

HOSPICE ANALYTICS



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Hospice Analytics is an information-sharing research organization whose mission is to improve hospice utilization and access to quality end-of-life care through analysis of Medicare and other national datasets. Please contact Hospice Analytics with any questions or ways we may assist you.

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Planning for 2015: How to Increase Census and Strengthen Sustainability

As budgeting and planning for 2015 get underway, it's the question every leadership team asks this time of year: *How can we not only survive but thrive in the coming year?*

To answer that question, and the cascade of questions that follow, you need data—and, more than that, you need data turned into information you can use, quickly and easily, to:

- Quantify hospice utilization in your service area;
- Identify missed or neglected population segments and referral sources;
- Track trends in census to better predict staffing needs and cash flow;
- Build profiles of competitors and potential partners;
- Compare revenues to costs for your hospice and your competitors;
- And more!

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Neurologists Offered Practical Introduction to Palliative Care

Palliative care has greatly expanded from its original roots in end-of-life care provided to patients with terminal cancer, and is increasingly considered appropriate for any patient living with advanced, progressive illness or multiple comorbidities. It is now “time for a paradigm shift” in neurology to embrace palliative care, according to an article published in *Neurology*, the official journal of the American Academy of Neurology.

“[P]alliative care has been successfully applied to chronic illnesses such as heart failure, chronic pulmonary disease, and end-stage renal disease,” write the authors. “Our goal...is to provide a practical starting point for neurologists to become more knowledgeable and comfortable with the principles of palliative medicine.”

The article provides an overview of the general principles of palliative care and explains the special needs of neurology patients and their families. Also included are an outline of resources neurologists might use to set up a palliative care team within a practice and suggested priorities for research and education to improve the quality of care.

PALLIATIVE CARE SKILLS

“All physicians, including neurologists, should have familiarity and comfort with several fundamental palliative care skills,” the authors state. These include communicating bad news, nonmotor symptom management, advance care planning, and caregiver assessment. For more complex issues, referral to palliative medicine or hospice services may be appropriate.

Communication: For communicating bad news (beginning with diagnosis), the authors suggest using an approach like the SPIKES protocol (Set up the interview, assess the patient’s Perception, obtain the patient’s Invitation, give Knowledge, address Emotions, establish a Strategy and Summarize).

“It is critical that neurologists finalize the meeting with a follow-up, including what to do when the patient has had a chance to process the information and now has more spe-

Palliative Care Augments Traditional Care by:

- Placing importance on planning for decline and death as a natural outcome and not as a failure of medical treatment.
- Emphasizing the relief of patient suffering.
- Transcending the historical patient-physician dyad by addressing caregiver strain and offering supportive services to family members, such as respite care and counseling.
- Assessing and treating medical, psychosocial, and spiritual issues. These include not only pathologic diagnoses, but also other sources of distress, such as normal reactions to living with a life-threatening, progressive, and/or disabling illness.”

— Adapted from Boersma et al, *Neurology*

cific questions,” they write. “This practice is particularly helpful to support the patient and minimize feelings of abandonment.”

Symptom assessment and management: Nonmotor symptoms have been found to be more function-limiting for the patient than motor symptoms and have more effect on caregiver burden and overall quality of life. “Some issues may not be readily treatable but should still be closely followed because they may require additional support or affect advance care planning.”

Advance care planning: Patients often expect the physician to initiate this discussion and report greater satisfaction with care when end-of-life discussions have occurred. The authors suggest that neurologists have information and documents specific to their region readily available and keep an updated copy of completed forms with the patient’s records.

Caregiver support: Caregivers who do not feel distress and are well supported have lower mortality rates, note the authors. Caregiver assessment should include questions about not only their ability to provide adequate patient care, but also about their self-care. “The very act of asking caregivers how they are doing is often met with gratitude” and can provide important personal validation.

