Using the Frame of Prognosis, not Diagnosis, in Hospice Care Decisions

Who is appropriate for hospice; and what should be related to their terminal prognosis?

A March 9 message from National Hospice and Palliative Care Organization President Don Schumacher to the hospice community encourages providers to reconsider how they think about their patients—and their own responsibility to care for them—more in terms of the patient’s terminal prognosis, rather than the single diagnosis listed as principal on hospice claims forms.

Determining hospices’ responsibility for aspects of their patients’ care has become a bigger issue for the government, with an expectation for providers to report more of their patients’ relevant co-morbidities, Schumacher states. “As providers of hospice care, we must reframe the way we characterize our patients, shifting from a single diagnosis to a more comprehensive depiction that utilizes all diagnoses and conditions that contribute to each patient’s terminal prognosis, thereby establishing their eligibility for hospice,” he notes.

“The question can be asked: ‘Does this diagnosis or condition contribute to or influence the patient’s terminal prognosis?’ If so, then it is our responsibility.” Even if it means paying for more things than some hospices have been accustomed to. What will be the actual financial impact on hospices from this greater focus on prognosis and covering more of the patient’s medications is not known, but will be explored in upcoming issues of HCL.

“This is a conversation we’ve been having with CMS for the last 18 months about the intent of the Medicare hospice benefit,” explains NHPCO vice president Judi Lund Person. According to the original 1982 statute that created the hospice benefit, eligible hospice patients have a medical prognosis of six months or less to live. “We think hospices should start there. It’s important because we are experts in managing the dying process and, by definition, dying involves the whole person. Our approach is not one of compartmentalization.”

— Suzanne Karefa-Johnson, MD

Relatedness to hospice care is a very critical part of this discussion, and all of it should be patient driven.

— Judi Lund Person

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risk as necessary for their patients’ medications. But with the volume of audits going on now, and auditors’ ability to identify providers where it is an issue, this strategy won’t work in the future, she adds. “If you look at what we already know is a concern of CMS, and the fact that 2013/14 audits of Part D claims are already happening, if you go down the road of focusing more on prognosis, rather than single terminal diagnosis, in this environment you could place yourself at lower risk of huge paybacks in the future.”

CMS has reported that 72 percent of providers submitted only one diagnosis on their claims forms in the first quarter of 2013, although that number was down to 67 percent for 2013 as a whole, Lund Person says. And in a technical report issued last May by Abt Associates, approximate average costs per patient per day for medications, as reported on hospices’ cost reports, were down from $20 in 2004 to $11 in 2012.

Some hospices have argued that this decline in average spending on medications reflects greater use of generics and discontinuation of drugs that are no longer appropriate for their patients. Still, she notes, “the optics don’t look good,” raising concerns for the government that the decline in spending could reflect hospices not paying for all of the medications their patients need as a result of defining their own scope of responsibility too narrowly.

“In the end, it all comes down to decisions about eligibility, how your admissions team determines eligibility and the principal and other diagnoses, the training and expertise of your medical director—and where those things intersect. It involves deciding what’s related and reviewing the medications that are no longer helpful to the patient. And as in all things, how well are you documenting that?”

NHPCO has explored these issues through a Relatedness Work Group of hospice physicians, clinicians and administrators. CMS has been receptive to proactive steps being taken by the hospice community to give a more comprehensive picture of the constellation of co-morbidities experienced by eligible hospice patients, Lund Person says, and in that way it is hoped that more draconian solutions by CMS won’t be necessary.

“We’ve also had a lot of discussions about the Local Coverage Determination policies used by the Medicare Administrative Contractors. While it’s not a fast-moving train to change the LCDs, we would expect changes reflecting these combinations of diagnoses to come down the road,” she says.

At the end of March, NHPCO also posted a video conversation on the subject. The Relatedness Work Group has developed other tools, including the “Determining Relatedness to the Terminal Prognosis Flow Chart,” which are available to NHPCO members in the Regulatory Section of its website. The prognosis challenge also will be addressed at NHPCO’s upcoming Management and Leadership Conference; look for an update in the May issue of HCL.

A More Holistic View of Hospice Care

For Weatherbee consultant Suzanne Karefa-Johnson, MD, these questions go to the heart of who hospices claim to be and what they claim to provide. “We are experts in managing the dying process and, by definition, dying involves the whole person. Our approach is not one of compartmentalization and, in palliating our patients’ total pain, ...
we must address the multifactorial etiology of their symptoms and the complexity of their dying trajectory.”

Dr. Karefa-Johnson sees the increasing integration of hospice into mainstream health care as essential for its survival. “This new emphasis on the multi-faceted nature of the determinants of terminal prognosis gives us a greater chance to prove our value. We are, in essence, a capitated, managed care delivery system for end-of-life care, accepting risk for all aspects of that care for our patients. We don’t help our credibility or prove our worth in the health care continuum by stepping away from that responsibility. We need to start by focusing on everything we are able to take care of, not things we can’t,” Dr. Karefa-Johnson says.

