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# HOSPICE NEWS NETWORK

*Recent News On End-of-Life Care*

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A Membership Service of the Hospice and Palliative Care Association  
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## EXPERT COMMENTS ON *THE WASHINGTON POST'S* ONLINE CONSUMER GUIDE TO HELP HOSPICE SELECTION

*Washington Post* developed an online consumer guide, designed to help individuals and families compare hospices. [See HNN 10/28] In an article for *Pallimed*, Dale Lupu, MPH, PHD, and AAHPM VP for Professional Development, examines this new resource, explaining ways in which it may be helpful, or potentially unhelpful.

*The Washington Post* gathered its data “largely from government sources on more than 3,000 hospices that participate in Medicare.” It notes the limitations of the data in predicting the quality of any hospice organization, and that “these figures do not offer a complete picture of any single hospice.” However, *The Post* believes, “Consumers can benefit from knowing how a hospice compares to others on these important measures.”

Lupu reflects on how often she has been asked to refer patients and families to a hospice and describes the difficulties of doing so. **Lupu takes a look at the *Post's* consumer guide in order to examine the information it provides, and to evaluate what parts of the site are most relevant for individuals and families making end-of-life decisions.** While Lupu agrees that the information provided by *The Post* can be helpful, at least “in a limited way,” she points out that some of the data are going to be more useful than others.

**Perhaps the most useful bit of information made available by *The Post's* consumer guide is a quick and easy reference to whether or not a hospice is accredited.** Lupu notes that only 40% of hospices are presently accredited, and she recommends that patients seek out those organizations that have gone through this process. Being accredited “speaks to a program’s willingness to open itself to review and, hopefully, improvement.”

**Lupu also advises paying close attention to the size and age of a hospice.** Experience matters, and size provides capabilities that may be lacking in smaller organizations. Lupu states that she would “stick with hospices with experience of at least 5 years (10 years is even better) and volume of at least 80 patients per day.” She acknowledges that this may not always be possible in rural areas, where population density is lower and choices are fewer.

**Lupu thinks that the proportion of “crisis care” and the “live discharge” rate are both relevant statistics that should be taken into account.** While Lupu is uncertain of *The Post's* methodology for reporting crisis care offerings, she acknowledges that this is an important factor

to take into account. **“I’d want to pick a hospice that demonstrated it had SOME capacity that it used for crises care, rather than picking from the 14% of hospices that provided no crises care.”**

**When it comes to live discharge rates, Lupu advises moderation.** A discharge rate that is too *low* may be just as problematic as a rate that is higher. While *The Post* may believe that a high discharge rate indicates unhappiness with care and services, Lupu thinks this more likely “represents a hospice that had a very (maybe overly) open admission policy.” Too few live discharges, on the other hand, “likely means the hospice is too tight and guarded in who they accept, and not willing to bend flexibly to each patient and family’s needs.” **Lupu suggests that she would opt for hospices with a live discharge rate in the middle range of 10% to 20%.**

According to Dale Lupu, however, not all of the information provided by *The Washington Post* is relevant quality-of-care metrics. In particular, ***The Post* has gone out of its way to highlight whether a hospice is for- or non-profit, as well as calculating the per-day, per-patient profit margin for each hospice. Lupu advises against taking these data into account in the selection of a hospice provider.**

**Not only are these numbers largely irrelevant to patient care, but they may also be unfair representations of the actual costs that a hospice organization faces in caring for patients.** Lupu points out that hospices are required to provide services - such as bereavement care - without any reimbursement from Medicare. “The ‘profit’ number doesn’t give any indication whether these dollars are truly ‘profit’ being returned to shareholders, reserves being saved for a rainy day, or carefully husbanded resources that fund additional community services.”

***The Washington Post* hospice consumer guide actually allows individuals to filter their search results by whether or not a hospice is non- or for-profit.** Lupu thinks this is unhelpful, implying that ownership status ought to have a bearing on which hospice one selects. **Lupu, for her part, does not judge profit status as being a useful indicator.** “In my experience, there are both good and not-so-good providers in both groups, and ownership status is not nearly as helpful in distinguishing between them as the other factors mentioned above.”

