) dry
- You likely have compliance experts on staff who take care of this
- But…
- If you're a physician who certifies Medicare hospice eligibility, you are personally responsible for what you sign and direct
  - Ignorance of the rules is not a defense
- Besides: this stuff is on the exam

Two terms to understand

- **Conditions of Participation:**
  - Rules for which "failure to comply … can result in sanctions, increased reporting requirements, and eventually, exclusion from participation in the program."
- **Conditions of Payment:**
  - Other rules for which "failure to comply … can result in the denial of the claim for payment…"

Lauer KA, et al. *Violations of Payment/Participation Conditions as Predicates for False Claims.* American Bar Association. Spring/Summer 2011. http://bit.ly/1AbKXEJ (last accessed 12/27/16)

Two definitions from the MHB

§ 418.3 Definitions.

"***Palliative Care*** means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information, and choice."

"***Terminally ill*** means that the individual has a medical prognosis that his or her life expectancy is 6 months of less if the illness runs its normal course."

Eligibility requirements § 418.20

"In order to be eligible to elect hospice care under Medicare, an individual must be --

"(a) Entitled to Part A of Medicare; and

"(b) Certified as being terminally ill in accordance with § 418.22"

Terminal illness § 418.22(b)(1)

"The certification must specify that the individual's prognosis is for a life expectancy of 6 months of less if the terminal illness runs its normal course."

Which is a true statement?

1. There are a limited number of hospice benefit periods.
2. The third hospice benefit period is 60 days long.
3. When readmitted after live discharge, a hospice patient enters the same benefit period they had last been in.
4. A hospice may live discharge a patient at any time, without cause.

Duration of hospice care coverage – Election Periods § 418.21

"(a) … an individual may elect to receive hospice care during one or more of the following election periods:

"(1) An initial 90-day period;

"(2) A subsequent 90-day period; or

"(3) An unlimited number of subsequent 60-day periods.

"(b) The periods of care are available in the order listed and may be elected separately at different times."

Election of hospice care § 418.24

"(a) *Filing an election statement.*

"(1) General. An individual who meets the eligibility requirement of § 418.20 may file an election statement with particular hospice….

"(2) Notice of election. The hospice chosen by the eligible individual (or his or her representative) **must file** the Notice of Election (**NOE**) with its Medicare contractor **within 5 calendar days** after the effective date of the election statement.

"(3) Consequences of failure to submit a timely notice of election. … Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election…."

- Exceptions are listed

Election of hospice care § 418.24

"(b) *Content of election statement.* The election statement must include the following:

"(1) Identification of the particular **hospice** and of the **attending physician** that will provide care to the individual. The individual … must acknowledge that the identified attending physician was **his or her choice**.

"(2) The individual's … acknowledgement that he or she has been given a full understanding of the **palliative rather than curative nature of hospice care**, as it relates to the individual's terminal illness.

"(3) Acknowledgement that **certain Medicare services … are waived** by the election.

"(4) The effective date of the election…."

"(5) The signature of the individual or representative."

Election of hospice care § 418.24

"(f) *Changing the attending physician.* To **change** the designated **attending physician**, the individual … must **file a signed statement** with the hospice that states that he or she is changing his or her attending physician.

"(1) The statement must identify the new attending physician and include the date the change is to be effective and the date signed by the individual…."

"(2) The individual … must acknowledge that the change in the attending physician is due to his or her choice.

"(3) The **effective date** of the change in attending physician **cannot be before** the date **the statement is signed**."

Admission to hospice care § 418.25

"(a) The hospice **admits** a patient only on the r**ecommendation of the medical director** in consultation with, or with input from, the patient's attending physician (if any).

"(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must **consider** at least the following information:

"(1) Diagnosis of the **terminal condition** of the patient.

"(2) **Other health conditions**, **whether related or unrelated** to the terminal condition.

"(3) Current clinically relevant information supporting **all diagnoses**."

Discharge from hospice care § 418.26

"(a) *Reasons for discharge.* A hospice may discharge a patient if –"

(1) **Moves** from area **or transfers** to another hospice;
(2) Hospice determines patient is **no longer terminally ill**; or
(3) Hospice determines that **delivery of care** to the patient or ability of the hospice to operate **is seriously impaired** by actions of the patient or persons in the patient's home
Must document good faith attempt to resolve issues

"(b) *Discharge order.* … hospice … must obtain a written physician's **discharge order from the hospice medical director.** …"
Attending physician (if any) should be consulted before discharge and his or her review and decision included in the discharge note

- Regular Medicare coverage resumes immediately
- Patient remains able to re-elect at any time (if eligible)

Discharge from hospice care § 418.26

(d) *Discharge planning.*

- Hospice is required to provide reasonable notification prior to discharge
- Time specified by state guidelines (range 1d – 30d)
- Appeal can be made to designated Quality Improvement Organization (QIO), which must respond in a timely fashion
- Hospice cannot continue care (regardless of QIO decision) if there is no certification or order for care

"(e) *Filing a notice of termination of election*. When the hospice election is ended due to [live] **discharge** … **must file** a notice of termination/revocation (**NOTR**) … **within 5 calendar days** after the effective date of discharge…."

Revoking the election of hospice care § 418.28

"(a) An individual or representative may revoke the individual's election of hospice care at any time . . ."

"(d) When the hospice election is ended due to revocation … must file a notice of termination/ revocation (NOTR) … within 5 calendar days after the effective date of discharge…."

Note:
Providers do *not* revoke someone's benefit.
Only the patient (or representative) can.

CMS statements on discharge

"Hospices may not automatically or routinely discharge the patient at its discretion, even if the care may be costly or inconvenient."

"Neither should the hospice request or demand that the patient revoke his/her election."

CMS FY 2015 Hospice Wage Index and Payment Rate Update

Core Services § 418.64

- Physician services
- Nursing services
- Medical social services
- Counseling services
  - Bereavement for up to 1 year (usually 13 months)
  - Dietary counseling
  - Spiritual counseling

Other physician-specific regulations

- Only one hospice **medical director** per provider number
  - All other physicians "must function under the supervision of the hospice medical director" *Physician Services § 418.64(a)*
- **If** the **attending physician** is **unavailable**, the **medical director** or physician designee "**is responsible for meeting the medical needs of the patient**" *Physician Services § 418.64(a)*

More physician-specific regulations

- "The **medical director** or physician designee ~~**has**~~ **responsibility** for the **medical component** of the hospice's patient care program"
  COP: Medical Director § 418.012
- **Physician**, nursing, medications "must be made routinely **available** on a **24-hour basis 7 days a week**."
  COP: Organization & Administration of Services § 418.100

Non-core services

- PT / OT / ST – § 418.72
- Hospice aide / homemaker services – § 418.76
- Volunteers – § 418.78
  - 5% of total patient care hours
- Drugs & biologicals – § 418.106
  - ". . . **related to the palliation and management of the terminal illness and related conditions**, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care"

Diagnosis reporting

- Until the past few years, hospices were required to report at least one diagnosis code on the hospice claim
  - Most hospices reported only a single diagnosis
- For FY 2015, hospices were required to report all related diagnoses
- Starting for FY 2016, "**all diagnoses** affecting the management and treatment of the individual within the [hospice] healthcare setting **are required to be reported**"
  - These must be reported using ICD10 coding guidelines

FY 2016 Hospice Wage Index and Payment Rate Update

CMS statements on *relatedness*

". . . **hospices** are required to **provide virtually all the care** that is **needed** by terminally ill patients…

"… **unless** there is **clear evidence that a condition is unrelated** to the terminal prognosis, all services would be considered related.

"It is also the **responsibility of the hospice physician to document** why a patient's medical need(s) would be **unrelated** to the terminal prognosis."

FY 2014 Hospice Wage Index and Payment Rate Update

NHPCO *Relatedness Process Flow*

- Identify the Principal (terminal) Hospice DX
- Are there other diagnoses caused by or exacerbated by Principal Hospice DX?
- Are there additional diagnoses or symptoms that contribute to the 6 month or less prognosis?
- Are there additional diagnoses, conditions, or symptoms caused or exacerbated by treatment of the related conditions?
- If "no" to ***all*** the above, then the diagnosis is unrelated.

Determining Terminal Prognosis. NHPCO. Dec 2014. http://bit.ly/1QYQc65
(NHPCO membership log-in required to access)

Identify the true statement.

1. All physician services are included in the hospice's *per diem* rate.
2. Routine home care has a single base reimbursement rate.
3. Continuous home care has the highest base reimbursement rate.
4. "Imminent death" is always an appropriate indication for General inpatient care.

Payment for MHB services

- Paid via the Medicare Administrative Contractors
- Single *per diem* rate, depending on level of care
  - Inclusive of all care related to the terminal illness*
- *Physician services are paid differently
  - Attending physician directly bills Part B
  - Other physicians (including HMDs) must bill hospice for related care

Levels of hospice care § 418.302

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

- Each change in LOC requires a physician order and update to the plan of care
- Every Medicare certified hospice must provide ***each*** of these levels of care

Routine home care (RHC)

- The 'basic' rate for anyone who has elected to receive hospice care
- Provision of core services in the patient's residence
  - Wherever the residence may be
- Payment is a fixed *per diem* rate that is paid per day of care provided, including day of admission and day of discharge
  - Modified beginning January 1, 2016

RHC U-shaped payment (1)

- Higher rate for days 1-60 of an episode of care
  - Base 2017 rate: $190.55*
- Lower rate for days 61+ of an episode of care
  - Base 2017 rate: $149.82*
- Episode of care resets if readmission occurs more than 60 calendar days after hospice discharge

*FY 2017 Hospice Wage Index and Payment Rate Update

RHC U-shaped payment (2)

- Service Intensity Add-on (SIA) payment
- Additional payment for direct nursing or social worker visits provided in the last 7 days of life
  - Up to 4 hours per day
  - Nursing care must be by Registered Nurse (RN)
  - Regardless of location
- Amount paid is tied to Continuous home care rate*
  - Calculated & applied by CMS

*FY 2017 Hospice Wage Index and Payment Rate Update

Continuous home care

- ". . . only furnished during brief periods of crisis . . . as necessary to maintain the terminally ill patient at home" – §418.302(b)(2)
- Must have a skilled care need
  - Collapse of family support is inadequate reason, unless family caregiver was providing skilled services
- Minimum of 8h of direct care in a 24h period
  - Prorated for actual time provided in 24h period
  - >50% provided by licensed nurse (RN or LVN/LPN)
  - Remainder by hospice aide
  - (Social worker, counselor, volunteer time does not count)
- Base 2017 *per diem* rate: $964.63*

*FY 2017 Hospice Wage Index and Payment Rate Update

Inpatient respite care

- ". . . care in an approved facility on a short-term basis for respite" – § 418.302(b)(3)
- Designed to provide respite for family members or other caregivers for the individual
  - Limited to no more than five (5) consecutive days
  - Medicare certified NF or acute care hospital
- Base 2017 *per diem* rate: $170.97*

*FY 2017 Hospice Wage Index and Payment Rate Update

General inpatient care

- ". . . inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings" – § 418.302(b)(4)
- Based on:
  - Uncontrolled symptoms managed only in facility
  - Having a skilled need
  - No specified number of days, but should include daily evaluation of ongoing necessity
  - Proper use is currently an Office of Inspector General (OIG) focus
- Base 2017 *per diem* rate: $734.94*

*FY 2017 Hospice Wage Index and Payment Rate Update

TIME FOR MORE ABOUT ELIGIBILITY CERTIFICATION

Certification of terminal illness § 418.22

"(a) ***Timing of certification***

"(1) *General rule.* The hospice must obtain written certification of terminal illness for each of the periods listed in § 418.21…"

"(2) *Basic requirement.* …the hospice must obtain the written certification before it submits a claim for payment.

"(3) *Exceptions.*

"(i) If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days…"

"(ii) Certifications may be completed no more than 15 calendar days prior to the effective date of election.

"(iii) Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period."

Certification of terminal illness § 418.22

"(b) ***Content of certification.***

"Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:

"(1) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

"(2) Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification…. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment."

Certification of terminal illness § 418.22

"(c) ***Sources of certification***.

"(1) For the initial 90-day period, the hospice must obtain written certification statements … from --

"(i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and

"(ii) The individual's attending physician, if the individual has an attending physician. The attending physician must meet the definition of physician specified in § 410.20 of this subchapter.

"(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph (c)(1)(i) of this section." [i.e. a hospice physician]

(Note: some *states* require ongoing certification by both.)

COP: Medical Director § 418.102

"(b) ***Standard: Initial certification of terminal illness***. The medical director or physician designee reviews the clinical information of each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination:

"(1) The primary terminal condition;

"(2) Related diagnosis(es), if any;

"(3) Current subjective and objective medical findings;

"(4) Current medication and treatment orders; and

"(5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness."

COP: Medical Director § 418.102

"(c) ***Standard: Recertification of terminal illness***. Before the recertification period for each patient …, the medical director or physician designee must review the patient's clinical information."

Other certification requirements

- Must clearly state the benefit period start & end dates on the certification form
- Can only be done by a physician (MD or DO)
- Standard to go by:

  "Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course." § 418.3

Initial & 2nd benefit periods

- Must include a physician narrative, **composed** by a certifying physician
  - Attending* or HMD may do initial
  - HMD to do 2nd BP

    *Many experts recommend *not* having the attending physician compose narratives since he/she is often unfamiliar with the narrative documentation requirements.
- Must include a narrative attestation statement
  - Signed and dated by the composing physician
- Must contain the actual certification
  - Signed and dated by the same physician who composed the narrative

3rd & subsequent benefit periods

- Must include a face-to-face (F2F) encounter (*additional requirement*)
- Must include a F2F encounter attestation (*additional requirement*)
- Must include a physician narrative (same as before)
- Must include a narrative attestation (same as before)
  - Signed & dated by the composing hospice physician
- Must include the actual certification
  - Signed & dated by same hospice physician who composed the narrative
  - Narrative should indicate use of the information from the F2F encounter

Timing for narratives & Face-to-Face

- Narratives / Certifications: all benefit periods (BP)
  - No earlier than ***15 days*** prior to the start of the BP
- Face-to-Face (F2F): 3rd and subsequent BPs
  - No earlier than ***30 days*** before start of the BP to which it applies
  - Must occur before (or on same day as) the narrative / certification
  - For 'readmissions' into 3rd or later benefit periods, F2F must be done ***before*** the oral or written certification, unless:
  - CMS has described "exceptional circumstances" for legitimate emergencies
- Missing the timing on either (F2F / certification) has significant financial implications

F2F encounters

"… a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care." § 418.22(a)(4)

Who may do the hospice F2F?

- Hospice physician
  - Must be employed or contracted by the hospice
  - Volunteers considered employed
- Hospice nurse practitioner
  - Must be ***employed*** by the hospice
  - May ***not*** be ***contracted***
- May ***not*** be:
  - Physician Assistant, Nurse Clinician, RN, etc.

F2F attestation

- Different attestation from the narrative attestation
- Hospice physician or hospice nurse practitioner:
  - "… must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit." § 418.22(b)(4)
- If hospice nurse practitioner or non-certifying hospice physician, F2F attestation:
  - "shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care." § 418.22(b)(4)
- Date the attestation is signed does not necessarily have to be the same date the F2F visit occurred
  - Recommend documenting the reason if different

What goes in the F2F documentation?

- Should be clinical data pertinent to prognosis and eligibility
  - History
  - Physical findings
- Remember: this is not 'the narrative'
  - So no requirement to document any conclusions
  - The certification narrative is a different document with a different attestation
- Potential concerns for making statements regarding prognosis without input from all IDG members

Are F2F encounters billable?

- F2F visits are not separately billable
  - CMS has said the F2F, as a component of the certification process, is an administrative function included in the hospice per diem
  - CMS also indicates that if non-administrative physician-level professional services are also provided at the time of the F2F, the professional (i.e. non-administrative) component could be billed
- For billable visits related to the terminal illness:
  - The visit must be reasonable and necessary, with documentation sufficient to justify the code billed
  - NPs may only bill if designated as the 'attending physician' (states sometimes restrict this further)

Physician narratives

- Regulations require a physician narrative for each certification
  - Done by the hospice physician (or attending for initial BP)
- "The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification or recertification forms" § 418.22(b)(3)

Physician narratives (2)

- "The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient." § 418.22(b)(3)(iii)
- "The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients" § 418.22(b)(3)(iv)

What is a narrative?

- Definition: *Narrative* (**nar**-*uh*-tiv) noun – *a story or account of events, experience or the like* [www.dictionary.com]
- Should be primarily in sentence format
- Should 'paint the picture' of the patient's prognosis, preferably in language understandable by a lay person with some knowledge of eligibility guidelines
- What is not a narrative?
  - A simple list of findings
  - Fragments or phrases that are jotted down
  - A "copy-and-paste" of someone else's note

Source: accumulating case law and external reviewer opinions

Paint a picture of the prognosis

- Every narrative/certification is an opportunity to paint the picture of the patient's prognosis
  - If the patient meets an applicable guideline, explain this
  - If the patient does not meet an guideline, but is still terminal, explain this
- If you lack the information needed to adequately document a terminal prognosis:
  DO NOT CERTIFY THE PATIENT
- Either:
  1. Quickly get the needed information & then certify, or
  2. For a prospective patient: do not admit, or for a current patient, initiate discharge

Misconceptions about certification

- *Myth*: The initial benefit period is less closely scrutinized for eligibility documentation – ***Wrong!***
- *Myth*: We can always finish out the current BP before discharging an ineligible patient – ***Wrong!***

- *Fact*: MHB CoPs allow hospices to only bill for those days for which documentation supports the patient's terminal prognosis

Painting the picture: key elements (1)

- Use sentence format
- State patient's age
- State patient's principal and related medical conditions
  - Describe how these impact prognosis; including a description of their severity
  - Try not to include unrelated diagnoses

Source: *KAH Physician Narrative Tips* by Kindred at Home Physician Leadership. Online at: http://bit.ly/2hl4XjK (last accessed 2016-12-27)

Painting the picture: key elements (2)

- Functional impairments
  - PPS, ADL dependence, etc. – reported serially
- Nutritional impairments
  - Weight, BMI, MAC, albumin, changes in oral intake, etc.
- Cognitive impairments
  - FAST for dementia, presence & severity of delirium, etc.