REFERRAL TO SPECIALTY PALLIATIVE AND HOSPICE CARE

“While traditional approaches emphasize the preservation of function and prolongation of life, palliative care draws additional

attention to the relief of suffering and places importance on planning for decline and death as an expected and natural outcome, rather than as a failure of medical treatment,” the authors write. It is thus an augmentation of traditional care. [See sidebar.]

BARRIERS TO REFERRAL

Barriers to appropriate referral of neurologic patients to palliative care services and hospice can include:

- Lack of training in fundamental palliative care skills
- Fear of diminishing the patient’s hope
- Unsatisfactory prognosis predictors for specific illnesses
- Limits of Medicare hospice guidelines

The article includes a table with hospice eligibility guidelines for neurologic disorders such as dementia, stroke, coma, and others. However, the authors warn that the Medicare hospice guidelines are often overly conservative compared with newer empiric criteria for patients with amyotrophic lateral sclerosis and dementia. Guidelines for patients living with less common conditions such as Parkinson’s disease and multiple sclerosis are “nonspecific or nonexistent,” they note.

SUGGESTED ‘RED FLAGS’ FOR HOSPICE REFERRAL INCLUDE:

- Frequent hospital admissions (such as for pneumonia, falls, and urinary tract infection)

Continued on Page 3

Most Physicians Would Enroll in Hospice if Terminally Ill, But Often Delay Discussing Hospice with Patients

Most physicians surveyed in a multi-regional study reported that they would choose hospice care for themselves if terminally ill with cancer. Yet, only about one-quarter would discuss hospice “now” with cancer patients with a four-to-six-month life expectancy, according to a research letter published in *JAMA Internal Medicine*.

“Having timely discussions with terminally ill cancer patients to establish goals for end-of-life care is important to maximize the quality of patient care,” says lead author Garrett M Chinn, MD, MS, of the Division of General Medicine, Massachusetts General Hospital in Boston. He suggests an effort among physicians to conduct these discussions earlier in the disease trajectory.

“We know that patients facing terminal illness often wish to spend their remaining days at home, surrounded by loved ones. Since end-of-life care in the U.S. often

stands in stark contrast to these preferences, it’s important to identify factors that may facilitate cost-effective care that supports patient preferences,” he notes.

Investigators analyzed survey data gathered from physicians (n = 4368) caring for patients enrolled in the CanCORS (Cancer Care Outcomes Research and Surveillance) study, a multiregional, population- and health-system-based cohort study measuring the quality of care delivered to more than 10,000 patients newly diagnosed with lung or colorectal cancer between 2003 and 2005.

Physicians were asked whether they would personally enroll in hospice if they were terminally ill with cancer. They were also asked when they would discuss hospice with an asymptomatic patient with advanced cancer whom they believed to have four to six months to live: “now,” “when the patient first develops symptoms,” “when there are no more non-palliative treatments to offer,” “only if the patient is admitted to the hospital,” or “only if the patient and/or family bring it up.”

KEY FINDINGS:

- Most physicians strongly (64.5%) or somewhat (21.4%) agreed that they themselves would enroll in hospice if terminally ill.
- However, only 26.5% reported they would discuss hospice “now” with a patient who had four to six months of life remaining.
- Nearly half (48.7%) of physicians said they would wait to discuss hospice until there were no more non-palliative options to offer.
- Others said they would wait until the patient had symptoms (16.4%), was hospitalized (4.1%), or until the patient/family brought up the subject (4.3%).
- In adjusted analysis, physicians who strongly agreed they would personally enroll in hospice were more likely than others to report discussing hospice

“now” (odds ratio [OR], 1.7; 95% confidence interval [CI], 1.5 to 2.0).

“Physicians should consider their personal preferences for hospice as a factor as they care for terminally ill patients with cancer,” write the authors. “Physicians with negative views of hospice may consider pursuing additional education about how hospice may help their patients.”