**For those within the hospice care community, this new consumer guide cannot be considered apart from the recent series of *exposé*-style articles published in *The Washington Post*, which have emphasized the problems in hospice care. Lupu acknowledges this dynamic, yet suggests that the hospice industry should welcome outside scrutiny.** She applauds *The Post* for making a wealth of information easily available to those seeking hospice care, even if not every detail is what many in the hospice community might prefer. (*Pallimed*, 10/31, [www.pallimed.org/2014/10/choosing-hospice-reviewing-washington.html?m=1](http://www.pallimed.org/2014/10/choosing-hospice-reviewing-washington.html?m=1); *Washington Post*, <http://www.washingtonpost.com/wp-srv/special/business/hospice-quality/>)

## **TAKING A CLOSER LOOK AT HOSPICE FRAUD ALLEGATIONS**

**In a recent edition of the *Hospice Analytics* newsletter, Jennifer Ballentine examined current journalistic investigations of fraud and waste in the hospice care industry.** “Some of the findings are without question concerning, and some hospices are without question operating

carelessly if not fraudulently. But is the whole industry engaged in [unethical behavior]?” Ballentine digs into these questions, exploring the overall data on hospice organizations across the country. She suggests that while the existence of unsavory practices is real, such revelations should be tempered with an appreciation for context. **“Without doubt, there are some bad apples in our hospice orchard,”** writes Ballentine, **but independent analysis reveals that the story is more nuanced than the negative portrait painted by some in recent months.**

In order to ascertain the overall state of the industry, Ballentine asks several questions that data analysis can address. The first question is, **“Does rapid growth in the hospice sector signal fraud, waste, and abuse?”** Hospice growth in the last decade has been unprecedented, with the for-profit sector representing the largest slice of this increase. **To some regulators and watchdogs, the sheer size of the hospice industry raises concerns about fraud and wasteful spending.**

**Ballentine asserts, however, that we would do well to maintain a sense of perspective when considering the overall numbers on hospice growth.** She notes that the average *total* cost of stay for hospice patients is \$11,600. This is only slightly more than the average cost of a *single* hospital stay (\$10,820). Furthermore, the \$17 billion price tag of hospice only represents 3% of all Medicare spending. **“Isn’t the concern not that we are spending too much on hospice care, but that we are not spending enough or that we are spending way too much on other sectors?”**

**Ballentine also asks whether the “per-diem payment model incentivize[s] minimal care to maximize profits.”** The author observes that the present per-diem rate demands that hospices take great care to steward resources and manage risks so that they are able to pay for both care services and administrative overhead. “The average profit margin in the industry is barely 5%, generally lower for nonprofits and sometimes higher in for-profits.” By encouraging longer stays hospices are able to offset the much higher costs associated with short-stay patients, and those requiring intensive attention. Crucially, **Ballentine notes, “There is no evidence in the Medicare claims data nor in the various tools currently available to evaluate quality of care.”**

**She also examines the data to evaluate whether “the per-diem payment model incentivize[s] withholding ‘crisis care’ or manipulating levels of care to maximize profits.”** Ballentine feels it is especially relevant to notice that virtually all of the agencies providing no intensive or ongoing care are brand new - founded since 2007 - and tend to be on the small side. **“As hospices become better established and able to take on more complex cases,”** the current concerns may be temporary, she writes,

**Ballentine also considers the claim that the per-diem model of care might encourage hospices to enroll longer-stay patients only to discharge them alive, either because the cost of care has risen or because regulations dictate that they must do so. The data suggests that this is not common practice.** On the whole, only a quarter of all hospice patients receive care that extends beyond 90 days, and the national average for live discharges is 16%. Hospice size seems to make a great difference in these cases. For example, in 2012 around one-fifth of hospices discharged more than a third of their patients alive, but these were overwhelmingly very small hospice agencies. **Hospices with live discharge rates above 33% in 2012 admitted just over eight percent of all patients admitted to hospice care that year.**