Source: *KAH Physician Narrative Tips* by Kindred at Home Physician Leadership. Online at: http://bit.ly/2hl4XjK (last accessed 2016-12-27)

Painting the picture: key elements (3)

- Disease specific and/or disabling symptoms
  - Dyspnea at rest, NYHA Class, refractory angina, etc.
  - Refer to applicable guidelines
- Burden of disease
  - Onset / duration / response to therapy / location of care / time-to-task completion / degree of frailty / asleep ≥12h/d
- Describe these serially, documenting trajectory of disease with absolute values over a time period

Source: *KAH Physician Narrative Tips* by Kindred at Home Physician Leadership. Online at: http://bit.ly/2hl4XjK (last accessed 2016-12-27)

Other key narrative elements

- Reference the basis for the narrative:
  - Review of clinical records (explain any apparent inconsistencies)
  - Physician or NP F2F assessment (not necessarily required, but best practice)
- Make explicit statement of prognosis
  - "Her prognosis is days or weeks, at most"
  - "He is unlikely to survive the next six months"
- Best practice is to have pre-printed statements and attestations to ensure legal requirements are met, and to supplement these by using your own words:
  - Personalized statements may have more impact

CMS guidance on narratives

- CMS has produced an *MLN Matters* resource entitled SE1628: *Documentation Requirements for the Hospice Physician Certification/Recertification*
  - Available online at: http://bit.ly/2iARbu6 (published 11/22/2016)

- Cautions within their examples
  - Example attestation says, "I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one)."
  - Placement of signature/printed name is not in the recommended order
  - Examples lack of some the just mentioned key elements

Common narrative trip-ups

- Lack of sentence format
- Copy-and-pasted narratives
- Illegible handwritten narratives
- Never addresses prognosis
- Lacks previously discussed elements
- Failure to include BP dates
- Trying to use a guideline that does not apply
- Using the word "decline" instead of documenting how the patient declined

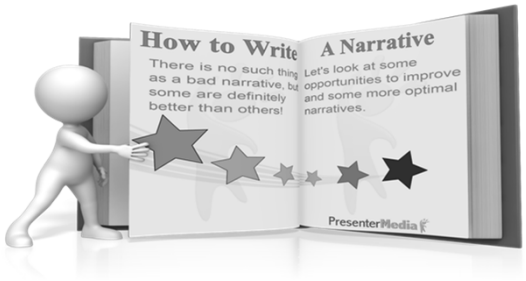
Language makes a difference

- Intent of the narrative is to explain how it is that this patient has a ***terminal prognosis***
- Stating the patient is *appropriate* for or *needs* hospice care can potentially be problematic since other factors may be involved
- Bottom line:
  - Address ***prognosis!***
- (If you are uncomfortable saying someone has a prognosis for a six-month or less life expectancy, question whether the patient should be on hospice.)

This is a lot to remember

- Which is why you should:
  - Always refer to the applicable guideline (when there is one)
  - Use a consistent prompt for the key elements
  - Proofread your narrative to ensure it paints the picture of a terminal prognosis
  - Consider dictating narratives
  - Make sure your electronic health record permits you to follow these requirements & best practices
- Did I say, *proofread your narratives*?

Example Narratives



Example #1 – narrative

"Obesity; Varicose veins"

- This is the actual narrative as related by a MAC Medical Director
- To be clear:
  This does not paint the picture of a terminal patient

Example #2 – narrative

- Metastatic cancer
- PPS 50% and incontinent of B&B
- Eats 50% most meals
- Family requested palliative care
- Appropriate for hospice

Example #2 – Question

Is this narrative adequate?

1. Yes
2. No

Example #2 – presentation

- 30 yo M with newly diagnosed non-Hodgkins lymphoma with spinal involvement
- Presented with weakness and incontinence
- Just completed radiation therapy to spine and is starting chemotherapy
- Family wanted palliative care consult (not hospice) for symptom management
- Is neither terminal nor "appropriate for hospice"

Example #3 – narrative

Mr. Doe is a 59 year old steel-worker who was diagnosed with mesothelioma nine months ago. This involves bilateral pleura and is invasive into lungs and mediastinum. He is now referred to hospice as he has completed all disease-directed therapies, and he has become functionally impaired from being fully active at the time of diagnosis. His PPS is now 60%, with him able to perform only 3/6 ADLs unassisted. He has significant dyspnea with any exertion and has significant pain. Analgesic requirements have increased from 200 mg of morphine daily just one week ago, to now 400mg daily. He has lost 26 pounds (12% body mass) in the last nine months, with a current BMI of 24. He continues to smoke despite increasing prn supplemental oxygen use. Because of his extent of disease, progressive decline, and functional/nutritional impairments, he is unlikely to survive the next six months.

Example #3 – Question

Is this narrative adequate?

1. Yes
2. No

Example #4 – narrative

88 yo ♀ entering her 10th benefit period with diagnosis of Alzheimer's Disease with contributory related conditions of recurrent delirium, abnormal weight loss, and a history of aspiration pneumonia four months ago. Her PPS is 30% and FAST is 7a (unchanged in the preceding six-months). Based on the NP's F2F done earlier today, she is bedbound and no current wt is obtainable. Her last recorded wt was ≈1 yr ago at 88 lbs. with BMI of 17.8. Her current MAC is 14 cm decreased from 16cm 4 months ago; her oral intake is minimal and it takes in excess of an hour per feeding by her devoted caregiver. She is extremely fatigued and sleeps >20 hr/d. She is visibly very debilitated and cachectic with severe muscle wasting. She is unable to self-report pain, but by RN, caregiver, and family assessment, she frequently has pain associated with movement requiring low dose opioids. Not infrequently, and for short periods, she has acute change in her mental status requiring haloperidol. Despite the period of time she has been on hospice services, it is my medical judgment, substantiated by her poor nutritional status with continued wt loss and recent aspiration event, that her prognosis remains less than 6 mo.

Source: *KAH Physician Narrative Tips* by Kindred at Home Physician Leadership.
Online at: http://bit.ly/2hl4XjK (last accessed 2016-12-27)

Question

Which is true for the Medicare Hospice Benefit:

1. There is a single national coverage guideline
2. There are fifty (50) local coverage determinations, one for each state
3. To be hospice eligible, a patient must meet a coverage guideline
4. There are three Medicare Administrative Contractors (MAC) administering coverage guidelines

Eligibility guidelines

- There is ***no*** national coverage determination for hospice
- Each Medicare Administrative Contractor (MAC) has its own guideline(s)
  - Designed to aid in making payment decisions (i.e. determinations)
  - Each jurisdiction's MAC develops: 'local coverage determination' (LCD)
- State Medicaid programs & commercial insurers may use one of these or have their own guidelines

What are the LCD guidelines?

- The following three (3) hospice MACs have published their own hospice LCD(s):
  - CGS Administrators, LLC – one (1) longer, single hospice LCD*
  - National Government Services, Inc. – one (1) longer, single hospice LCD*
  - Palmetto, GBA – seven non-cancer (7) hospice LCDs

  * the CGS and NGS LCDs are very similar
- While substantially similar, there are a few notable differences among the different MACs' LCDs
  - Be familiar with your location's LCD(s)

Where are the guidelines?

- Available for access online: www.cms.gov/medicare-coverage-database/
  - Choose "Local Coverage Determinations"
  - Select your geographic area (usually your state or choose 'all states')
  - Enter "hospice" as a keyword
  - Click "Search by type"
- Updates occur with minimal notice, though usually changes just represent minor tweaks or corrections (last accessed 12/27/2016)

Must a patient meet an LCD?

- **No!** Not necessarily
  - Palmetto has no LCDs covering cancer
- CMS requires each MAC include a statement that says something to the effect that:
  - Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less. Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy not included in these guidelines is provided.

Whirlwind tour of the MHB now ends

Questions for us?

Please fill out a card for response in the Q&A session

Hospice Medical Director Update and Exam Prep

Medical Leadership:
Communication and Professionalism

Kate Faulkner, MD, FAAHPM
Medical Director, Good Shepherd Community Care
Newton, MA
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Disclosures

- I have no relevant financial relationships to disclose
- We will not be discussing off-label use of medications

HMD Exam Content Blueprint
Medical Leadership and Communication (21%)

- Demonstrate interpersonal communication skills
- Model empathic communication (e.g., expression of compassion)
- Communicate with referring and consultant clinicians about the care plan
- Facilitate conflict resolution and 'service recovery'
- Educate Hospice staff about communication with physicians

HMD Exam Content Blueprint…
Medical Leadership and Communication (21%)

- Demonstrate the ability to reflect on his/her personal leadership style and use different styles to suit the situation and goals
- Demonstrate skill as a supervisor and mentor
- Supervise team providers (e.g., physician and nurse practitioner)
- Demonstrate the ability to reflect on his/her personal leadership style and use different styles to suit the situation and goals
- Provide oversight of skills management for Hospice staff

HMD Exam Content Blueprint
Professionalism (10%)

- Recognize and manage fatigue and burnout
- Recognize and accept responsibility for errors when appropriate
- Disclose medical errors in accord with institutional policies and professional ethics
- Make recommendations to attending and consulting physicians(s) and coordinate medical care
- Collaborate with other health professionals to coordinate the plan of care
- Demonstrate commitment to continuing professional development and life-long learning

Communication Skills

- **"I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug."**
  - Adaptation of the Hippocratic Oath written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine Tufts University
  - http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html

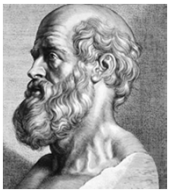


Photo credit: Peter Paul Rubens/public domain

"It is much more important to know what sort of patient has a disease, than what sort of disease a patient has."

William Osler, MD (1849-1919)
In 'The Principles and Practice of Medicine', 1892

Communication Techniques with Focus on Palliative Care and Hospice

Buckman's S-P-I-K-E-S Protocol

- (**S**etting) up the interview
- Find out what the patient knows (Patient **P**erception)
- Find out what the patient wants to know (**I**nvitation)
- Give the information (**K**nowledge)
- Respond to patient's reactions/(**E**motions)
- Close with a plan for future contact (**S**trategize/Summary)

- Buckman R et al (2000) SPKES-a six step protocol for delivering bad news. The Oncologist 5:302-11
- Buckman R (2010) Practical plans for difficult conversations in medicine. Book & DVD. ISBN-13 978-0801895586
- Reddy S (2015) How doctors break bad news. Wall Street Journal 'Personal Journal' Tuesday, May 19, 2015

Back's 'VITAL talk' smartphone app 'GUIDE' for serious news, and Oncotalk program

- **G**et Ready
- **U**nderstand
- **I**nform
- **D**eepen
- **E**quip
  - http://www.vitaltalk.org/clinicians/disclose-serious-news
  - http://depts.washington.edu/oncotalk/

Back's 'VITAL talk' app

- 'Get Ready' section (know the basics and/or watch an expert)
  - Key Concept of each step
  - Why key concept is important to outcome
  - Specific 'to-do' list of actions to support key concept
- 'Debrief' section
  - Self-rating and review
  - Ability to review past debriefings

The Wisdom of David & Debbie Oliver

AAPHM Keynote 2013

- Patient goals and challenges
  - **H**--home
  - **O**--surrounded by others
  - **P**—pain free
  - **E**—excited by living up to the end
    - http://www.pallimed.org/2013/03/david-and-debbie-olivers-aahpm-plenary.html
    - http://dbocancerjourney.blogspot.com/

Caregiver Goals and Challenges

- **C**—calm in the midst of fear
- **O**—organized boundaries
- **U**—uncertainty while waiting
- **R**—respite from ongoing stress
- **A**—asking for help
- **G**—grieving publicly
- **E**—eventual loss and starting over

Communication Techniques with Focus on Specialized Situations

Polling question:
What is your most difficult communication challenge?

- Patient doesn't make a decision
- Family discord
- Put decision making 'in God's hands'
- Competing with another 'expert'—family member, friend, religious leader
- Competing with another 'expert'—other members of the health care team

Motivational Interviewing (MI)

- A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
  - May not want to talk about the future or make decisions when deeply ambivalent (no 'good' choices)
  - May be 'non-compliant' or resist therapeutic suggestions
    - Pollak KI et al (2011) Applying motivational interviewing techniques to palliative care communication. J of Palliative Medicine 14:587-92

Traditional Approach vs MI

- Common role of the MD is to be the 'expert'-- the objective is to assess and prescribe
- In MI, the role of the MD is to understand and collaborate—the objective is to elicit 'change talk' and build motivation for change
  - Listen, probe and reflect back understanding
  - Elicit desire, ability, reasons, and need to change
  - Find out what works and doesn't for this individual
  - Give a short summary and elicit plan of action
- Palliative care patients/families find this style helpful and empathetic
    - Pollak K et al (2015) Patient and caregiver opinions of MI techniques in role-played palliative care conversations. JPSM 50:91-8

MI Philosophy

- Uses skills developed from behavior science, such as reflective statements and summarizing
- Guiding philosophy emphasizes partnership and elicits patients' internal motivations
- Collaboration--work together toward common goal
- Autonomy—respect patients' ability to make wise decisions
- Evocation—elicit information from patients about internal motivations, and help them reflect on advantages of and barriers to change
  - Pollak KI (2011) Applying motivational interviewing techniques to palliative care communication. J Palliat Med 14:587-92

MI tips

- Open ended questions often begin with the words: 'what', 'how', and 'why'
- Close ended questions often begin with the words: 'is', 'are', and 'do'
- Recognize change talk: 'I want to..,' 'I might be able to...,' 'I would probably feel better if...,' "I really should...,' 'I am going to...'
- Importance ruler: 'On the scale of 0 to 10, how important is it to you to...?'

Prospect Theory

- A good medical decision reflects the patient's values, applies scientific evidence, considers medical expertise, and acknowledges uncertainty
- Prospect theory offers insights into how patients make choices in the face of uncertainty and explores the importance of integrating behavioral science into medical decision making
  - Verma A (2014) Understanding choice: why physicians should learn prospect theory. JAMA 311:571-2
  - Schwartz A (2008) Prospect theory, reference points, and health decisions. Judgment & Dec Making 3:174-80

Prospect Theory Model

- People simplify choices
  - Focus on key differences between options while ignoring similarities—isolation effect
- Select a reference point from which they can frame their decision
  - For instance, past, current or expectation of future state of health
- Then estimate the overall value of their options
  - Based on how pleasurable or painful an outcome is expected to be and probability of its occurrence

Prospect Theory Example

- Helps us understand why patients with illness are more likely than healthy patients to prefer aggressive life-sustaining interventions
  - To healthy patients, disability and death seem remote relative to their current health status, so the difference between those states seems small
  - Patient in poor health live with disability, and therefore the difference between disability and death seems large. They will risk more to avoid death

Complexity Science

- Describes systems characterized by nonlinear interactive components, self-organization, emergent phenomena, and unpredictability
- Focuses on patterns of interactions and relationships among system parts and provides new insights for working with unpredictable nature of complex systems
- Well suited to help explain why inter-disciplinary teams lead to more successful interactions with patients/families than less complex approaches, given multiple stakeholders, multifaceted issues, uncertain outcomes and differing opinions
  - Ciemins EL (2016) Why the interdisciplinary team approach works: insights from complexity science. JPM 19:767-70

Complexity Science

- May explain the negative results of one study augmenting usual support of surrogates with 2 structured conversations delivered by palliative care-trained consultants
  - Failed to improve surrogates' depression and anxiety at 3 months
  - Actually increased surrogates' posttraumatic stress symptoms at 3 months
- Several possible explanations, including lack of consultant integration into established care team, and lack of inclusion of the whole palliative care team
  - Carson SS (2016) Effect of palliative care-led meetings for families of patients with chronic critical illness. JAMA 316:51-62
  - White DB (2016) Strategies to support surrogate decision makers of patients with chronic critical illness. JAMA 316:35-7

Age-Related Adaptations to Decision Making

- Older adults adapt to perceived declines in cognitive resources by triage, conserving cognitive effort for situations judged to be of high relevance and meaning
- They become skilled in 'pattern recognition' which lessens cognitive demands
- As healthy people age, 'affective' processing tends to become more prominent, dominating 'deliberative' processing
    - Peters E et al (2008) Age differences in dual information-processing modes. Cancer 11:3356-67

Impact of Age on Affective (Emotional) Processing

- Increased importance of emotional goals
- Increased attention to emotional content, with increased recall of emotional content relative to neutral content
- Increased focus on positive information and decreased focus on negative information, with associated memory bias