Female physicians and those practicing in managed care settings were more likely to agree that they would enroll in hospice if terminally ill with cancer (OR, 1.80; 95% CI, 1.49 to 2.18; and OR, 1.30; 95% CI, 1.12 to 1.51, respectively). Compared with primary care physicians and oncologists, radiation oncologists (OR, 0.57; 95% CI, 0.42 to 0.76) and surgeons (OR, 0.65; 95% CI, 0.55 to 0.78) were less likely to agree they would personally enroll in hospice.

“Our results suggest that most doctors would want hospice care for themselves, but we know that many terminally ill cancer patients do not enroll in hospice,” says senior author Nancy Keating, MD, MPH, associate professor, the Harvard Medical School Department of Health Care Policy, Boston. “In the overall CanCORS study, only about half of the patients who died of metastatic lung cancer had ever discussed hospice care with their physician.”

While physicians’ personal preferences may have an important influence on the timing of hospice discussions, there may be other barriers preventing physicians from having end-of-life care discussions, notes Chinn. He suggests that these barriers may include a lack of knowledge about guidelines for end-of-life care for such patients, cultural and societal norms, and the continuity and quality of communication with patients and their family members.

Source: “Physicians’ Preferences for Hospice If They Were Terminally Ill and the Timing of Hospice Discussions with Their Patients,” *JAMA Internal Medicine*; March 2014; 174(3):466-468. Chinn GM, et al; Division of General Medicine, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston.

Neurologists (from Page 2)

- Unexplained weight loss
- Dysphagia
- Restricted activities of daily living
- Increased somnolence
- Rapid decline in function

“Research suggests that patients are referred to hospice too infrequently or too late,” write the authors. Only 30% of patients with advanced dementia are enrolled in hospice, they note. According to the Medicare Payment Advisory Commission, 25% of hospice stays in 2010 and 2011 were for only five days or less.

Source: “Palliative Care and Neurology: Time for a Paradigm Shift,” *Neurology*; Epub ahead of print, July 2, 2014; DOI: 10.1212/WNL.0000000000000674. Boersma I, Miyasaki J, Kutner J, Kluger B; Departments of Neurology, Psychiatry, and Internal Medicine, University of Colorado Anschutz Medical Campus, Aurora; and Department of Neurology, University of Alberta, Edmonton, Canada.

Hospice Analytics Expands Staff

Jennifer Ballentine, MA, Vice President

Jennifer comes to Hospice Analytics with a robust skill set in hospice and palliative care research, public policy and legislative efforts affecting end-of-life care, education, program development and management, event coordination, and strategic communication. She held previous positions as Executive Director of Life Quality Institute, Research Program Strategist for The Denver Hospice, and Director of Professional Programs for the Colorado Center for Hospice and Palliative Care. Jennifer has presented hundreds of educational programs at state and national conferences and published numerous articles and book chapters on health care ethics, advance care planning, and hospice and palliative care.

Contact Jennifer at jballentine@hospiceanalytics.com or 303-521-4111.

Rod McFain, Director of Research

Rod brings significant success in hospice operations and business development to Hospice Analytics. He has successfully helmed two hospices, Hospice and Palliative Care of Northern Colorado and Hospice of Western Kentucky, bringing strong service, innovation, and financial stability to both organizations during his tenure. Rod also has extensive experience in

research underpinning strategic planning, marketing, communications, and business development. He has special expertise in research design and statistical analysis, feasibility and needs assessment studies, data collection and analysis. His past client list includes international corporate giants as well as community-based nonprofits.

Contact Rod at RodMcFain@hospiceanalytics.com or 970-744-9842.

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—Hospice CEO (TX)

This is really wonderful data . . . The report . . . really helped our Board to picture where we are and where we need to go as an organization.
—Hospice Executive Director (NY)

I like your reports and find them invaluable to our business development work. Keep up the good work!
—Hospice Business Development Manager (WA)

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Hospice Analytics is an information-sharing organization whose mission is to improve hospice utilization and access to quality end-of-life care through analysis of Medicare and other national datasets.

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