**The author concludes that, while there is more data analysis yet to be done, the research done so far indicates a hospice industry, though experiencing some growing pains, is healthy overall.** “Yes, there are bad apples; no, they are not on every tree nor even in every orchard; yes they should be plucked and discarded...” With further data analysis, Ballentine suggests, we may find that we may not yet even be asking the right questions or considering the most pressing problems. (*Hospice Analytics*, 10/16, email newsletter, [www.hospiceanalytics.com/](http://www.hospiceanalytics.com/))

## HOSPICE AND END-OF-LIFE NOTES

\* **NHPCO is spreading the word about a new “Guide to Palliative and Hospice Care” published by Consumer Reports.** NHPCO worked with Consumer Reports to develop the guide in PDF format, available for free in both English and Spanish. The Moments of Life campaign is featured prominently in the Guide. (*NHPCO News Briefs*, 11/6, <http://www.nhpc.org/press-room/press-releases/nhpc-works-consumer-reports>; <http://consumerhealthchoices.org/wp-content/uploads/2014/10/PalliativeCareNHPCO-ER.pdf>)

\* ***The Charleston Daily Mail* published a letter to the editor from Chris Zinn, Executive Director of the Hospice Council of West Virginia.** Zinn’s letter is in response to the recent series of negative articles about hospice in *The Washington Post*. (*Charleston Daily Mail*, 11/10, <http://www.charlestondaily.com/article/20141110/DM04/141119988/1323>)

\* **OIG has released its FY 2015 work plan. For hospices, the plan says OIG will “review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities.”** The goal will be to “determine the length of stay, levels of care received and common terminal illnesses” of these patients served by hospice. OIG “**will also review the use of hospice general inpatient care to assess the appropriateness of general inpatient care claims and the content of election statements**” for hospice patients who receive general inpatient care. (*CHAP*, 11/6, <http://www.chapinc.org/NewsAndEvents/News%20Room/2013/OIG%20FY2015%20Work%20Plan>)

\* **Medicare may pay for physicians to conduct end-of-life conversations with patients, though no changes are expected before 2016.** “CMS intends to consider whether to pay for this voluntary consultation through the regular rulemaking process in order to give the public ample opportunity to weigh in on this topic.” (*Medscape*, 11/3, [www.medscape.com/viewarticle/834305](http://www.medscape.com/viewarticle/834305); *Social Security Report*, 11/7, [socialsecurityreport.org/medicare-weighs-paying-for-end-of-life-counseling/](http://socialsecurityreport.org/medicare-weighs-paying-for-end-of-life-counseling/))

\* ***Wisconsin Public Radio* is airing “Death,” a five-part series on dying. Each segment is one hour and the topics include discussion on issues faced before, during and after death.** The weekly segments run from 11/9 through 12/7 and are available online after the original airing. **The series is a part of “To the Best of Our Knowledge” podcasts distributed by PRI.** (*Wisconsin Public Radio*, <http://www.ttbook.org/series/death>; *PRI*, 11/9, <http://www.pri.org/programs/best-our-knowledge>)

\* **End-of-life care discussions may frequently miss the mark on patient priorities.** A new study conducted in Canada has found that doctors often did not discuss the issues that were most important to patients and their families. The top issues to patients and families were identified as preferences for care, patient values, prognosis, fears or concerns, and additional questions regarding care. (*HealthDay*, 11/3, [consumer.healthday.com/senior-citizen-information-31/misc-death-and-dying-news-172/end-of-life-care-discussions-may-miss-patient-priorities-693210.html](http://consumer.healthday.com/senior-citizen-information-31/misc-death-and-dying-news-172/end-of-life-care-discussions-may-miss-patient-priorities-693210.html))

\* **Simple trigger reminders given to oncologists at key moments in patient care may have the effect of prompting earlier discussions regarding advance care planning, according to preliminary research presented at the Palliative Care in Oncology Symposium.** “The main point is that having a trigger in the selection of patients draws the attention of the oncology team to the fact that patients may benefit from a conversation about their values, priorities, and prognosis.” (*Medscape*, 10/28, [www.medscape.com/viewarticle/833969](http://www.medscape.com/viewarticle/833969))