Similarities Between Aging and Physiologic Frailty from Serious Illness

- Significant similarity between normal aging and serious illness with regard to impact on ability to focus attention and engage working memory
- Potential for impaired ability to focus attention suggests that effective communication strategies need to enhance ability to prioritize and therefore remember key decisional elements
- Primary means of engaging attention and memory is to understand personal emotional context and align information with positive goals

Cimprich B et al (2001) Attention and symptom distress in women with and without breast cancer. Nursing Res 50:86-94

Cimprich B (2010) Prechemotherapy alternations in brain function in women with breast cancer. J Clin Exp Neuropsychol 32:324-31

Teaching and Education

Words as Tools of Communication

- "The most powerful tool we have in our arsenal for end-of-life decision-making discussion is language."
    - Limerick M (2002) Communicating with surrogate decision-makers in end-of-life situations. Am J Hosp Pall Care 19:376-80
    - Fine RL (2007) Language matters: "sometimes we withdraw treatment but we never withdraw care." J of Palliat Med. 10:1239-40
    - Pantilat S (2009) Communicating with seriously ill patients. JAMA 301:1279-81
    - Landrey A (2012) Learning to talk. JAMA 308:145-6
    - Altilio T et al (2013) Attention and intention. AAHPM Quarterly Review 14:14-17

Sociodramatic Method to Teach Communication Skills

- "Tell me and I'll forget; show me and I may remember; involve me and I'll understand"
    - Chinese proverb
- Derived from psychodrama, technique using group enactments of life situations aimed at helping medical caregivers deepen their understanding of and resolve interpersonal conflicts or mental problems
- Portray situations rather than just describe them
    - Baile WF and Walters R (2013) Applying sociodramatic methods in teaching transition to palliative care. JPSM 45:606-19

Learner Centered Approach

- Allows participants to 'hear' from another's viewpoint
  - 'withdrawal of care' vs 'withdrawal of treatment'
  - 'positive nodes' have negative meaning
- Encourages learning substitutive language
  - 'I'm afraid I have bad news to give you' vs 'I have serious information to share with you'
- Often evokes same physiological, cognitive and emotional challenges of real situations
  - Prognostic truth telling is more difficult than lying
    - Panapoulou E (2008) Concealment of information in clinical practice. J of Clin Onc 26:1175-7
- Enables practice of uncommon situations

Communication Challenges for Residents, Fellows and PCPs

- Current emphasis/pressure on 'high-value care'
  - Ordering less testing
  - Deprescribing
  - Overcoming the therapeutic illusion
  - Communicating value to patients
  - Providing cost effective care
  - "But I want all the tests…the scans…antibiotics…experimental chemotherapy"
    - Lakin JR (2016) Improving communication about serious illness in primary care: a review. JAMA Int Med 176:1380-7
    - Lowenstein M (2016) Choosing our words wisely. JAMA Int Med 176:1249-50
    - Casarett D (2016) The science of choosing wisely—overcoming the therapeutic illusion. NEJM 374:1203-5

Mentorship

- *"The delicate balance of mentoring someone is not creating them in your own image, but giving them the opportunity to create themselves." Steven Spielberg*
- HMD often called upon to mentor students through fellows who are interested in the palliative medicine field
- Medical mentorship system may be associated with practices that are not in best interest of the person being mentored, such as when mentors:
  - Don't have the time or interest to attend to needs of trainee
  - Hijack their ideas, projects or grants
  - Are physically absent for much of the trainee's time
    - Chopra V (2016) Mentorship malpractice. JAMA 315:1453-4

Communication between Clinicians

Communication between Clinicians

- The Joint Commission's patient-centered communication standards for hospitals fully implemented in July 2012
- Joint Commission 2013 webinar on "Fostering safe, effective care transitions" from hospital to home health and hospice
- 'Continuity, coordination and care transitions' deemed priority issues for cancer end-of-life care

http://www.jointcommission.org/At_home_with_the_joint_commission/sbar_%E2%80%93_a_powerful_tool_to_help_improve_communication/default.aspx

Seow H et al (2009) Developing quality indicators for cancer end-of-life care. Cancer 115:3820-9

'SBAR' Aid to Communication

- **S**ituation
  - Concise statement of the problem
- **B**ackground
  - Pertinent and brief information related to the situation
- **A**ssessment
  - Analysis and consideration of options
- **R**ecommendation
  - Action requested or recommended
    - http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx
    - Haig KM et al (2006) SBAR: a shared mental model for improving communication between clinicians. J on Quality and Patient Safety 32:167-75
    - Thomas CM et al (2009) The SBAR communication technique: teaching nursing students professional communication skills. Nurse Educator 34:16-80

'I-PASS' Handoff Program

- Prospective intervention study of resident handoff-improvement program in 9 hospitals
- After implementation, medical error rate decreased by 23%, and rate of adverse events by 30%
- No significant change in the duration of oral handoffs (2.4 to 2.5 minutes/patient)
  - Starmer AJ et al (2014) Changes in medical errors after implementation of a handoff program. NEJM 371:1803-12

'I-PASS'

- **I**llness severity
- **P**atient summary
- **A**ction items
- **S**ituation awareness and contingency plans
- **S**ynthesis by receiver
  - http://www.nejm.org/doi/suppl/10.1056/NEJMsa1405556/suppl_file/nejmsa1405556_appendix.pdf

Web-Based Hand-Off Tool

- Study at Boston Brigham & Women's Hospital, where tool use reduced medical errors from 3.56/100 to 1.76/100
- Included auto-population of core fields, such as demographics, medications, allergies, diagnoses, and resuscitation preferences
- Templated fields that directed users to include key pieces of clinical information
- Merging of workflow such that users updated components of the handoff and progress notes simultaneously
  - Mueller SK (2016) Association of a web-based handoff tool with rates of medical errors. JAMA Int Med 176:1400-3

Physician to Physician Communication Disagreement and Conflict

- Common for patients to see myriads of specialists in last months of life
- Who is responsible for coordinating different roles, opinions, and interventions?
- Can there be constructive criticism of other MDs, when one harbors misgivings or acknowledges a nagging voice?
  - Srivastava R (2013) Speaking up—when doctors navigate medical hierarchy. NEJM 368:302-5

Supervising Team Providers—Hospice Physicians and NPs

- Use conflict as a natural resource
- Don't react
- Deal with feelings
- Attack the problem, not the person
- Practice direct communication
- Look past positions to underlying interests
- Focus on the future
  - http://www.mediate.com/articles/belak4.cfm
  - http://www.forbes.com/sites/mikemyatt/2012/02/22/5-keys-to-dealing-with-workplace-conflict/

'D-E-S-K' for Guidance in Direct Communication

- **D**escribe the problem behavior (just the facts)
- **E**xplore what happened and **E**xplain why it's a problem
- **S**how the desired behavior
- Make sure he or she **K**nows the consequences

Adapted from the StuderGroup tool kit

Pope Diagnoses a 'Sick Vatican Bureaucracy'

- 'It is the sickness of the cowardly who, not having the courage to speak directly to the people involved, instead speak behind their backs.'
  - Pope Francis
    - Wall St Journal 12/23/14
    - Front page, A7

Dealing with Mistakes: Service Recovery and Medical Errors

'H-E-A-R-T' for Service Recovery

- **H**ear the concern
- **E**mpathize with the way the person is feeling
- **A**pologize for the experience the person is having
- **R**espond with action to the problem
- **T**hank the person for the opportunity to make things right
  - https://vimeo.com/51700947

Medical Errors and Adverse Events

- Medical Error: failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim
- Adverse Event: ***harm*** resulting from the process of medical care rather than from the patients' underlying disease
- Majority of medical errors are not associated with an adverse event; most adverse events are not associated with a medical error
  - http://depts.washington.edu/toolbox/content.pdf, pages 45-51

Key Elements in the Disclosure Process

- An explicit statement that an error occurred
- What the error was and the error's clinical implications
- Why the error happened
- How recurrences will be prevented
- An apology
  - Gallagher TH (2007) Disclosing harmful medical errors to patients. NEJM 356:2713-9
  - Pronovost PJ (2015) From shame to guilt to love. JAMA 314:2507-8

Professionalism

Professionals Dedicated to a Primary Guiding Goal

- "To promote the well-being of patients, which constitutes advancing their health and health care within the parameters of the patient's life values and interests."
- Making money is a secondary objective that should not compromise a physician's obligations to the well-being of patients
  - Emanuel E (2015) Enhancing professionalism through management. JAMA 313:1799-1800

Self-Regulation Is a Central Tenet of Professionalism

- Agreed upon standards by which individuals may enter the profession and by which they then practice
- Responsibility for teaching these professionals how to exercise those standards on a day-to-day basis
- Enforcing those standards and deciding when and how those who violate them will be disciplined
  - Madara J (2015) Professionalism, self-regulation, and motivation. JAMA 313:1793-4

Physicians' Motivation

- 50% of all Medicare payments will be tied to quality or value by the end of 2018
- Important considerations regarding the most effective balance between:
  - Extrinsic motivators (e.g. Financial reimbursement or award recognition)
  - And Intrinsic motivators (e.g. Personal satisfaction, peer comparisons)
    - Judson TJ (2015) Harnessing the right combination of extrinsic and intrinsic motivation to change physician behavior. JAMA 314:2233-4
    - Navathe AS (2016) Physician peer comparisons as a nonfinancial strategy to improve the value of care. JAMA 316:1759-60

Enhancing Professionalism

- Develop and teach better management skills
- Encourage responsiveness and adaptability on the part of professional organizations
- Craft better practice environments that leverage intrinsic motivators
- Focus on most effective techniques for life-long learning
  - Berwick DM (2015) Postgraduate education of physicians. JAMA 313:1803-4
  - Teirstein PS and Topol EJ (2015) The role of maintenance of certification programs in governance and professionalism. JAMA 313:1809-10
  - Nissen SE (2015) Reforming the continuing medical education system. JAMA 313:1813-4

Leadership Styles

Leadership Styles

- All styles can become part of a leader's repertoire
- Leadership styles should be adapted to the demands of the situation, the requirements of the people involved and the challenges facing the organization
  - http://guides.wsj.com/management/developing-a-leadership-style/how-to-develop-a-leadership-style/
  - Goleman D (2013) "Primal leadership: unleashing the power of emotional intelligence" Harvard Business Review Press

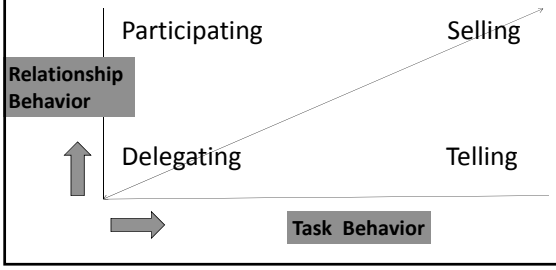
Situational Leadership Model

- Developed by Dr. Paul Hersey in the late 1960's
- Looks at both ***leadership qualities***
  - Degree of *supportive* relationship behavior and *directive* task behavior
- And ***follower readiness***
  - Based on ability, willingness and confidence
    - https://situational.com/

Leader Behavior

- **Task behavior**
  - Goal setting
  - Organizing
  - Establishing timelines
  - Directing
  - Controlling
- **Relationship behavior**
  - Giving support
  - Multi-way communicating
  - Facilitating interactions
  - Active listening
  - Providing feedback

Interplay Between Relationship and Task Behavior



Balancing Task and Relationship Behavior

- Delegating
  - Low relationship/Low task
    - Observing/Monitoring
- Participating
  - High relationship/Low Task
    - Problem solving/Encouraging

Balancing Task and Relationship Behavior

- Selling
  - High relationship/High task
    - Explaining/Persuading
- Telling
  - Low relationship/High task
    - Guiding/Directing

Follower Readiness

- Three characteristics of the person/group being led, that may effect the leadership style chosen, or the success of your leadership:
  - Able and willing and confident
  - Able but unwilling or insecure
  - Unable but willing or confident
  - Unable and unwilling or insecure

Promoting Resiliency

Definitions: 'Burnout'

- Psychological syndrome affecting professionals whose work involves service to others, characterized by:
  - Emotional exhaustion
  - Cynicism (depersonalization)
  - Feelings of ineffectiveness (low personal accomplishment)
    - Maslach C (1993) Professional burnout. Taylor & Francis:1-16

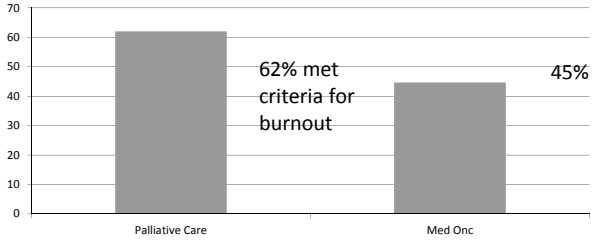
Definition of Burnout Cont.

- Initially defined at the level of the individual
  - Later recognition that how the system is structured also contributes
- Can focus on factors that lead to burnout
  - Or on factors that foster a clinician's ability to bounce back from stressful events
    - Leiter MP (1999) Six areas of worklife. J Health Hum Serv Adm 21:471-489
    - Aspinwall LG (2010) The value of positive psychology for health psychology. Ann Behav Med:39;4-15

Poll Question:
How many of you have at least one symptom of burnout?

- Emotional exhaustion
- Cynicism (depersonalization)
- Feelings of ineffectiveness (low personal accomplishment)
- None of the above symptoms

2014 AAHPM Clinician Member Survey of Burnout



AAHPM Survey 2014

- Used Maslach Burnout Inventory Human Services Survey
- 62% of clinicians experienced at least one symptom of burnout based on reporting high emotional exhaustion or high depersonalization
- Less than half (42%) reported that their work schedule left them enough time for personal and family life
- Almost half of the clinicians expected to leave their job in the next 10 years, with 24% citing burnout as the primary cause
  - Kamal AH(2016) Prevalence and predictors of burnout among hospice and palliative care clinicians in the US. JPSM 51:690-6
  - Shanafelt TD (2014) Burnout and career satisfaction among US oncologists. JCO March 1;678-86

To Be Fair…

- Response rate was 30%
- Highest burnout rates were reported by non-physician clinician AAHPM members
- Respondents differed significantly from the AAHPM membership roster, limiting the generalizability of the findings to the entire membership
- Factors associated with higher rates of burnout included:
  - Working in smaller organizations
  - Working longer hours
  - Being younger than 50 years
  - Working weekends

'Burnout' and Promoting Resiliency

- ***Systemic Stressors***
  - Limited resources
    - Time, money, staff
  - Competing demands
    - Administrative duties, patient needs, staff requests
  - Conflicting expectations
    - Provider discord regarding goals of treatment
  - Unpredictable schedules
    - Leading to working longer hours at expense of personal need
      - Perez GK (2015) Promoting resiliency among palliative care clinicians. J Palliat Med: 18:332-7

'Stressors' Continued

- ***Patient-centered stressors***
  - Intensity of cases
  - Managing patient/family expectations
- ***Personal challenges***
  - Setting boundaries
  - Recognizing and accepting limitations

Coping Strategies

- Physical self-care
  - Diet, physical activity, sleep, hobbies
- Emotional and physical distancing
  - Physical distancing (go for a walk), mind-body techniques, distraction
- Social and emotional support
  - Seek support from colleagues, friends, religious community

Definitions: 'Resiliency'

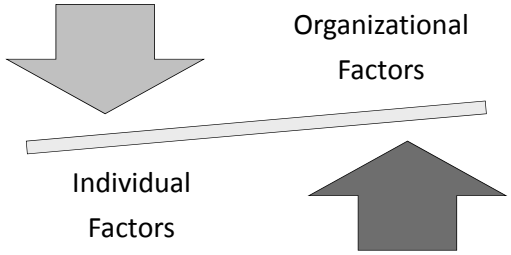
- The capacity to ***meet challenges***,
- ***recover from difficulties***, and
- ***thrive at work***

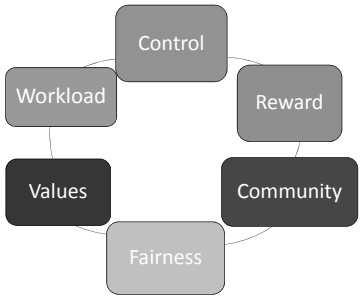
  - Back AL, Jackson VA, Steinhauser KE & Kamal AH (2015) Building resilience in yourself and your team. AAHPM conference

Common False Assumptions Related to Burnout

- Clinicians posses a fixed quantity of energy, or compassion, that becomes fatigued because it can be 'used up' and cannot be modified
  - 'Flourishing' is based on specific skills and can be increased
- When one is fatigued from overwork, the most efficient approach is to work continuously until the tasks are complete
  - Short breaks actually improve efficiency and productivity
- Clinicians are responsible to cope with their workplace stress outside of the workplace
  - The system is as responsible for burnout as is the individual
    - Back AL (2016) Building resilience for palliative care clinicians: an approach to burnout prevention based on individual skills and workplace factors. JPSM 52:284-91

Sustainability depends on improvements in 2 areas





Improving Organizational Factors

- Work load balance
- Buddy/mentor systems
- 'Late-start' clinicians
- Mini-sabbaticals from pt care
- Call schedule equity
- Financial reward/equity
- Appreciation/recognition
- Open discussion of conflict
- Team building
- 360 performance evaluations

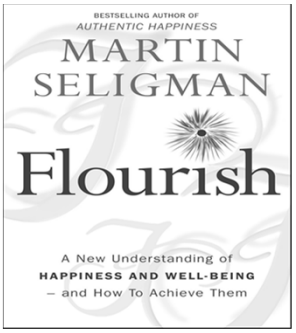
Back AL (2016) Building resilience for palliative care clinicians: an approach to burnout prevention based on individual skills and workplace factors. JPSM 52:284-91

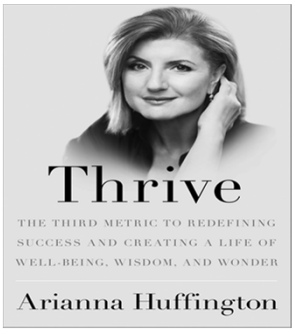
Merlo, LJ (2016) Healing physicians. JAMA 316:2489-90

Improving Individual Factors

- Identify work priorities; let other things slip
- Schedule easy pt visit days
- Focus on your strengths rather than shortcomings
- Take breaks
- Identify sacred boundaries
- Learn to recognize situations provoking emotional vulnerability
- Review mistakes, but don't ruminate over them
- Monitor your happiness quotient

- Montross-Thomas LP (2016) Personally meaningful rituals: a way to increase compassion and decrease burnout among hospice staff and volunteers. JPM 19:1043-50
- Gazelle G (2014) Building your resilient self. www.gailgazelle.com





Questions for us?