\* **Senator Ron Wyden (D-Oregon) says Oregon “is leading the way when it comes to palliative care, with more than two thirds of the state's hospitals offering such care.”** Wyden was speaking at the American Cancer Society Cancer Action Network’s forum on palliative care. “One of the goals of the event was also to build support for 2015 legislation that would create a committee on palliative care in Oregon.” (*Portland Business Journal*, 11/6, [http://www.bizjournals.com/portland/blog/health-care-inc/2014/11/oregon-is-on-the-leading-edge-in-palliative-care.html?utm\\_source=feedburner&utm\\_medium=feed&utm\\_campaign=Feed%3A+industry\\_6+%28Industry+Health+Care&page=all](http://www.bizjournals.com/portland/blog/health-care-inc/2014/11/oregon-is-on-the-leading-edge-in-palliative-care.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+industry_6+%28Industry+Health+Care&page=all))

## PHYSICIAN-ASSISTED SUICIDE NOTES

\* **Peg Sandeen, PhD and Executive Director of the Death with Dignity National Center, writes for *Time Magazine* about the end-of-life options available under Oregon’s “Death with Dignity” law, most recently highlighted by the story of Brittany Maynard.** “The grim specter of death has been used over and over to thwart policy reform, but it seems unlikely to be successful going forward,” thanks to Maynard and her family. (*TIME*, 11/4, [time.com/3556280/brittany-maynard-death-with-dignity-options/](http://time.com/3556280/brittany-maynard-death-with-dignity-options/))

\* **Dr. Atul Gawande says that his ideal is for patients to live long and comfortable lives, until they end in painless death.** “He believes this scenario is achievable through the use of medicine we have already, without legalizing physician-assisted suicide.” **Gawande says that Brittany Maynard’s decision to have assisted suicide is an indication that the US health care system has failed her.** “She can’t count on the idea that, as her symptoms progress, that she would be prevented from having suffering... that her priorities will be met.” (*The Huffington Post*, 11/4, [www.huffingtonpost.com/2014/11/04/atul-gawande-being-mortal\\_n\\_6068162.html](http://www.huffingtonpost.com/2014/11/04/atul-gawande-being-mortal_n_6068162.html))

\* **With coverage of Brittany Maynard’s story, “Oregon voters changed the debate on death and dying,” declares the Editorial Board of *The Statesman Journal*.** “Oregon’s law changed the national debate on dying. Physicians and other providers began to pay more attention to palliative care, reducing suffering and improving patients’ quality of life through their final days,

and hospice care greatly expanded.” (*Statesman Journal*, 11/4, [www.statesmanjournal.com/story/opinion/editorials/2014/11/04/oregon-voters-changed-debate-death-dying/18504941/](http://www.statesmanjournal.com/story/opinion/editorials/2014/11/04/oregon-voters-changed-debate-death-dying/18504941/))

\* **There may not be an “aid in dying” law in Montana - but physician-assisted suicide is legal here, anyway.** “It’s not illegal here and if it’s not illegal, it’s legal,” says Compassion and Choices Campaign Manager Emily Bentley. (*KBZK News*, 11/4, [www.kbzk.com/news/no-aid-in-dying-law-in-montana-legal-anyway/](http://www.kbzk.com/news/no-aid-in-dying-law-in-montana-legal-anyway/))

\* **What is the future of physician assisted suicide?** A *Medscape* article examines the ongoing discussion and highlights the wide variance of opinions. One physician, for example, says, “The opposition to assisted dying by physicians is sadistic. The message sent is, ‘I will feel better by keeping you alive against your wishes even though you will suffer more.’ It’s not about us,” he added, “it’s about the patient.” Another physician says, “Physicians ARE NOT and SHOULD NOT BE in the business of killing people.” (*Medscape*, 11/5, [www.medscape.com/viewarticle/833791](http://www.medscape.com/viewarticle/833791))

**Re. Washington Post Online Hospice Consumer Guide** (referenced in first article), we are hearing from our members that much of the information provided for NYS hospices is incorrect. Please check the guide, [click here](#) to view the guide or copy and paste the following link into your browser <http://www.washingtonpost.com/wp-srv/special/business/hospice-quality/> for your hospice and contact the Washington Post with any corrections.

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# SAVE THE DATES



HEALTHCARE ASSOCIATION OF NEW YORK STATE

HANYS Event

## Care Transitions in Palliative Care Yield Improved Patient Outcomes:

On June 19, HANYS will continue its ten-part, monthly webinar series to help health care providers initiate or expand access to palliative care services for patients, residents, and families, with a webinar on care transitions.

Please register online using the links below and join us the third Thursday of each month at 3 p.m. for these one-hour programs.

HANYS, with the generous support from the [Milbank Foundation for Rehabilitation](#), is providing a webinar series for healthcare providers seeking to initiate or expand access to palliative care.

While the demand for palliative care services exists across acute and community care settings, needed resources for palliative care services? Such as palliative care expertise, experience, and knowledge? May not always be readily available. Cross-setting collaborative partnerships where palliative care services are deployed across organizational boundaries have resulted in improved access to palliative care for patients, residents, and their families. Developing these cross-setting partnerships is especially important as providers begin to prepare projects for the Medicaid waiver Delivery System Reform Incentive Payment (DSRIP) program.

Please register online using the links below:

[November 20, 2014: \*Models of Running a Hospital-Based Palliative Care Consultation Service\*](#)

December 18, 2014: Models of Palliative Care in the Nursing Home Setting (registration will be available soon)

January 15, 2015: Models of Palliative Care in the Home Care Setting (registration will be available soon)

February 19, 2015: Models of Palliative Care in the Assisted Living Setting (registration will be available soon)



This Webinar series is complimentary and open to all New York State providers. Faculty are nationally recognized experts in their fields.

The New York State Palliative Care Access Act requires hospitals, nursing homes, home care agencies, special needs assisted living residences, and enhanced assisted living residences to provide access to information and counseling regarding options for palliative care appropriate for patients with advanced life-limiting conditions and illnesses. These providers and residences must facilitate access to appropriate palliative care consultation and services, including associated pain management, consistent with patient or resident needs and preferences.

Hospitals, nursing homes, home care agencies, and assisted living organizations across the state are in the midst of rapid transformation as they seek to achieve the "triple aim" of improving health, enhancing quality, and lowering costs. Research has demonstrated that palliative care helps support the triple aim goals by reducing unnecessary hospitalization and emergency department visits, improving the quality of life, and reducing the cost of care for seriously ill individuals.

### ***VCU - Advanced Palliative Care Nursing Externship***

Virginia Commonwealth University Massey Center  
401 College Street, Richmond, Virginia 23298-0037

**Take your APRN to the next clinical level! Now Available: An Opportunity to Apply for the Advanced Palliative Care Nursing Externship**

**December 8-12, 2014**

This is a week-long mentored immersion course with national faculty in a well-recognized palliative care program. It is targeted for novice APRNs or APRNs new to palliative care. This externship focuses on adult patients and their families. The goal of this project is to provide palliative education to APRNs to have them bring palliative care to their community. The course includes pain and symptom management in clinical practice, communication building, quality, program development, and professional development.

There are only 12 externship spots, 6 participants in each cohort. The program is competitive. Selection into the program will be based on geography, entry level into practice, practice setting, as well as the applicant's ability to describe their potential impact to his or her community as well as numerous locations.