Please fill out a card for
response in the Q&A session

AAHPM Hospice Medical Director Update and Exam Prep

Systems-Based Practice: Hospice Regulatory and Compliance Issues: ADRs, QI, COPs, Physician billing etc.

Edward W Martin MD MPH

Disclosures

- Dr Ed Martin has nothing to disclose.

Objectives

- Discuss audit triggers and Office of Inspector General workplans
- Understand the specific requirements of the hospice physician
- Identify the components of the hospice item set
- Understand the role of the hospice physician in the appeal process
- Understand the coding requirements for billing physician services for hospice patients

Systems-Based Practice (25%)

Demonstrate knowledge of hospice regulation and reimbursement

Utilize local coverage determinations (LCDs) and understand limitations

Participate in the process of:

- 1. additional development requests (ADR)
- 2. redetermination or reconsideration
- 3. testifying to the Administrative Law Judge (ALJ)
- 4. differentiate and respond to technical and medical denials
-

Systems-Based Practice (25%)

Participate in the following aspects of the survey process:

- 1. the role of clinical documentation
- 2. focused or targeted medical review
- 3. of a Corrective Action Plan

Comply with Medicare/Medicaid Hospice Benefit (e.g., Conditions of Participation, requirements for certification, related/unrelated to terminal diagnosis, and levels of hospice care)

Systems-Based Practice (25%)

Understand these elements of quality improvement (QI) in the hospice setting:

- 1. differentiate quality assurance and performance improvement
- 2. role of clinical indicators
- 3. approach to data collection for quality review
- 4. role of focused QI studies

Systems-Based Practice (25%)

Assist in the design of clinically relevant quality-of-care outcome measures

Use data to demonstrate clinical, utilization, and financial outcomes of hospice care

The Good News

- Almost all of the new regulations require an increased role for the hospice medical director.
- **Job Security**

Hospice in the Headlines

Hospice fraud becoming a costly problem for Medicare
Pittsburgh Post-Gazette, March 6, 2016

Doctors convicted in $8.8 million Medicare hospice fraud
McKnights, May 8, 2016

Mississippi's sky-high hospice discharge rates point to fraud
Mississippi Today, October 20, 2016

False Claims Act

- Whitsleblower (Qui Tam) Lawsuits
- Google "Hospice Fraud"
- Attorneys are standing by ready to speak to your employees who may believe you are not following the regulations.
- The whistleblower stands to collect money if legal action is initiated
- Google Top Listing:
- **Hospice Fraud Qui Tam Lawyers-No Legal Fee-Unless You Win**

False Claims Act

- **"Fired Nurse Files Lawsuit "**

KPBS website Friday, February 22, 2013

- "alleging the hospice routinely admitted patients who did not meet Medicare eligibility."
- Nurse expected to receive 1 million dollars

Regulatory Scrutiny

- What appears to be fraud and abuse in hospice is in the news and it is unlikely that the regulatory environment will improve.
- We will have to deal with it.

When was your hospice last surveyed?
(state survey team, JCAHO, CHAP….)

- In the past year
- > 1 year but less than 3 years
- > 3 years
- We have never had a survey
- Don't know

Improving Medicare Post-Acute Care
Transformation Act of 2014
IMPACT

- mandates that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025

- **42 CFR Part 418, 2016 Hospice Wage Index, page 30**

Regulatory Scrutiny

Contractors reviewing hospice claims:

- Office of Inspector General (OIG)
- Medicare Audit Contractor (MAC)
- Recovery Audit Contractors (RAC)
- Medicaid Integrity Contractors
- Medicaid Recovery Audit Contractors
- Zone Program Integrity Contractors (ZPIC)
- Comprehensive Error Rate Testing (CERT)
- Department of Justice

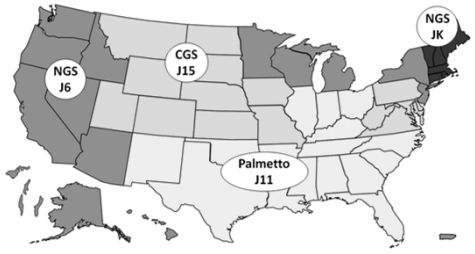
MACs – Medicare Administration Contractors

- Process and pay claims
- Medical record review to determine if payments appropriate
- Educate providers
- First level of claim appeals
- Pay claims for Part A and B
- Use LCD guidelines
- KNOW your MAC and what they look for

MACs – Medicare Administration Contractors

- MAC websites
- Webinars and teleconferences
- Variety of hospice topics to educate providers about regulatory changes
- Great opportunity to question MAC and learn about focus of MAC edits

Home Health and Hospice Jurisdictions
as of October 2013



RACs – Recovery Audit Contractors

- Recoup overpayments
- Pilot demonstration program – lead to permanent program - jan 2010 by doing post pay reviews
- Incentivized to make money (9 -12.5%)

ZPICS – Zone Program Integrity Contractors

- Investigate Medicare fraud
- Conduct audits
- Suspend payments
- Look at contracts, licenses, medical records
- Refer provider for exclusion to Medicare program
- Able to extrapolate
- Can find thousands in denials and extrapolate to millions
- Call your lawyer if they show up

ZPIC: Zone 5
Increased Physician Scrutiny

- AdvanceMed: AL,AR,GA,NC,SC,TN
- AUG 12,2013: Physicians referring to hospice will be under increased scrutiny
- Will look to see that patient was eligible
- Are MDs given incentives to refer?
- Are MDs made "hospice medical directors" for referral
- Are physicians who are being paid by hospice doing work such as face to face visits and then getting fair market value compensation

CERT – comprehensive error rate testing

- Randomly select claims
- Usually single chart pulled
- Calculates error rate for MACs
- Can request charts to see if overpayment occurred
- Usually cannot see billing patterns that indicate fraud

Office of Inspector General: OIG

- Fraud and Abuse
- Medicare and Medicaid

OIG Report March 2016

- **"Hospice Inappropriately Billed Medicare over $250 Million for General Inpatient Care"**
- **"includes care being billed but not provided and beneficiaries receiving care they did not need"**

OIG Report March 2016

- 31% of total 1 billion paid in 2012.
- "Beneficiary did not have uncontrolled pain or unmanaged symptoms or the beneficiary received care that could have been provided at home"
- 2/3 beneficiary did not need GIP at any time during the stay
- In some cases no evidence the beneficiary elected hospice or had terminal illness
- "inappropriate" stays more likely in SNF

OIG Report March 2016

- Part D paid for > half of the drugs which were primarily used for relief of pain and symptom control
- Care planning issues: requirements not met, missing key elements, not all required team members participated in planning
- Pastoral/counselor, social work, MD and in some cases nurse not involved in care planning.

OIG Recommendations

- MACs should review more GIP claims and Part D payments, focus on SNF
- Ensure that physician is involved in decision to use GIP
- Conduct prepay reviews for GIP with long LOS (>7 days)
- Greater scrutiny of care plans
- Additional enforcement remedies short of termination
- Follow up on problem providers
- Fraud prevention: look at high part D billing

Hospice Response to OIG Recommendations

- Document GIP eligibility on admission and each day of GIP
- Document physician involvement in decision to admit: best practice obtain an order
- Review LOS especially for pts with stays > 7 days
- Review GIP plan of care, are all disciplines documented
- Review part D billing

NHPCO Regulatory Alert April 1, 2016

OIG Work Plan 2017

- Hospice Regulatory Compliance
- Hospice Nursing Visits
- "Recommendations for Improvement"

Office of Inspector General
Work Plan 2017

Hospice Regulatory Compliance

- "We will review hospice medical records and billing documentation to determine whether Medicare payment for hospice services were made in accordance with Medicare requirements"

Hospice Nursing Visits

- RN required to make an on-site visit every 14 days
- To assess hospice aide care
- To determine if services ordered by IDG are meeting patient's needs

Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement

- Will summarize investigations, evaluations and audits
- Provide recommendations for "protecting beneficiaries and improving the program"

OIG review of Election Statements and Certification of Terminal Illness

- Did not specify Medicare 19%
- Required waiver information or was missing or stated inaccurately 12%
- Required information about palliative care was missing 9%
- Revocation or discharge information was inaccurate or unclear 4%
- Looked at GIP records

OIG review of Certification of Terminal Illness

Physician narrative was insufficient 14%

Physician did not include a narrative at all or only included the beneficiary's diagnosis 10%

Physician attestation was missing 5%
(OIG was looking for PPS scores, changes in BMI, weight loss, Changes in ADLs, "quantifiable measures")

CMS analysis of OIG report on Part D

- Analgesics, anti-nausea, laxative, antianxiety
- Part D paid 76% less in 2016 vs 2013

Hospice Wage Index 2017

- 2015 most common diagnoses
- Alzhemier's Disease 12%
- Congestive Heart Failure, unspecified 8%
- Lung Cancer 6%
- COPD 5%
- Senile Degeneration of the Brain 3%

Hospice Wage Index 2017

- % of claims with one diagnosis
- 2014: 49%
- 2015 37%
- 2 diagnoses 64%,
- 3 diagnoses 46%

Hospice Wage Index 2017

- Mean lifetime length of stay
- All Diagnoses 73.9 days
- Alzheimer's, Dementia, Parkinson's 118.8 days
- CVA/Stroke 55.6 days
- Cancers 47.3 days
- Chronic Kidney Disease 29.8 days
- Heart Disease 78.8
- Lung Disease (includes pneumonia) 69.4

Hospice Wage Index 2017

- Non-hospice spending "leakage"
- "unusual and exceptional" to see services outside of hospice
- This has declined from 2012-2014
- Still > 1 billion for Part A, B and D in 2014

Long Term Care Facility/Hospice Update

- Final Rule Issued June 2013
- Regulations complement the hospice Conditions of Participation (COPs) of June 2008
- Long Term Care (LTC) facilities can choose whether they will allow hospice services and who they will contract with.
- They must assist the resident in arranging transfer to another facility if the resident requests this.
- Part D impact???
- 42 CFR 483.75(t)

2016 Nursing Home Requirements for Participation

- Resident has right to choose health care provider
- PRN anti-psychotics must be rewritten every 14 days

Narrative Attestation Update

- Suggested language from 2013 presentation
- "I confirm that this narrative is based on my review of the patient's medical record and/or examination of the patient and the prognosis is less than six months if the disease runs its normal course".
- This was standard language in many EMRs
- Care denied in 2013 because statement did not say **composed.**

Narrative Attestation

No specific language required **but:**

- The attestation statement must indicate the physician composed the narrative
- Put the word **composed** in the attestation statement

NHPCO Regulatory Alert, November 20,2013

Program for Evaluating Payment Patterns Electronic Report PEPPER

- Provides data on live discharges and long length of stay discharges
- Allows programs to compare to national, jurisdictional and state data
- Delivered annually to hospice CEO ~ May
- Provides feedback on your admission criteria
- Provides data on the 80th percentile
- Concern is overutilization not denying access

Live Discharges: 80th Percentile

- FY 2010 21.2%
- FY 2011 19.3%
- FY 2012 13.8%
- FY 2013 17%
- FY 2014 18.4%
- Above 80th percentile: "could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet eligibility criteria"
- But you do expect to see some live discharges or eligible beneficiaries are not being enrolled

Live Discharges 2015 80th percentile

- No longer terminally ill: 15.9% (stable)
- Revocation: 13.0 % (slightly decreased)
- LOS 61-179 days 40.5% (stable)

Long Length of Stay: 80th Percentile

- FY 2010 21.9%
- FY 2011 22.0%
- FY 2012 22.1%
- FY 2013 23.5%
- FY 2014 23.8%
- FY 2015 23.3%

- Above 80th percentile: "could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet eligibility criteria"
- But you do expect to see some lengths of stay longer than 180 days or eligible beneficiaries are not being enrolled

PEPPER: New areas

- Continuous Home Care Provided in Assisted Living Facility (ALF0)

Of pts in an ALF how many got at least 8 hours of CHC: 80th percentile, 55.8%

- Routine Home Care in an ALF,

80th percentile, 28.3%

Also now reporting on :

single diagnosis claims 87.2% (was 99.8%)

No GIP or CHC 99.7%

PEPPER: New areas

- Routine Home Care in a Nursing Facility

80th percentile, 41.9%

- Routine Home Care in an SNF

80th percentile,19.9%

Additional Development Requests (ADRs)

- Usually related to a particular focus ie a particular diagnosis or long length of stay patients.
- Often the beginning of a long burdensome process for the hospice
- The Medicare Administrative Contractor (MAC) will be reviewing your documentation

Additional Development Requests (ADRs)

- Critical role for hospice MD
- Review for clinical documentation of eligibility
- Develop a cover letter that makes the case for eligibility
- Highlight/Tag information that makes the case
- OK to include information ie face to face visit not in that claim period

- NHPCO ADR Tip Sheet 2009

Additional Development Requests (ADRs)

- Address LCDs
- Address why patient has a 6 month life expectancy but does not meet LCD
- Use medical literature on prognosis when needed (ie information about preserved ejection fraction)

-

Additional Development Requests (ADRs)

- May need to consider an outside consultant , especially if the volume is large
- The claim may be paid after review or it may be denied and you will have the opportunity to appeal the denial.

Five Levels of Appeal

- 1st Level: Redetermination by Medicare Audit Contractor (MAC)
- 2nd Level: Reconsideration by Qualified Independent Contractor (QIC)
- 3rd Level: Hearing with Administrative Law Judge (ALJ)
- 4th Level: Appeals Council Review
- 5th Level: Judicial Review in U.S District Court

The Medicare Appeals Process ICN006562 January 2013

Appeals

- If your case is denied you have 120 days to appeal the decision (request a redetermination).
- The MAC has 60 days to respond
- You have the opportunity to review their reasoning for the denial but it may be minimal

Appeals

- Technical Denials cannot be appealed
- **But:** appeal if you think they missed something ie they did not see a document that was in the package or if the denial is not consistent with the regulations.
- You cannot argue that it is not fair that they are taking back thousands of dollars just because a signature was not dated.

Appeals

- If for some reason you did not submit a cover letter summarizing clinical information this certainly accompany the appeal
- Now you can directly address concerns, weaknesses that they pointed out that you did not wish to call attention to
- This may be months later: If the patient has died be sure to let them know

Appeals

- You may in some case decide not to appeal.
- In looking at the case you may realize the patient was not eligible
- If you don't think the patient was eligible this would be a good point to stop this process, review current eligibility and proceed with discharge if appropriate

Appeals: Qualified Independent Contractor (QIC)

- If the MAC upholds the denial you can move on to the next step
- Qualified Independent Contractor, QIC
- This is the last step that new evidence can routinely be included
- Make sure you have all supporting documentation in this package
- You have 180 days to appeal
- The QIC has 60 days to give you a decision

Appeals: Administrative Law Judge (ALJ)

- Finally you will get to tell your story to a human!
- The appeal must be filed within 60 days
- The ALJ is supposed to issue a decision within 90 days of getting the request
- Don't hold your breath!

Appeals: ALJ

Hearing requests have increased from 1250/week to >15,000 per week

You may wait years for a hearing, but you will get a hearing

Unless: the judge issues a decision in your favor based on reviewing the record

Court order to eliminate backlog by 2020

Appeals: ALJ

- No longer in person
- Telephone, but video teleconference may be an option
- Line up the staff you want to provide testimony
- Ideally the clinician who has seen the patient should be present
- Nothing is as compelling as a physician who can testify 'based on my examination I determined the patient had a prognosis of less that 6 months"

Appeals: ALJ

- Address LCDs
- Address why patient has a 6 month life expectancy but does not meet LCD
- Comment on medical literature on prognosis when needed (ie information about preserved ejection fraction)
- The ALJ may be very familiar with the LCDs and may ask about the ejection fraction or why the heart disease was Class III and not IV

Appeals: ALJ

- By the time you get to this level, it is very likely your patient has died. Be sure to mention that.
- Be sure to point out errors in the denial letters.
- You may find cut and paste sections that do not make sense and obvious errors that will make the denial seem less thoughtful.