Application process opens July 15 and closes August 15

As this is grant funded, accepted applicants agree to maintain contact in order to evaluate of this educational program. Course underwritten by The Y.C. Ho/Helen & Michael Chiang Foundation, New York

\* **CEUs** - 36 CEs with 6 pharmacology CEs. Attendance is mandatory. **No partial CEs**

**Faculty: Constance Dahlin**, ANP-BC, ACHPN, FPCN, FAAN, and **Patrick Coyne** MSN, ACHPN, FAAN, FPCN

**For detailed information and application [click here](#)**

*Program made possible by the Y.C. Ho/Helen & Michael Chiang Foundation.*



# HPCANYS EVENTS

## ***Providing Interdisciplinary Pediatric Palliative Care***

Thursday, November 20 thru Friday, November 21, 2014

8:30am – 5:00pm

Holiday Inn Rochester Airport

911 Brooks Avenue

Rochester, NY 14624

Every day families are faced with the heart breaking news that their child is seriously ill; in New York State, approximately 2,200 to 2,400 children and infants die each year from congenital and chronic conditions, including cancer. The American Academy of Pediatrics (AAP) recommends that children living with a life-threatening or terminal condition have access to quality pediatric palliative care throughout the course of their illness.

The interdisciplinary team approach for both the child and family is what sets an excellent pediatric palliative care program apart. This two day training will focus on how disciplines overlap and support each other to provide optimum care for children at end of life.

### **Training Modules will include the following:**

- Introduction and Overview
- Interdisciplinary Team Dynamics
- Massage Therapy, Expressive Therapies and Other Interventions
- Palliation of Distressing Symptoms
- Care at Death
- Identifying and Managing Pain
- Spiritual Care
- Ethics and the Law
- Public Policy in NYS
- Grief and Bereavement
- Communication

### **Faculty:**

***Philene Cromwell, RN, MSN, PNP***, Assistant Director, CompassionNet, Rochester, NY

***Marilyn Fisher, MD, MS***, Associate Professor of Pediatrics, Albany Medical Center, Albany, NY

***Alyssa Gupta, LCSW***, Assistant Director, CompassionNet, Rochester, NY

***Sharon Kinch-Meade, RNC, CHPN***, Palliative Care Coordinator, Catskill Area Hospice & Palliative Care, Oneonta, NY

**Emily Knuth, MD, PhD, FAAP**, Assistant Professor, Albany Medical Center, Albany, NY

**David Korones, MD**, Professor of Pediatrics, Oncology & Neurology, University of Rochester, Rochester, NY

**Kathy McMahon, BS**, President & CEO, Hospice & Palliative Care Association of NYS, Albany, NY

**Eric Towse**, Former Pastoral Care Coordinator, MJHS H&P Care, New York, NY

**Jill Wegener, RN, BSN, CCRN**, Chief Nursing Officer, Blythedale Children's Hospital, Valhalla, NY

**Yelena Zatulovsky, LCAT, MA, MT-BC, CCL**, Music Therapist, MJHS Hospice & Palliative Care, New York, NY

[Click here to register](#) / [Click here to view the program brochure](#)

### **Chaplains Peer Group**

Thursday, December 4, 2014

10:30am – 3:30pm

Frank E. Campbell

1076 Madison Avenue

Manhattan, New York 1002

[Click here](#) for On-line Registration!

### **Clinical Peer Group**

Friday, December 12, 2014

10:30am – 2:30pm

Hilton Garden Inn

235 Hoosick Street

Troy, NY 12180

[Click here](#) for On-line Registration!

## **HPCANYS Interdisciplinary Pediatric Palliative Care (HIPPC) 'Train the Trainer' Faculty Training**

*Currently Seeking Applications*

**HPCANYS is seeking palliative care professionals in NY State** who are established in their field with a desire to achieve a higher level in the practice of pediatric palliative care and to engage in the development of a statewide professional support network.

With support from the NYS Health Foundation, HPCANYS has developed a 2-year project to ['Expand Access to Pediatric Palliative Care'](#)

We are looking to build qualified interdisciplinary training teams capable of delivering HIPPC trainings in their own geographical regions, communities or institutions.

**Date & location for 2014 HIPPC Faculty Training:**

April-22, 23, and 24, 2015, Holiday Inn Rochester Airport, 911 Brooks Avenue, Rochester, N

**We are currently accepting applications** from professionals interested in becoming members of our training team.

Individuals from any discipline interested in becoming a HIPPC Faculty Trainer may

[Complete this application.](#)