Appeals: Final 2 levels

- 4th level: Appeals Council Review
- 5th level: Judicial Review in U.S District Court (must have at least $1400 at risk)

Question:

What is the first appeal level you will have the opportunity to speak to the reviewer and state your case

- A) MAC
- B) QIO
- C) ALJ
- D) US District Court

Question:
Which of the following is not a part of the core hospice team as defined under the Medicare Hospice Benefit

- Nurse
- Home Health Aide
- Dietary counselor
- Medical Social Worker
- Spiritual Counselor

Review: Core hospice team as defined under the Medicare Hospice Benefit

- Nurses, medical social workers, bereavement, spiritual, and dietary counselors, and physicians
- **Must be employees** of the hospice (physicians may be contracted)

Effective Compliance Program

- Mitigating Factor for OIG
- Reduce risks and exposures
- Reduce corporate liabilities
- Enhances image with intermediaries
- Public image
- Increase quality
- Increase profitability

Elements of an Effective Compliance Program

- Written policies, procedures and standards of conduct;
- Designate a Compliance Officer and Compliance Committee;
- Conduct effective training and education;
- Develop effective lines of communication;
- Enforce standards through clear disciplinary guidelines;
- Conduct internal monitoring and auditing; and
- Respond promptly to detected offenses and develop corrective action plans.

Compliance Program- Examples

- Long Length of Stay (LOS) pts – eligibility form – does the chart reflect continued decline/poor prognosis
- Billing/coding – accuracy
- Documentation – reflect medical necessity
- Certs/recerts/Face to Face (F2F) visits – consistency among providers
- Corrective action plan – improvement

Quality Assessment and Performance Improvement (QAPI)

- At one point Hospice MD was to chair this effort
- Expectation remains that Hospice MD is an active participant in performance improvement

Quality Assurance: QA

- "QA is a process of meeting quality standards and assuring that care reaches an acceptable level".
- Often used interchangeably with Quality Assessment
- QAPI At A Glance: CMS Publication

Performance Improvement: PI

- "PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems "
- QAPI At A Glance: CMS Publication

Hospice Item Set (HIS)

- Affordable Care Act mandated CMS hospice quality reporting program beginning in FY 2014
- Standardized set of 7 patient-level data items based on National Quality Forum (NQF) endorsed process measures

Question:

Which of the following is not an item in the Hospice Item Set?

- Pain Assessment
- Dyspnea Screening
- Depression Screening
- Treatment Preferences

Hospice Item Set

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #1638 Dyspnea Treatment
- NQF #1639 Dyspnea Screening
- NQF #1641 Treatment Preferences
- Modified NQF #1647 Beliefs/Values Addressed (if desired by the patient)

Question

Which one of the following statements about the Hospice Item Set is **true**?

- Presence of DNR order prior to admission is sufficient evidence that hospice has addressed CPR preference
- Evidence of comprehensive pain assessment must include multiple characteristics (location, severity, character, etc.)
- Admission and Discharge HIS must be submitted on all Medicare hospice patients admitted after July 1, 2014, even if revocation/discharge occurs before HIS care processes can be completed
- Treatment preferences are recorded in the HIS

Hospice Item Set (HIS)

- HIS-Admission and HIS-Discharge to be submitted on every hospice patient admitted after July 1, 2014, even if patient revokes or is discharged before all HIS-related care processes are complete

Hospice Item Set (HIS)

- If a particular HIS care process is not documented in hospice clinical record, care process is considered not to have occurred
- Completion timing
  - HIS-Admission: admission date + 14 calendar days
  - HIS-Discharge: discharge date + 7 calendar days
- Submission timing
  - HIS-Admission: admission date + 30 calendar days
  - HIS-Discharge: discharge date + 30 calendar days

Hospice Item Set (HIS)

- Detailed patient information including demographics and site of care
- Diagnoses are coded as
  - Cancer
  - Dementia/Alzheimer's
  - None of the above

Treatment preferences

- Was the patient/responsible party asked about preference regarding
  - Use of CPR?
  - Life-sustaining treatments other than CPR?
  - Hospitalization?
- Yes/No and date of 1st discussion or patient/responsible party refusal to discuss

Beliefs/Values addressed

- Was the patient and/or caregiver asked about spiritual/existential concerns?
- Yes/No and date of 1st discussion or patient and/or caregiver refusal to discuss

Pain screening

- Was the patient screened for pain?
  - Yes/No and date
- The patient's pain severity was
  - None, mild, moderate, severe, or not rated
- Type of standardized tool used
  - Numeric, verbal descriptor, patient visual, staff observation, or no standardized tool used

Pain assessment

- Was a comprehensive pain assessment done?
  - Yes/No and date
- Check all that apply (must have evidence of at least one of the seven characteristics)

1. Location	**5. Frequency**
2. Severity	**6. What relieves/worsens**
3. Character	**7. Effect on function or QOL**
4. Duration	**9. None of the above**

Dyspnea screening

- Was the patient screened for shortness of breath?
  - Yes/No and date
- Did the screening indicate the patient had shortness of breath?
  - Yes/No

Dyspnea treatment

- If patient screened positive for shortness of breath, was treatment for shortness of breath initiated?
  - Yes/No/Patient declined treatment and date
- Type(s) of treatment initiated (check all that apply)

1. Opioids	**3. Oxygen**
2. Other medication	**4. Non-medication**

Patients on Opioids Get Bowel Regimen

- Was a scheduled opioid initiated or continued?
  - Yes/No and date
- Was a PRN opioid initiated or continued?
  - Yes/No and date
- Was a bowel regimen initiated or continued?
  - Yes/No or documentation why not

New Quality Measures

- % of patients receiving a visit from a Nurse, physician, NP or PA in last 3 days of life
- % of patients receiving at least visits from a social worker, chaplain, LPN or hospice aid in the last 7 days of life
- Data collection to begin April 2017

National Benchmarks: Mean

CASPER: Certification And Survey Provider Enhanced Reports

• Beliefs/Values addressed	93.3%
• Treatment preferences	98.4%
• Pain Screening	94%
• Pain Assessment	76.3%
• Dyspnea Screening	97.7%
• Dyspnea treatment	94.8%
• Bowel Regimen	94.1%

July 2015-June 2016

Question:
What will now be used to survey families/caregivers about their experience with hospice

- Family Evaluation of Hospice Care: FEHC
- Consumer Assessment of Healthcare Providers and Systems: CAHPS HOSPICE
- Hospice Experience of Care Survey: HECS
- Bereaved Caregiver Hospice Survey: BCHS

CAHPS HOSPICE
Consumer Assessment of Healthcare Providers and Systems

- Previously known as Hospice Experience of Care Survey.
- Replaces the Family Evaluation of Hospice Care, FEHC
- 9 quality measures
- 47 questions

- *Hospice Team Communication*
- *Getting Timely Care*
- *Treating Family Member with Respect*
- *Providing Emotional Support*
- *Support for Religious and Spiritual Beliefs*
- *Getting Help for Symptoms*
- *Information Continuity*
- *Understanding the Side Effects of Pain Medication*
- *Getting Hospice Care Training (Home Setting of Care Only)*

- **CAHPS Hospice**

National Benchmarks: Mean
CASPER: Certification And Survey Provider Enhanced Reports

• Hospice Team Communication	80%
• Getting Timely Care	78%
• Treating Family Member with Respect	90%
• Getting Emotional and Religious Support	89%
• Getting Help for Symptoms	75%
• Getting Hospice Care Training	72%
• Rating of Hospice	80%
• Willingness to Recommend	85%

April 2015-March 2016

HOSPICE COMPARE

- Will use HIS and Hospice CAHPS data
- Target "mid-year" 2017

Hospice Provider Billing

- Direct patient care related to terminal diagnosis
  - If MD *employed/contracted* by hospice → Hospice bills Medicare Part A. Billings paid at 100% rate by Medicare Admin Contractor (MAC). Can be attending or consulting
  - If NP acting as attending (patient must be informed and choose NP) → Medicare Part A Billings paid at 85% of physician rate. Have to use GV modifier on NP billable visits

Hospice Attending of Record (AOR)

- If AOR *Not* employed/contracted by hospice they bill Medicare Part B
  - Use GV modifier – if care related to hospice
  - Use GW modifier – if care unrelated to hospice
  - Can bill for Care Plan Oversight

  If your physicians are complaining that they are NOT getting paid, ask them if they are using the GV modifier.

Other Physicians Caring for the Patient not employed/contracted by the hospice.

- Care related to the terminal diagnosis (prognosis): Must be billed through the hospice who can bill part A for the service
- Care unrelated to the terminal diagnosis (prognosis): billed to Medicare Part B with GW modifier

Part A vs Part B

- Part A: reimbursed at 100%
- Part B: reimbursed at 85% and patient is to pay the balance

Modifiers

- GV
  - Used by AOR who is *not* employed by hospice when visit *related* to hospice
  - NPs employed by hospice on billable visits hospice related
- GW
  - Visit is *unrelated* to hospice diagnosis *(e.g. patient with COPD seen for diabetes)*
- Q5
  - When acting in place of AOR *(e.g. covering doctor making weekend rounds in IPU)*

Question: A physician has a contract with a hospice but still maintains a private office. One of her private patients is now on hospice with a diagnosis of cancer. She sees that patient in the office to adjust pain medications. How should the visit be billed.

- Bill Medicare Part B with GV modifier
- Bill Medicare Part B with GW modifier
- Bill through the Hospice (Medicare Part A)
- No bill as this comes under the medical director responsibilities

Questions?

Please fill out a card for response in the discussion session

AAHPM Hospice Medical Director Update and Exam Prep

Eligibility, Relatedness and Prognostication

Shaida Talebreza MD, AGSF, FAAHPM, HMDC
Associate Professor, University of Utah, Division of Geriatrics
Geriatric Palliative Care Specialist,
George E. Wahlen SLC VAMC
Medical Director, Inspiration Hospice

Disclosure

- **No relevant financial relationships to disclose**

Objectives

- Describe the difference between Medicare Hospice Eligibility Requirements and Hospice Local Coverage Determination (LCD) for Determining Terminal Status
- Describe and utilize the Hospice LCDs for Determining Terminal Status
- Discuss the available prognostic evidence for various disease states (and limitations of the Hospice LCDs)

Medicare Hospice Eligibility	Local Coverage Determination (LCDs)	Terminal Diagnosis/Prognosis
• An individual must be entitled to Medicare A and be **certified** as being **terminally ill** • Certified with a life expectancy of 6 months or less if the illness runs its normal course based on the **clinical judgment** of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one	• **Guidelines** to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less	• The diagnosis (ICD Code) that **the certifying hospice physician** determines to be the most contributory to the patient's terminal condition. • Hospices are to report this **principal diagnosis** (ICD Code) on their **claims form** • CMS expects all of a patient's coexisting or additional diagnoses (ICD Codes) ***related* to the terminal illness or related conditions** should be reported in the additional coding fields on the hospice claim **(i.e. secondary diagnoses**)

Medicare Hospice Local Coverage Determinations (LCDs)

- "Prognostic Indicators"
- Created in 1996 as a ***GUIDE*** to be used in conjunction with clinical judgment to determine prognosis
- Never intended to be used as public policy
- Never validated
- **Often ineffective at predicting prognosis**
- **Not hospice "eligibility requirements"**

Fox et al., JAMA 1999; 282:1638-1645

Schonwetter, Am JHPM 2003

Medicare Hospice Local Coverage Determinations (LCDs)

- **Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less**
  - Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy is provided
- Medical review of records of hospice patients that do not document that patients meet the guidelines [LCDs] may result in denial of coverage unless other clinical circumstances reasonably predictive of a life expectancy of six months or less are provided

CMS.gov
CGS Local Coverage Determination: Hospice Determining Terminal Status

Local Coverage Determination (LCDs) CGS and NGS (1 LCD with Multiple Indicators)	Local Coverage Determination (LCDs) Palmetto	Terminal Diagnosis
• Non-disease specific decline in clinical status • ALS • Cancer • Dementia due to Alzheimer's disease • Heart disease • HIV disease • Liver disease • Pulmonary disease • Renal disease • Stroke and Coma	• Adult failure to thrive syndrome • Alzheimer's disease • Cardiopulmonary conditions • HIV disease • Liver disease • Neurological conditions • Renal care LCDs are NOT diagnoses! They are general guidelines of a <6 month prognosis based on expert consensus for these categories of diseases.	• The diagnosis **(ICD Code)** that **the certifying hospice physician** determines to be the most contributory to the patient's terminal condition.

Slide 8

Primary Terminal Diagnosis NOT Debility or Failure to Thrive

- Debility
  - An unspecified syndrome characterized by unexplained weight loss, malnutrition, functional decline, multiple chronic conditions contributing to the terminal progression, and increasing frequency of outpatient visits, emergency department visits and/ or hospitalizations
- Multiple comorbid conditions
  - Individually, may not deem the individual to be terminally ill
  - Collective presence contributes to the terminal status of the individual

Federal Register 8/7/2013

- "We are not stating that individuals with the clinical manifestations of ''debility'' and ''adult failure to thrive'' are ineligible for hospice services under the Medicare Hospice Benefit.
- "Eligibility is determined by the certifying physician and based on the review of the clinical records and comprehensive assessment."

Slide 10

Primary Terminal Diagnosis NOT Debility or Failure to Thrive

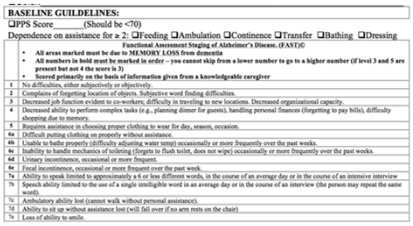
- Hospices should not use debility or adult failure to thrive as the **principal terminal diagnoses on the claims forms** because these diagnoses are associated with multiple conditions.
- Instead hospices should list the underlying conditions that have caused debility and adult failure to thrive
- "Debility'' and ''adult failure to thrive'' could be listed on the hospice claim as other, additional, or coexisting diagnoses

Local Coverage Determination (LCDs) CGS and NGS (1 LCD with Multiple Indicators)	Local Coverage Determination (LCDs) Palmetto	Terminal Diagnosis
• Non-disease specific decline in clinical status • ALS • Cancer • Dementia due to Alzheimer's disease • Heart disease • HIV disease • Liver disease • Pulmonary disease • Renal disease • Stroke and Coma	• Adult failure to thrive syndrome • Alzheimer's disease • Cardiopulmonary conditions • HIV disease • Liver disease • Neurological conditions • Renal care	• The diagnosis **(ICD Code)** that **the certifying hospice physician** determines to be the most contributory to the patient's terminal condition. • Do not list Debility or Adult Failure to Thrive as the primary terminal diagnosis

Review Local Coverage Determinations (LCDs) for a Number of Conditions

CGS/NGS	Palmetto
• **Alzheimer's Disease and Related Disorders**	• **Alzheimer's Disease & Related Disorders**
• **Heart Disease**	• **Cardiopulmonary Conditions**
• **Non-Disease Specific Decline In Clinical Status**	• **Adult Failure To Thrive Syndrome**

Alzheimer's Disease LCD Summary CGS/NGS (1 of 2)



BASELINE GUILDELINES:

☐PPS Score_____(Should be <70)

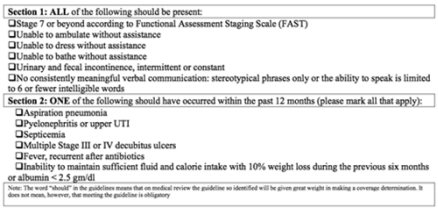
Dependence on assistance for ≥ 2: ☐Feeding ☐Ambulation ☐Continence ☐Transfer ☐Bathing ☐Dressing

Functional Assessment Staging of Alzheimer's Disease. (FAST)©

- **All areas marked must be due to MEMORY LOSS from dementia**
- **All numbers in bold must be marked in order - you cannot skip from a lower number to go to a higher number (if level 3 and 5 are present but not 4 the score is 3)**
- **Scored primarily on the basis of information given from a knowledgeable caregiver**

1	No difficulties, either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective word finding difficulties.
3	Decreased job function evident to co-workers; difficulty in traveling to new locations. Decreased organizational capacity.
4	Decreased ability to perform complex tasks (e.g., planning dinner for guests), handling personal finances (forgetting to pay bills), difficulty shopping due to memory.
5	Requires assistance in choosing proper clothing to wear for day, season, occasion.
6a	Difficult putting clothing on properly without assistance.
6b	Unable to bathe properly (difficulty adjusting water temp) occasionally or more frequently over the past weeks.
6c	Inability to handle mechanics of toileting (forgets to flush toilet, does not wipe) occasionally or more frequently over the past weeks.
6d	Urinary incontinence, occasional or more frequent.
6e	Fecal incontinence, occasional or more frequent over the past week.
7a	Ability to speak limited to approximately a 6 or less different words, in the course of an average day or in the course of an intensive interview
7b	Speech ability limited to the use of a single intelligible word in an average day or in the course of an interview (the person may repeat the same word).
7c	Ambulatory ability lost (cannot walk without personal assistance).
7d	Ability to sit up without assistance lost (will fall over if no arm rests on the chair)
7e	Loss of ability to smile.

Alzheimer's Disease LCD Summary CGS/NGS (2 of 2)



Section 1: ALL of the following should be present:

☐Stage 7 or beyond according to Functional Assessment Staging Scale (FAST)
☐Unable to ambulate without assistance
☐Unable to dress without assistance
☐Unable to bathe without assistance
☐Urinary and fecal incontinence, intermittent or constant
☐No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to 6 or fewer intelligible words

Section 2: ONE of the following should have occurred within the past 12 months (please mark all that apply):

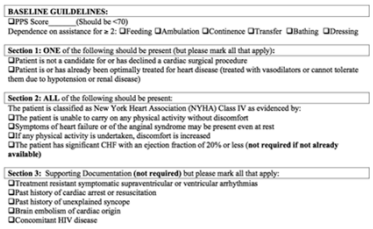
☐Aspiration pneumonia
☐Pyelonephritis or upper UTI
☐Septicemia
☐Multiple Stage III or IV decubitus ulcers
☐Fever, recurrent after antibiotics
☐Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or albumin < 2.5 gm/dl

Note: The word "should" in the guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is obligatory

Alzheimer's Disease LCD Summary Palmetto

- Ultimately, the combined effects of the Alzheimer's Disease (FAST stage 7 and beyond) and any comorbid and secondary condition should be such that most beneficiaries with Alzheimer's Disease (FAST stage 7 and beyond) and similar impairments would have a prognosis of six months or less.
  - Comorbid conditions are distinct from the Alzheimer's Disease itself
    - Coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD)
  - Secondary conditions are directly related to the Alzheimer's Disease
    - Delirium and pressure ulcers

Heart Disease LCD Summary CGS/NGS



BASELINE GUILDELINES:

☐PPS Score_____(Should be <70)

Dependence on assistance for ≥ 2: ☐Feeding ☐Ambulation ☐Continence ☐Transfer ☐Bathing ☐Dressing

Section 1: ONE of the following should be present (but please mark all that apply):

☐Patient is not a candidate for or has declined a cardiac surgical procedure
☐Patient is or has already been optimally treated for heart disease (treated with vasodilators or cannot tolerate them due to hypotension or renal disease)

Section 2: ALL of the following should be present:

The patient is classified as New York Heart Association (NYHA) Class IV as evidenced by:
☐The patient is unable to carry on any physical activity without discomfort
☐Symptoms of heart failure or of the anginal syndrome may be present even at rest
☐If any physical activity is undertaken, discomfort is increased
☐The patient has significant CHF with an ejection fraction of 20% or less **(not required if not already available)**

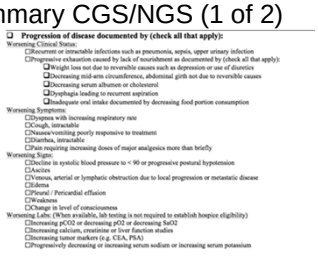
Section 3: Supporting Documentation **(not required)** but please mark all that apply:

☐Treatment resistant symptomatic supraventricular or ventricular arrhythmias
☐Past history of cardiac arrest or resuscitation
☐Past history of unexplained syncope
☐Brain embolism of cardiac origin
☐Concomitant HIV disease

Cardiopulmonary Conditions LCD Summary Palmetto

- The identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care-planning.
- Use of the International Classification of Functioning, Disability and Health (ICF) to help identify and document the unique service needs of individuals with cardiopulmonary conditions is suggested, but not required.
- Documentation of comorbid (e.g. Alzheimer's) and secondary conditions (e.g. delirium, pneumonia, stasis ulcers and pressure ulcers)

Non-Disease Specific Decline In Clinical Status
LCD Summary CGS/NGS (1 of 2)



☐ **Progression of disease documented by (check all that apply):**

Worsening Clinical Status:
- ☐Recurrent or intractable infections such as pneumonia, sepsis, upper urinary infection
- ☐Progressive exhaustion caused by lack of nourishment as documented by (check all that apply):
  - ☐Weight loss not due to reversible causes such as depression or use of diuretics
  - ☐Decreasing mid-arm circumference, abdominal girth not due to reversible causes
  - ☐Decreasing serum albumen or cholesterol
  - ☐Dysphagia leading to recurrent aspiration
  - ☐Inadequate oral intake documented by decreasing food portion consumption

Worsening Symptoms:
- ☐Dyspnea with increasing respiratory rate
- ☐Cough, intractable
- ☐Nausea/vomiting poorly responsive to treatment
- ☐Diarrhea, intractable
- ☐Pain requiring increasing doses of major analgesics more than briefly

Worsening Signs:
- ☐Decline in systolic blood pressure to < 90 or progressive postural hypotension
- ☐Ascites
- ☐Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
- ☐Edema
- ☐Pleural / Pericardial effusion
- ☐Weakness
- ☐Change in level of consciousness

Worsening Labs: (When available, lab testing is not required to establish hospice eligibility)
- ☐Increasing pCO2 or decreasing pO2 or decreasing SaO2
- ☐Increasing calcium, creatinine or liver function studies
- ☐Increasing tumor markers (e.g. CEA, PSA)
- ☐Progressively decreasing or increasing serum sodium or increasing serum potassium

Non-Disease Specific Decline In Clinical Status
LCD Summary CGS/NGS (2 of 2)

- ❑ **Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to Progression of Disease.**
- ❑ **Increasing ER Visits, Hospitalizations, or Physician's Visits Related to the Hospice Primary Diagnosis**
- ❑ **Progressive Decline in Functional Assessment Staging (FAST) for Dementia (from ≥7A on the FAST).**
- ❑ **Progression to Dependence on Assistance for Two or More Activities of Daily Living (ADLs):**
  - **Feeding, Ambulation, Continence, Transfer, Bathing, Dressing**
- ❑ **Progressive Stage 3-4 Pressure Ulcers in Spite of Optimal Care**

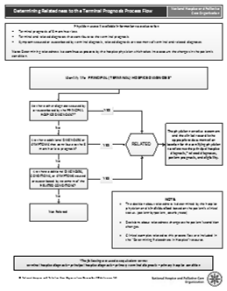
Adult Failure To Thrive Syndrome LCD Summary Palmetto

- (BMI) will be below 22 kg/m ^{2} and the patient is either declining enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.
- Palliative Performance Scale value less than or equal to 40%.
- BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date**.**

Relatedness (simplified version)

	Reasonable and necessary for palliation and management	Not reasonable and necessary for palliation and management
Condition related to terminal prognosis	***Hospice Pays (for medication on hospice formulary)***	***Discuss Discontinuing (if not harmful patient may purchase)***
Condition unrelated to terminal prognosis	***Paid by Prior Payor***	

Relatedness



Relatedness

- "The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions." [Federal Register March 10, 2014]
- "We expect that Medicare hospice providers will continue to provide **all of the medications** that are **reasonable and necessary** for the palliation and management of a beneficiary's **terminal illness and related conditions.**" [Federal Register July 18, 2014]

Relatedness

- For prescription drugs **to be covered under Part D** when the enrollee has elected hospice, the drug must be for treatment of a condition that **is completely unrelated to the terminal illness or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual**. [Federal Register March 10, 2014]

Relatedness

- Medications would not be covered under the Medicare hospice benefit, if they are **determined not to be reasonable and necessary for the palliation of pain and/or symptom management by the hospice interdisciplinary group**, after discussions with the hospice patient and family.
- If a beneficiary still chooses to have these medications filled through his or her pharmacy, **the costs of these medications would then become a beneficiary liability** for payment and not covered by Part D." [Federal Register July 18, 2014]

Relatedness

- "If a beneficiary requests a drug for his or her terminal illness or related conditions that is **not on the hospice formulary and the beneficiary refuses to try a formulary equivalent first; or the drug is determined by the hospice provider to be unreasonable or unnecessary for the palliation of pain and/or symptom management, the beneficiary may opt to assume financial responsibility for the drug.** However, no payment for the drug will be available under Part D." [Federal Register July 18, 2014]

Group Case Review

- An 85 year old patient with Alzheimer's disease FAST 6E , CHF NHYA Stage III. The patient has decreased oral intake (10% of meals), malnutrition (Albumin of 2.5), weight loss (10% of body weight over last year), BMI of 18.6, all despite 1:1 feeding assistance. The patient also has decreasing functional status (PPS was 60% six months ago currently 30%), and has progressed from using a walker to chair/bedbound status in less than six months, requires a 1 person transfer. Stage III pressure ulcer despite optimal wound prevention and treatment. This patient was determined to be terminally ill with a prognosis of less than 6 months by the certifying physicians.

Group Discussion Question

Is this patient Medicare Hospice Eligible?

A. Yes
B. No

Medicare Hospice Eligibility	Local Coverage Determination (LCDs)	Terminal Diagnosis/Prognosis
• An individual must be entitled to Medicare A and be **certified** as being **terminally ill** • Certified with a life expectancy of 6 months or less if the illness runs its normal course based on the **clinical judgment** of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one	• **Guidelines** to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less	• The diagnosis (ICD Code) that **the certifying hospice physician** determines to be the most contributory to the patient's terminal condition. • Hospices are to report this **principal diagnosis** (ICD Code) on their **claims form** • CMS expects all of a patient's coexisting or additional diagnoses (ICD Codes) ***related to the terminal illness or related conditions*** should be reported in the additional coding fields on the hospice claim **(i.e. secondary diagnoses**)

Group Discussion Question

- Which Medicare **LCD/Indicator** could you use to support documentation of a prognosis of less than 6 months for **CGS/NGS**?

A. Dementia due to Alzheimer's Disease
B. Non-Disease Specific Decline In Clinical Status
C. Heart Disease

Non-Disease Specific Decline In Clinical Status LCD

- Progressive exhaustion caused by lack of nourishment as documented by:
  - Weight loss not due to reversible causes such as depression or use of diuretics
  - Decreasing serum albumen or cholesterol
  - Inadequate oral intake documented by decreasing food portion consumption
- Worsening Signs - Weakness
- Decline in Palliative Performance Score (PPS) from <70% due to Progression of Disease
- Progression to Dependence on Assistance for Two or More Activities of Daily Living (ADLs): Feeding, Ambulation, Continence, Transfer, Bathing, Dressing
- Progressive Stage 3-4 Pressure Ulcers in Spite of Optimal Care

Patient

- Weight loss (10% of body weight over last year), BMI of 18.6, all despite 1:1 feeding assistance.
- Malnutrition (Albumin of 2.5)
- Decreased oral intake (10% of meals)
- The patient also has decreasing functional status (PPS was 60% six months ago currently 30%)
- Progressed from using a walker to chair/bedbound status in less than six months, requires a 1 person transfer.
- Stage III pressure ulcer despite optimal wound prevention and treatment.

Group Discussion Question

- Which Medicare **LCD/Indicator** could you use to support documentation of a prognosis of less than 6 months for **Palmetto**?

A. Adult Failure to Thrive Syndrome
B. Alzheimer's Disease and Related Disorders
C. Cardiopulmonary Conditions

Adult Failure to Thrive Syndrome LCD

- (BMI) will be below 22 kg/m^2 and that the patient is either declining enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake
- Palliative Performance Scale value less than or equal to 40%.
- BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date**.**

Patient

- BMI of 18.6 despite 1:1 feeding assistance
- PPS was 60% six months ago currently 30%

Group Discussion Question

What is your primary diagnosis?

A. Adult Failure to Thrive
B. Alzheimer's Disease
C. Congestive Heart Failure

Group Discussion Answer

Secondary diagnoses:

A. Adult Failure to Thrive, Pressure Ulcer

Group Discussion Question

Would your cover Donepezil, Memantine, Simvastatin under the hospice benefit?

A. Yes
B. No

Group Discussion Answer

Would you cover Donepezil, Memantine, Simvastatin under the hospice benefit?

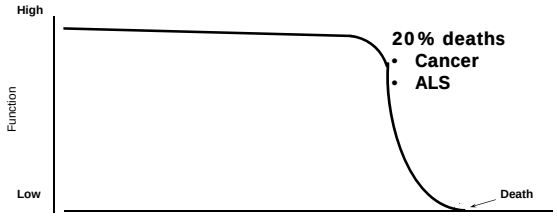
Are these medications determined to be **reasonable and necessary** for the **palliation and management** of a beneficiary's **terminal illness and related conditions by the hospice interdisciplinary group** after discussions with the hospice patient and family?

Remember LCD is not = Prognosis

- "Prognostic Indicators"
- Created in 1996 as a *GUIDE* to be used in conjunction with clinical judgment
- Never intended to be used as public policy
- Never validated
- **Often ineffective at predicting prognosis**

Fox et al., JAMA 1999; 282:1638-1645
Schonwetter, Am JHPM 2003

Short Period of Decline



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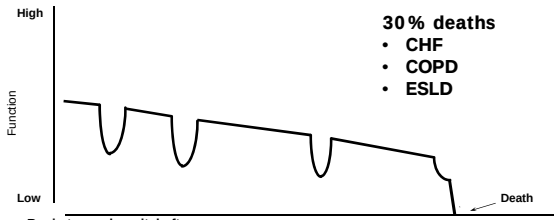
Chronic Illness with Exacerbations



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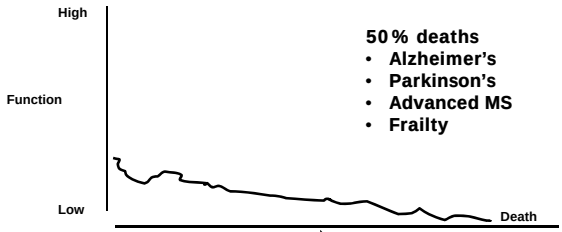
Progressive Deterioration



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Resources for determining prognosis

- Fast Facts and Concepts (website and app)
  - http://www.mypcnow.org/#!fast-facts/c6xb
  - https://itunes.apple.com/us/app/palliative-care-fast-facts/id868472172?mt=8
- ePrognosis (website)
  - http://eprognosis.ucsf.edu
- Mediquations (app)
  - http://www.mediquations.com/iPhone_iPodTouch_iPad/index.html

Prognosis Pearls: General Indicators of Poor Prognosis

- Recurrent infections
- Weight loss [persistently low albumin (<2.5 mg/L) and/or cholesterol]
- Worsening functional status
- Increased medical utilization: hospitalizations, ER and physician visits
- **Consider the time-frame of the decline: years, months, weeks, days? This often reflects the time-frame of remaining life-expectancy**

Prognosis Pearls: General Indicators of Poor Prognosis

- **Answer "no" to the surprise question:**

Would you be surprised if this patient died within the next year?

Prognosis Pearls: Cancer

- The single most important predictive factor in cancer is Performance Status
  - **Karnofsky/PPS < 40 and/or ECOG 3** → Median survival 8-50 days
  - **Karnofsky/PPS < 20 and/or ECOG 4** → Median survival 7-16 days

Goldstein NE, Morrison RS. *Evidence-Based Practice of Palliative Medicine*. Phileadelphia, Pa.: Elsevier/Saunders; 2013.

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

ECOG Performance Status

1. Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
2. Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3. Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4. Completely disabled; cannot carry on any self-care; totally confined to bed or chair

Prognosis Pearls: CHF

- **NYHA Functional Classification 1 year mortality:**
  - Class II (mild symptoms): 5-10%
  - Class III (moderate symptoms): 10-15%
  - Class IV (severe symptoms): 30-40%

PC Now Fast Fact #143
https://drive.google.com/file/d/0BylFEWCSwGsUR2swOEtJTTRBcWs/view?pref=2&pli=1

Prognosis Pearls: CHF

- **Seattle Heart Failure Model**
  - **Am J Cardiol 2006; 98:1076-1082**
  - www.depts.washington.edu/shfm

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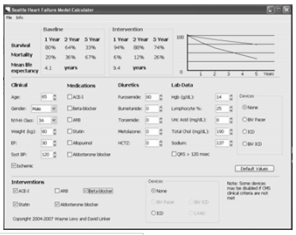

From "The Seattle Heart Failure Model: Prediction of Survival in Heart Failure," by WC Levy, D Mozaffarian, DT Linker, et al, 2006, Circulation, 113, 1424-1433. http://seattleheartfailuremodel.org. © 2013 University of Washington. Reproduced with permission. All rights reserved.

Prognosis Pearls: End Stage Renal Disease

- The annual death rate for patients initiating dialysis is 20-25%
- Mean survival after dialysis withdrawal is 8-10 days
- Poor prognostic factors for initiating dialysis:
  - older age: 61% 1-year mortality ages 80-84
  - low serum albumin: 50% 1-year mortality if albumin < 3.5
  - poor functional status
  - comorbid illnesses such as diabetes and cardiovascular disease

PC Now Fast Facts #191
https://drive.google.com/file/d/0BylFEWCSwGsUT2RjRmpoTXprdWM/view?pref=2&pli=1

Prognosis Pearls: End Stage Liver Disease

Condition	Approximate Median Survival
Compensated chronic liver failure (no ascites, variceal bleeding, encephalopathy, or jaundice)	12 years
Decompensated Liver Failure	2 years
Type-1 Hepatorenal Syndrome (rapid and severe renal failure)	8-10 weeks
Type-2 Hepatorenal Syndrome (chronic and less severe renal failure)	6 months

PC Now Fast Facts #189
https://drive.google.com/file/d/0BylFEWCSwGsUaTZzOWRYWE9sZ0U/view?pref=2&pli=1

Prognosis Pearls: End Stage Liver Disease

MELD SCORE	Predicted 6 Month Mortality
0-9	2%
10-19	8%
20-29	22%
30-39	60%

PC Now Fast Facts #189
https://drive.google.com/file/d/0BylFEWCSwGsUaTZzOWRYWE9sZ0U/view?pref=2&pli=1

Prognosis Pearls: Acute Ischemic Stroke

- 85% CVAs
- 5% hospital mortality
- 17-21% 90 day mortality
- Medical complications in the hospital increase the mortality rate
- NIHSS and age – strongest predictors

Prognosis Pearls: Hemorrhagic Stroke

- 15% CVAs
- 52% 30 day mortality
- 90% 30 day mortality if a brainstem bleed
- Volume of the bleed:
  - < 30 cc – 20% mortality
  - 30 to 60 cc – 100% with Rankin Score > 4 – Unable to walk or any ADLs without assistance
  - >60 cc – 90+% mortality

Mitka, JAMA 2007; 297(23): 2573

Prognosis Pearls: Dementia

- "A 2012 systematic review found malnutrition, feeding issues, and dysphagia were the strongest associated factors with 6 month mortality in elderly patients with advanced dementia.
- Six month mortality after hospitalization for pneumonia was 53% compared with 13% for cognitively intact patients.
- For patients with a new hip fracture, 55% of end-stage dementia patients died within 6 months compared with 12% for cognitively intact patients"

PC Now Fast Fact 150
https://drive.google.com/file/d/0BylFEWCSwGsUZGhXZTAtR0wwTFE/view?pref=2&pli=1

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Prognosis Pearls: Frailty

- FRIED Tool
  - Validated in Community-dwelling men and women 65 years or older
  - Based on the physiological concept of Frailty
  - Older adults identified as frail had:
    - Worsened mobility
    - Worsened ADLs
    - Disability
    - Increased Falls
    - Increased Hospitalizations
    - **Higher Mortality**

Durso SC, Sullivan GM, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine.* 8th ed. New York: American Geriatrics Society; 2013.

Slide 58

Prognosis Pearls: Frailty

Characteristic	Criteria for Women (≥3 indicates frailty)
Weight loss	Lost >10 pounds unintentionally last year
Exhaustion	Felt that everything I did in the last week was an effort or could not get going in last week
Slowness	Walking 15 feet in: ≥7 sec for height ≤ 159 cm ≥6 sec for height >159 cm
Low activity level	<270 kcal of physical expenditure on 18-item activity scale
Weakness	Grip strength of the dominant hand: ≤17 kg for BMI ≤ 23 ≤17.3 kg for 23 < BMI ≤ 26 ≤18 kg for 26 < BMI ≤ 29 ≤21 kg for BMI > 29

Durso SC, Sullivan GM, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine.* 8th ed. New York: American Geriatrics Society; 2013.

Slide 59

Prognosis Pearls: Frailty

FRIED SCORE	Prognosis	Management = Palliation (Hospice)
4-5 & low cholesterol and albumin	Severely frail older adults appear to be in an **irreversible**, pre- death phase with high mortality over 6-12 months	•Associated with high short-term mortality rates and suggest a poor response to treatment •Focus on optimizing the abilities needed to reach individual patient goals •Compensate for diminished abilities by modification of living environment and/or increased support from caregivers

Durso SC, Sullivan GM, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine.* 8th ed. New York: American Geriatrics Society; 2013.

Prognosis Pearls: Food and Hydration

- The amount of time a person can survive without food depends on their health, body weight, and whether or not they are taking in fluids
  - Eating small amounts and drinking fluids might live for years
  - Not eating at all but taking sips of water have been known to live up to 20-40 days
  - Voluntary refusal of food and hydration, death typically ensues after 10 to 14 days.
    - If the individual is dehydrated or over-hydrated, the time may range from approximately 1-3 weeks
    - The early use of ice chips or sips of water to reduce thirst may delay this slightly

https://www.scientificamerican.com/article/how-long-can-a-person-sur/ (based on observation)

Prognosis Pearls: Food and Hydration

"In the last stages of severe, incurable illness, when death is near and a person is no longer taking in food or water by mouth, families often worry that the person will "starve to death." In fact, for people with those medical problems, no longer taking in food and water is a natural, non-painful part of the dying process. In this case, the person is not dying because they have stopped eating, rather they have stopped eating because they are in the dying process. "

Berkowitz K, **Brandon ST**, Crowley S, Dominitz J, Douglas S, Lowery J, O'Hare A, Paski, S Pearlman R, Sharpe VA, Tokar S (01/01/2016). Information for Patients and Families about Feeding Tubes [Web]. National Center for Ethics in Health Care. Available: http://vaww.ethics.va.gov/Education/LST/ClinicalStaff.asp.

Questions?

Please fill out a card for response in the discussion session

Hospice Medical Director Update and Exam Prep

System-Based Practice:

Ethics

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Disclosures

- No relevant financial disclosures
- No discussion of off-label drug use
- I am neither an ethicist nor a lawyer
- BUT I had the privilege of working with a true ethicist when co-authoring the chapter on "Ethical Decision Making" for the 2016 edition of The Hospice Medical Director Manual, and feel some of Dr. Rainone's wisdom rubbed off on me!

HMD Exam Blueprint

- Informed consent
- Truth-telling
- Confidentiality
- Shared decision making
- Decision-making capacity for patient and surrogate
- Limits of surrogate decision-making
- Medical futility

HMD Exam Blueprint

- Withholding/withdrawing life-sustaining therapies
- Use of artificial hydration and nutrition
- Principle of double effect
- Physician-aided dying (assisted suicide)
- Euthanasia
- Indications for referring to an ethics consultant

Why Medical Ethics?

- Practice of medical ethics offers a way of thinking about how to make moral decisions
- Hospice medical directors are called on to make decisions that significantly affect the well-being of patients and families
    - Rainone F (2016) Ethical Decision Making. The Hospice Medical Director Manual. Third Edition. Eds: Cote TR, Correoso-Thomas LJ

ETHICAL PRINCIPLES AND CHALLENGES IN HOSPICE

Principle Based Ethics

- Beneficence
  - Balance benefits against burdens to promote well-being
- Autonomy
  - Respect the freely made choices of individuals with capacity
- Nonmaleficence
  - do no harm, as much as possible
- Justice
  - Distribute benefits, risks and costs so patients in similar positions are treated similarly

Caring-Based Ethics

- Narrative
  - Particular patient story
  - Relationships between those involved
- Virtue
  - Particular values of the people involved
  - Fidelity, honesty, compassion, altruism, devotion, love
  - Relationship and commitment
  - Virtues - inner character and motivation of participants
  - Partnership and nonabandonment

Ethical Challenges in Hospice

Themes	**Subthemes**
• Inadequate communication	• Lack of goals-of-care discussions
	• Patient/surrogates given conflicting information
• Provision of non-beneficial care	• Health professional offering or families asking for non-beneficial treatment
	• Continuing non-beneficial treatment

Cheon J (2015) Ethical issues experienced by hospice and palliative nurses. J Hosp Palliat Nurs. 17:7-13

Ethical Challenges cont.

- Patient autonomy usurped/threatened
- Concerns about distressing symptoms and use of opioids
- Decision Making
- Discontinuing life-prolonging therapy

- Family wants information kept from the patient
- Family or medical team not in agreement with patient's wishes
- Under or overmedication
- Disagreement as to whether patient is in pain
- Unsure if patient has decision making capacity
- No decision maker
- Discontinuing no longer beneficial or life-sustaining therapies

INFORMED CONSENT, SHARED DECISION-MAKING, ADVANCE CARE PLANNING

Polling Question: can a patient with decision-making capacity (albeit limited) be enrolled in hospice, when the family requests that you not use the word 'hospice'?

- No
- Yes, if you use another phrase like palliative care
- Yes, if patient defers decision-making capacity to family
- Yes, if PCP will activate the health care proxy
- Yes, because the family knows best whether the patient will become emotionally distraught

Hospice Application of Informed Consent

- Why do patients have to give informed consent to sign onto hospice?
  - Giving up Part A hospitalization coverage
  - Felt to be approaching end of life, with 6 month prognosis
  - Palliative rather than disease-directed/curative focus
- Who signs the patient onto hospice?
  - Does patient have decision making capacity? Health care proxy activated?
- Does the patient/family understand the prognosis criteria are 6 months or less until death?
  - Or is hospice pitched as "extra help in the home" or "extra eyes on the patient"?

Informed Consent

- Legal doctrine of informed consent was first promulgated in post-WW II Nuremburg Code, designed to ensure the end of unethical medical experiments
- 1972 American Hospital Association's "Patient's Bill of Rights" established patients' new legal right to give informed and free consent or refusal of treatment
  - Murray A (2012) Informed consent: what must a physician disclose to a patient? AMA J of Ethics 14:563-6
  - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2673833/
  - http://www.uchile.cl/portal/investigacion/centro-interdisciplinario-de-estudios-en-bioetica/publicaciones/76983/honesty-in-medicine-should-doctors-tell-the-truth

Fundamentals of Informed Consent

- Patients have the right to be informed about and consent to (or refuse) any potentially effective treatment
- Surrogates can have the same authority when the patient is incapacitated, but should base their decisions on what is known of the patient's wishes and values
- If the patient's wishes and values are not known, decisions should be based on the patient's best interests.

Elements of an Informed Consent Discussion

- Inclusion of risks and benefits of the proposed intervention
- Listing of alternative treatments that are available
- Mention of the risks and benefits of forgoing the intervention
- BUT….

- Studies have documented that physicians choose or would choose a 'no or limited' treatment option more often than they offer that option to patients
- For 3 out of 5 end-of-life care intensity measures, physicians received significantly less intensive care than the general population
  - Ubel PA (2011) Physicians recommend different treatments for patients than they would choose for themselves. Arch Intern Med 171:630-4
  - http://www.nytimes.com/2013/11/20/your-money/how-doctors-die.html?_r=0
  - Weissman JS (2016) End-of-life care intensity for physicians, lawyers, and the general population. JAMA 315:303-4

Limits to Informed Consent

- Often defined by court cases
  - On the one hand, informed patients or surrogates can refuse potentially effective therapy for religious or personal reasons
  - On the other hand, patients or surrogates cannot demand non-beneficial or futile treatment
    - Defining non-beneficial or futile treatment poses a real challenge

MD Opinions on Continued Life-Sustaining Treatment

- Physicians are more willing to accommodate requests to continues life-sustaining treatment:
  - When those requests are based on particular religious communities or traditions
  - But not when based on expectations of divine healing
    - Ayeh DD (2016) US physicians' opinions about accommodating religiously based requests for life-sustaining treatment. J Pain Symptom Manage 51:971-978

Shared Decision-Making

- 1972 court decision established two principles applied to medical decisions today:
  - Consent is not merely the granting of permission but an exercise in choosing
  - Choice requires disclosure of a certain amount of information
- But how much information is adequate?
  - Rosenbaum L (2015) The paternalism preference—choosing unshared decision making. NEJM 373:589-92

Shared Decision-Making

- Shared decision-making is widely accepted as the gold standard of clinical care
- May be better achieved by having MD elicit goals of care and then help translate those goals into treatment options
- 20% of diverse, older adults want MDs to make their medical decisions
  - Gillick MR (2015) Re-engineering shared decision-making. J Med Ethics 41:785-8
  - Fried TR (2016) Shared decision making—finding the sweet spot. NEJM 374:104-6
  - Chiu C (2016) "Doctor, make my decision": decision control preferences, advance care planning, and satisfaction with communication among diverse older adults. JPSM 51:33-40

- "The doctors I admire most are characterized not by how much they know but by a sophisticated intuition about how best to share it."
  - Rosenbaum L (2015) The paternalism preference—choosing unshared decision making. NEJM 373:589-92

Advance Care Planning

- Proactive discussions are the hallmark of good palliative care
- Advance care planning promotes hope and lessens anxiety among patients
- Hospice length of stay increases and revocations for hospitalization decreases when patients have completed advance care planning. Patients are more likely to die in their homes, as was their stated preference
  - Green M (2015) Advance care planning does not adversely affect hope or anxiety among patients with advanced cancer. J Pain Symptom Manage 49:1088-96
  - Ache K (2014) Are advance directives associated with better hospice care? J Am Geriatr Soc 62:1091-6

Polling Question: a 59 year old woman with Stage IV breast cancer comes to her PCP to discuss treatment options to gain more time with her family. She is ECOG 3. Who should have the 'goals of care' discussion?

- The primary care physician (PCP), because that is who she came to, in order to discuss options
- The oncology team, because they have a better knowledge of her prognosis
- A palliative care team, because they are more skilled at having these discussions

Reference for Polling Question

- Clinical Decisions (2016) End-of-Life Advance Directive. NEJM 372:667-70

Bundling Informed Consent and Advance Care Planning

- E.g., in the course of treatment for cardiovascular disease, treatments could be presented in light of patient preferences
  - A patient with advancing dementia might not be benefited by pacemaker placement
    - Butler K (2010) What broke my father's heart. New York Times http://www.nytimes.com/2010/06/20/magazine/20pacemaker-t.html
  - Implantation of ICDefibrillator could include indications for implantation, and also discussion of when its use might best be discontinued
    - Kirkpatrick J (2015) Bundling informed consent and advance care planning in chronic cardiovascular disease. JAMA Int Med 175:5-6

ETHICAL CHALLENGES OF PROGNOSTICATION

Prognostication and Truth Telling

- Patients' rights to make decisions about their care can be effectively exercised only if the patient possesses enough information to enable an informed choice
- AMA Code of Medical Ethics: "The physician has an ethical obligation to help the patient make choices from the therapeutic alternatives consistent with good medical practice."
  - Basis for shared decision-making
    - The AMA Code of Medical Ethics (2012) Opinions on informing patients. AMA J Ethics 14:555-6

'Therapeutic Privilege'

- Term used for the practice of withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated
- AMA Code states, "It creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully…Withholding medical information from patients without their knowledge or consent is ethically unacceptable."

Discussing Poor Prognosis

- Hospice Medical Directors may be prime community resource for physicians reluctant to share prognosis because
  - It will make patients depressed or lose hope
  - It will shorten a patient's life (especially when coupled with hospice referral)
  - "We really don't know anyone's prognosis anyway"
    - Mack J (2012) Reasons why physicians do not have discussion about poor prognosis, why it matters, and what can be improved. J of Clin Onc 30:2715-7

Prognostic Disclosure to Children

- Similar to the trend with adults, the pendulum has swung toward fuller prognostic disclosure to children with life-threatening conditions
- There continues to be a growing divide between diagnosis and prognosis, but also longer term threats to health (e.g. second cancers and PTSD because of treatment)
- Considerable literature on resiliency of hope with full disclosure
  - Sisk BA (2016) Prognostic disclosure to children: a historical perspective. Pediatrics 138:e20161278
  - Rosenberg AR (2016) Nondisclosure. JAMA 316:821
  - Dorones DN (2016) Talking to children with cancer: sometimes less is more. JCO http://ascopubs.org/doi/full/10.1200/JCO.2016.67.9282

Considerations when determining disclosure

- Individual child characteristics
  - Age, developmental level and illness experience
  - Awareness of child's communication cues
  - Unique needs of individual children
- Family considerations
  - Cultural beliefs of family
  - Family communication style
  - Evolution over time
- Clinician considerations
  - Lack of training and comfort
  - Consideration of the purpose of telling

DECISION-MAKING CAPACITY, SURROGATE DECISION-MAKING

Decision-Making Capacity

- Informed consent based on principle that patients should make autonomous decisions
- Decision-making capacity thus serves as a gatekeeper concept
- Patients who lack decision-making capacity need a surrogate decision maker, such as a designated health care proxy/agent

Decision-Making Capacity vs. Competency

- Terms are defined differently:
  - Competency is a legal term used by judges in determining if person are capable of managing their financial and legal affairs
  - Decision-making capacity is generally determined by physician. It does not require a psychiatric evaluation, although sometimes one is requested

Determining Decision-Making Capacity

- Is the patient capable of understanding the information given to him/her?
- Is the patient making decisions that seem logical and consistent with the stated goals of care?
- Is the patient making decisions that are consistent over time?
- Medical conditions such as delirium, severe pain or nausea, an encephalopathic state, or hypoxia could cause *intermittent* inability to make decisions

Surrogate Decision-Making For Patients without Capacity

- Healthcare Proxy/Agent (pre-designated by patient)
  - May or may not have instructional directives
  - Makes decisions as the patient would
- Close family member or friend
  - Priority may be determined by state law
  - May also be selected by who knows the patient best
- Court ordered surrogate
  - If no one is available to represent the patient
  - Or if those available are not capable
    - Note: this reflects order preference of many, but not all, states.

Limits of Surrogate Decision-Making

- Ethically strong consensus that close relatives should represent the patient based on "substituted judgment" if possible, or "best interests" if patient preferences unknown
- Laws in some states may set special limits on feeding tube decisions, requiring "clear and convincing" evidence of the patient's wishes
- State laws also often set much more specific limits on treatment refusal decisions for never capacitated patients

What About Children?

- Parents are empowered to consent to, more than refuse, unless treatment is futile or near futile
- Treatment refusal based on religious reasons sometimes allowed, but less often allowed based on family preference
- Mature minors should be given a large voice in decision-making along with parents
  - Renjilian CB (2013) Parental explicit heuristics in decision-making for children with life-threatening illnesses. Pediatrics 131:e566-72
  - Lyon (2009) Who will speak for me? Improving end-of-life decision-making for adolescents with HIV and their families. Pediatrics 123:e199-e206

Hospice Application of Surrogate Decision-Making

- Interpretation of prognostic information
  - Surrogates more optimistic than statistics warrant
- Use substituted interests rather than substituted judgments
  - Ask surrogates to provide knowledge of patient's values and interests rather than guess what decision they would have made
    - Zier LS (2012) Surrogate decision makers' interpretation of prognostic information. Ann Intern Med 156:360-6
    - Sulmasy DP (2010) Substituted interests and best judgments. JAMA 304:1946-7

Consistency of Surrogate Decisions

- Evaluation more complex than comparing written ACP documents, surrogate decisions, and treatments patient actually receives at EOL
  - ACP is often a process unfolding over several time points
  - Patient's decisions 'in the moment' may differ from their written documents
  - Surrogates may make decisions based on patient's last verbally expressed preferences, rather than the written documents
  - Healthcare team may choose to discount surrogate preferences
    - Song MK (2016) Determining consistency of surrogate decisions and end-of-life care received with patient goals-of-care preferences. J Palliat Med 19:610-6

CONFIDENTIALITY, CONFLICT OF INTEREST, COST

Confidentiality

- Clinicians are bound by confidentiality
  - Safe place to tell the entire story
  - Need to delve at times into very personal information
- Limits of clinician confidentiality
  - Patient is a danger to himself or others
  - Need to (selectively) inform colleagues involved in the patient's care
- Other challenges to confidentiality
  - Electronic medical record
  - "My chart" – patients accessing their own record

Hospice Application of Confidentiality

- What if a patient 'confesses' doing something illegal in the past?
- Texting/emailing patient information
  - Many applications are inherently non-secure and non-compliant with HIPPA regulations
- Signing in at facilities when visiting patients
  - Does your staff register in such a way that an observer could tell a patient was on hospice?
    - http://www.hipaajournal.com/text-messages-and-hipaa-compliance/
    - http://www.hipaajournal.com/hipaa-compliance-guide/
    - http://www.hipaajournal.com/hipaa-compliance-for-email/

Conflicts of Interest

Potential hospice/palliative care factors that might not be in the interest of patient well-being (always disclose: real or perceived)

- Hospice owned by hospital or SNF
- Hospice employed palliative care consultants
- Tension about eligibility/continued eligibility
- Need to maintain relationship with referring physicians/NPs
- Hospice referrals removed from hospital mortality statistics
  - http://www.nhpco.org/sites/default/files/public/regulatory/Ethics_Principals_NHPCO.pdf

Ethical Tensions in 'High-Value Care'

- In health care, value is usually thought of as a ratio—health benefits achieved per unit of cost
- Different ways to increase value:
  - Achieve better outcomes with less-than-commensurate increases in cost
  - Achieve the same outcome while reducing costs
- Practicing high-value care requires navigating the ethical tension between physicians' commitment to providing cost-effective care while maintaining the primacy of patient welfare without compromise
  - DeCamp M (2016) Navigating ethical tensions in high-value care education. JAMA 316:2189-90

LEGAL/ETHICAL METHODS TO HASTEN DEATH

Legal and Ethical Ways all US Patients May Choose to (Potentially) Shorten Their Lives

- Withholding or withdrawing life-prolonging or sustaining therapies
- Voluntarily stopping eating and drinking (VSED)
- Requesting end-of-life palliative sedation for unrelieved physical distress and possibly for unrelieved existential distress

Withholding and Withdrawing (Potentially) Life-Sustaining Therapies

- Both practices ethically and legally permissible
  - Assess benefits and burdens in light of prognosis
  - Patient (or surrogate) consent required
  - Need for guidance and recommendations
  - Special legal rules for the never capacitated
- Withdrawing more psychologically challenging than withholding
- Wide range of treatment (mechanical ventilation, CPR, dialysis, antibiotics, artificial feeding and hydration)

Hospice Applications of Withholding or Withdrawal

- Use of antibiotics to treat pneumonia in persons with advanced dementia
  - Patients treated with antibiotics lived longer, but there was lower comfort levels in the treated group than the non-treated group, with an association between greater discomfort and more aggressive routes of treatment
    - Givens JL (2010) Survival and comfort after treatment of pneumonia in advanced dementia. Arch Intern Med 170:1102-7
    - Juthani-Mehta M (2015) Antimicrobials at the end of life. JAMA 314:2017-8
- Discontinuing ICDs and pacemakers
  - Many hospices have policies regarding ICD deactivation, but don't have the same comfort level with pacemaker discontinuation
    - Lampert R (2010) HRS expert consensus statement on the management of CIEDs in patients nearing end of life or requesting withdrawal of therapy. Heart Rhythm 7:July
    - Bevins MB (2011) The ethics of pacemaker deactivation in terminally ill patients. J Pain & Symptom Mgmnt 41:1106-10

Artificial Nutrition

- Circumstances where feeding tubes may help
  - Oropharyngeal or esophageal cancer treatment
  - Patients with ALS with swallowing challenges
  - Brain injury until prognosis is clarified
- Circumstances where feeding tubes won't help
  - Advanced dementia
  - Cancer cachexia
    - http://www.mypcnow.org/blank-a11lk
    - Bowman C (2015) Feeding tube placement in patients with advanced cancer. JAMA Int Med 175:15-6
    - Kitzninger C (2014) withdrawing artificial nutrition and hydration from minimally conscious and vegetative patients: family perspectives. J Med Ethics 41:157-60

Artificial Hydration and Nutrition

- ANH is a medical treatment (as defined by the courts)
  - Adult patients with capacity can legally consent to or refuse
  - States may set special standards for incapacitated patients
  - Some religious traditions equate ANH with ordinary life preserving measures
- Heightened decisional conflict with children
  - Making decisions when there is prognostic uncertainty
  - Disruption of parental nurturing and bonding around feeding
    - http://aahpm.org/positions/anh
    - Mahant S et al (2011) Decision-making around gastrostomy-feeding in children with neurologic disabilities. Pediatrics 127:e1471-81

- Case of an 80 year old man with Alzheimer's disease whose Living Will enumerated that he did not want artificial feeding tubes, or treatment that only serves to prolong the process of his dying, but did not specifically address hand feeding
- SNF refused surrogate request to D/C hand feeding of patient, feeling it would cause him discomfort by 'starving him' and that he did not appear to be distressed with feeding

- An 80 year old man with Alzheimer's disease, FAST 7A, lived in a SNF where his loving daughter visited daily. As his ability to feed himself diminished, and as his diet needed to be modified to pureed with thickened liquids in order to keep him from aspirating, she remembered that his 'Living Will' enumerated that he did not want artificial feeding tubes, or treatment that only served to prolong the process of his dying. Though it did not specifically address whether he wanted to be hand fed, she felt he would be disgusted by the type of food he now needed, and would want to die. She asked the SNF to discontinue hand feeding of her father. The SNF refused, feeling it would cause him discomfort and that he did not appear to be distressed with feeding. His daughter appears on your hospice doorstep, requesting admission in order to advocate for allowing what she felt was a 'natural death.'

Polling Question: Would you support the daughter's request?

- Yes
- No

Voluntary Stopping of Eating and Drinking (VSED)

- Groundbreaking study in 2003 documented the experience of hospice nurses in Oregon, who reported they had cared for twice as many patient who chose voluntary refusal of food and fluids to hasten death as had cared for patients who chose physician assisted death
- They also reported that it was a 'surprisingly peaceful way to die'
  - Ganzini L (2003) Nurses' experiences with hospice patients who refuse food and fluids to hasten death. N Engl J Med 349:359-65
  - Jacobs S (2003) Death by voluntary dehydration—what the caregivers say. N Engl J Med 349:53

Definition of VSED

- Voluntary stopping eating and drinking refers to "a conscious and deliberate decision, by a capacitated patient suffering from advanced illness or an extremely debilitating medical condition, to intentionally refrain from receiving food or fluids by mouth, with the purpose of hastening death"
- In order to qualify as VSED, a decision to stop eating and drinking must be fully autonomous and self-directed, but medical support is often required
- Netherlands study show VSED involved in 2.1% of all deaths in that country
  - Pope TM (2014) Legal Briefing: Voluntarily stopping eating and drinking. The J of Clin Ethics 25:68-80
  - Ivanovic N (2014) VSED at the end of life. BMC Palliat Care 13:1-8
  - Schwarz JK (2014) Hospice care for patients who choose to hasten death by voluntarily stopping eating and drinking. J of Hosp & Palliat Nursing 16:126-31

Polling Case Resolution

- In Comfort Care Only (CCO) feeding, hand-feeding traditionally is continued as long as the patient is not showing any signs of distress or refusal
- His daughter was making arrangements to take him home to stop feeding him, when patient died of unrelated causes
- *Our healthcare system does not **yet** have a mechanism by which patients can choose VSED by advanced directives or surrogate decision makers*
  - Meier CA (2015) To feed or not to feed? JPSM 50:887-890
  - Menzel PT (2014) Advance directives, dementia, and withholding food and water by mouth. Hastings Center Report 44:23-37

One Court Case: Ending Hand -Feeding of a Patient with Dementia

- Case of person with dementia living in SNF who had previously and consistently expressed wish not to be hand fed
- Her adult children wanted to honor her wishes, and enlisted support of patient's geriatrician and a palliative care specialist
- Went to NH probate court and were granted right to discontinue feedings
  - Singer K (2012) Doing the right thing. Annals of Long Term Care. 20: June http://www.annalsoflongtermcare.com/article/doing-right-thing
  - Smucker DR (2012) Ending hand feeding of patients with advanced cognitive decline: what is 'doing the right thing'? 20: June http://www.annalsoflongtermcare.com/article/ending-hand-feeding-patients-advanced-cognitive-decline-what-%E2%80%9Cdoing-right-thing%E2%80%9D

Acceptability of an advance directive that limits food and liquids in advanced dementia

- 2 focus group studies to find out how acceptable would be an advance directive that includes discontinuation of feeding at a certain stage of dementia
- Conditions that all focus group participants would not want to live with included: 1) severe pain (from all causes), 2) inability to recognize family or best friends, and 3) being force-fed
- Participants felt no conflict with their religious beliefs
  - Volicer L (2016) Acceptability of an advance directive that limits food and liquids in advanced dementia. Am J of Hosp & Palliat Med 33:55-63
  - Terman SA Natural Dying Living Will Cards. Carlsbad, CA:Life Transitions Publications; 2009

Principle of Double Effect

- 4 elements of the principle of double effect
  - Good effect must be intended
  - Bad effect can be foreseen but not intended
  - Bad effect cannot be the means to the good effect
  - Suffering must be severe enough to warrant the risk (proportionality)
- Endorsed as a guiding principle by Catholic Church
- Not needed for basic pain management
- Applies to terminal opioid acceleration for pain or dyspnea
- Applies to palliative sedation
  - Olsen ML (2010) Ethical decision making with end-of-life care: palliative sedation and withholding or withdrawing life-sustaining treatments. Mayo Clin Proc 85:949-954

Hospice Application of Double Effect: Palliative Sedation

- Intention is to alleviate the symptom/s but not cause death
- Used most commonly for agitated delirium and refractory pain
- In US palliative care and hospice, tends to be used ***'proportionally'***
  - In lowest doses needed to control symptom/s
  - Can be used in 'time-limited' fashion
    - Bush SH (2014) End-of-life delirium: issues regarding recognition, optimal management, and the role of sedation in the dying phase. J Pain & Symptom Manage 48:215-30
    - Schildmann EK (2015) Medication and monitoring in palliative sedation therapy: a systematic review and quality assessment of published guidelines. JPSM 49:734-46

Palliative Sedation

- Legal foundation from US Supreme Court ruling against physician-assisted suicide, affirming that there was "no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."
  - Kamdar MM et al (2015) Case 17-2015: a 44-year old woman with intractable pain due to metastatic lung cancer. NEJM 372:2137-47

PHYSICIAN ASSISTED DEATH, EUTHANASIA

Physician-Assisted Death/Physician Aid in Dying: a Way to Shorten Life for Some US Patients

- In June 2016 updated statement and advisory brief, AAHPM recommends using the term 'Physician Assisted Death' or 'Dying' rather than 'Suicide'
- PAD defined as a physician providing, at the patient's request, a lethal medication that the ***patient*** can take ***by her/his own hand*** to end otherwise intolerable suffering.
- Prognosis 6 months or less required in US, but public pressure to include persons with dementia who make decision when they have longer prognosis
  - http://aahpm.org/positions/pad
    http://mobile.nytimes.com/2015/05/17/magazine/the-last-day-of-her-life.html?referrer=&_r=5

Physician Assisted Death

- In 1997, the Supreme Court ruled that the federal government could not prohibit MDs from PAD if authorized under state law
- Legal in five states via legislation
  - Oregon 1994, Washington 2008, Vermont 2013, California 2015, Colorado 2016
  - Passed by District of Columbia City Council and signed by mayor, but has to be approved by Congress
- Legal in one state via court ruling
  - Montana 2009
    - Gostin LO (2016) Physician-assisted dying: a turning point? JAMA 315:249-50
    - Prokopetz JJ (2012) Redefining physicians' role in assisted dying. NEJM 367:97-9

Debate in the Medical Community

- Some physicians see PAD as part of the continuum of involvement at the end-of-life
- Others feel that physicians should seek only to heal and refuse to use their skills to do harm
- For the first time, a 2015 poll found that more than half of physicians surveyed favored medical assistance in dying
- Physicians who work closely with terminally ill patients are more likely to support PAD than their peers
- Many fears about PAD have been largely invalidated by >18 years Oregon experience
  - Quill TE (2016) Responding to patients requesting physician-assisted death. JAMA 315:245-6
  - Yang VT (2016) Why physicians should oppose assisted suicide. JAMA 315:247-8
  - Gostin LO (2016) Physician-assisted dying: a turning point? JAMA 315:249-50
  - Loggers ET (2013) Implementing a death with dignity program at a comprehensive cancer center. NEJM 368:1417-24

Attitudes and Practices: PAD--Public

- At end of 2016, >80 million people the US and Canada will live in a jurisdiction allowing PAD
- Older, white, and well-educated patients are ones who use PAD
- 67-75% of public favors PAD
- Older persons are more in favor of PAD
- Those with religious/spiritual views less in favor (but still >50% support it)
- No difference in gender or ethnicity
  - Ganzini L (2016) The challenge of new legislation on physician-assisted death. JAMA Int Med 176:427-8
  - http://lifewayresearch.com/2016/12/06/most-americans-say-assisted-suicide-is-morally-acceptable/
  - Periyakoil VS (2016) Multi-ethnic attitudes toward physician-assisted death in California and Hawaii. JPM 19:1060-5

Attitudes and Practices: PAD--Physicians

- Refinement of clinical criteria: how to respond and how to assess patient decision making criteria
- 'Engaged neutrality' allows for diverse views while providing a patient-centered response
- Are physicians obligated to tell their terminally ill patients that they are eligible for PAD? A court case brews in Vermont…
  - http://aahpm.org/positions/padbrief
  - Orenticher D (2016) Clinical criteria for physician aid in dying. JPM 19:259-62
  - Frye J (2016) A call for a patient-centered response to legalized assisted dying
  - http://www.washingtontimes.com/news/2016/jul/21/vermont-doctors-push-back-against-assisted-suicide/

Attitudes and Practices: PAD—Other Interests

- Valeant Pharmaceuticals, Seconal's manufacturer, raised the price of a lethal dose from $200 in 2009 to $3000 in 2013, after California legalized PAD
- Pentobarbitol's manufacturers have stopped producing it for the US, because of it's use as a lethal injection drug for executions
- Variations on whether insurance companies are required to cover aid-in-dying medication
- Most legalization bills require that a patient's decision will not affect annuities, advanced medical directives or health, accident or life insurance policies
  - http://www.reuters.com/article/us-health-death-drug-costs-idUSKCN12A2HJ
  - http://www.coloradoindependent.com/162747/aid-in-dying-colorado

Hospice Applications: PAD

- Large portion of patients receiving PAD are enrolled in hospice care
- 79% of cases involve cancer, 7% ALS, 5% chronic lower respiratory disease, 2% heart disease, 1% AIDS
- Only 24% report inadequate pain control, with >80% reporting loss of autonomy, less able to engage in activities, and loss of dignity
- 45% did not have a health care provider present at time of death
- <1% of physicians write prescriptions for PAD each year
  - Emanuel EJ (2016) Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. JAMA 316:79-90
  - http://time.com/3551560/brittany-maynard-right-to-die-laws/

Euthanasia: Illegal in US as Means to Shorten Life

- Requires a voluntary, active request by patient
- ***Physician*** evaluates patient, provides the means and then ***carries out the final act***
- Legal in the Benelux countries
  - 2002 Netherlands and Belgium
  - 2009 Luxembourg
  - 2014 Belgium extends law to children with terminal illness
- Legal in Quebec, Canada since 2014

THE ETHICS COMMITTEE, CONSULTATIONS

Indications for Ethics Consult

Unclear treatment goals and options

- Help decide among reasonable treatment options
- Treatment offered/encouraged against patient values
- Requested treatments not part of usual practice
- Difference of opinion about benefits and burdens
- Discord among team/patient/family
- Administrative/business ethics (e.g., employee conflicts, volunteer conflicts, ethical marketing practice)

Indications for Ethics Consult

Clarification of medical-legal questions

- Do legal precedents have application in this case?
- Do you want (or need) formal legal input?
  - https://www.google.com/search?q=nhpco+ethical+principles+guidelines+for+hospice+and+palliative+care+clinical+and+organizational+conduct&ie=utf-8&oe=utf-8
  - http://www.nhpco.org/committees/ethics-advisory-council
  - Fife RB (1997) The role of ethics committees in hospice programs. Hosp J 12:57-63

Some Important Distinctions Between Ethics and Palliative Care Consultations

- Ethics consult can be requested by any member of the healthcare team or patient or family (requestor's identity can be kept confidential)
- Ethics consult is not billed (to patient or insurance); consultant's time is fully supported by the healthcare organization
- Ethics teams address decision-making processes, goals and boundaries, but usually not specific clinical treatment details

Questions for us?

Please fill out a card for response in the Q&A session