Joan Harrold, MD, Vice President of Medical Services of Hospice and Community Care in Lancaster, PA, and a member of NHPCO’s Relatedness Work Group, adds that hospice patients have become increasingly complex as cancer is less dominant than a hospice diagnosis. “If hospices are going to deliver comprehensive, coordinated care to these complex patients, then we have to deal with the whole range of diagnoses other than cancer, which tend to travel with additional conditions that together make the patient eligible for hospice care. It’s a regulatory issue—it’s what’s expected of us—but it’s also the right thing to do. We need to demonstrate that we’re responsible for taking on the myriad of diagnoses that contribute to a patient having a prognosis of six months or less to live.”

Another physician member of the work group, Gail Cooney, MD, Chief Medical Officer of Access Services for TrustBridge Health, Palm Beach, Fla., says the trend could be considered a good thing for hospices. “It makes it easier for me as a medical director to support someone’s hospice eligibility with a little of this and a little of that—when it’s really all of those conditions together,” she says.

“What’s different for hospices is that we can no longer just look at the terminal diagnosis and say: This is what we cover. In fact, most people have more than one diagnosis at the end of life although, of course, there are exceptions. I find it an exciting challenge, and a lot of good can come from this. Plus it’s a way to show that we’re listening to the government’s concerns and that we’re stepping up to the plate.”

**What Can Hospice Teams Do?**

The change that needs to take place is for hospice teams to reframe their admissions process, Lund Person says. “Admissions staff, the medical director, clinical staff, all have a role in consistently asking: Does this diagnosis contribute to or influence the patient’s terminal diagnosis? If we ask that question, all by itself, it will start to change practice. What is related, what is unrelated, what treatments can be discontinued, will naturally follow. Clinical teams can work on these issues and then talk to the patient and family about the appropriateness of their medications,” she says.

“Hospices need to understand that we have a responsibility to manage the medications that are most helpful for the patient—managing them with a palliative approach. That’s a lot of work. It takes a dedicated medical director,” Dr. Harrold says. “How are we managing co-morbid conditions? Are we covering treatments for those the way one would expect from hospice care? When the medical director certifies a terminal illness, that’s a place to list the various diagnoses. In the narrative statement, and in working with the rest of the team, always ask: What treatments can be helpful to this patient?”

For Dr. Karefa-Johnson, the team needs to remind itself, “We are there to manage the dying process, whether somatic, psychospiritual, or emotional. We need to keep talking about the dying process at the interdisciplinary team meeting. Where is the patient on that trajectory? What are our clinical goals for managing that process and how can we bring all of our tools to bear?”

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Dying Veterans’ Demands for Hospice Care Continue to Challenge Provider Community

Resources can help hospices give higher quality care to these patients

In January National Public Radio reported that the Department of Veterans Affairs (VA) is gearing up for the increasing numbers of veterans in need of hospice care as World War II and Korean War-era veterans reach their 80s and 90s, with Vietnam-era veterans not far behind. The VA estimates that 600,000 veterans will need end-of-life care every year between now and 2020, approximately one-fourth of all deaths in this country.

All VA medical centers now have an interdisciplinary palliative care team, but only a fraction of veterans are enrolled in VA and able to enter VA hospice programs, Scott Shreve, DO, who directs VA hospice care nationwide, told NPR. Hospice and palliative care are part of the VA’s Medical Benefits Package, for which all VA-enrolled veterans are eligible if they meet a clinical need for service. However, many more veterans are being served by hospices in the community. Dr. Shreve also referenced the We Honor Veterans Program established by NHPCO and the VA as a campaign for hospices to build their capacity for providing quality care for veterans and their families at the end-of-life.

“It follows a long-standing collaboration with the VA, exploring best practices in hospice care for veterans,” explains NHPCO’s Gwynn Sullivan. “The program includes four levels of recognition for hospices to work on and achieve, leading to a demonstration of quality improvement processes and programs. It means they are recognized for taking care of veterans, and they can use this recognition as a way to highlight their services and stand out in their communities,” she says.

We Honor Veterans now includes non-hospice community partners such as the Dignity Memorial chain of funeral homes and related services. A total of 2,604 hospices have signed on, as well as 933 community partners, Sullivan says. “Those hospices that have not joined should take a look at this opportunity to collaborate with the VA and other community partners in ensuring that patients who are veterans have their special concerns addressed,” she says. The WHV website also includes a searchable Partner Directory, billing resources, and information about Hospice-Veterans Partnerships, which are coalitions of VA facilities, community hospices, state hospice organizations and other groups.

“This all starts with asking the question of every new patient: Are you a veteran? A lot of things follow from that,” Sullivan says. “Hospices are taking care of veterans whether they know it or not, but veterans at the end of life have some unique needs based on their military experience, branch of service, theater of combat, and the like. Using a checklist of things to look for with veteran patients is just part of having a good, appropriate plan of care for these patients.”

Starting in 2010, the End-of-Life Nursing Education Consortium (ELNEC), which is a partnership between the American Association of Colleges of Nursing and

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City of Hope National Medical Center, developed a specialized, veteran-specific curriculum and training program to promote better palliative care for veterans. It trained 745 VA nurses and other team members through six national courses, says ELNEC project director Pamela Malloy. A follow-up curriculum addressed ICU-based end-of-life care for veterans.

“What I learned in four years on this project is the importance of understanding the whole culture the veteran comes from. If we don’t ask, we miss a whole subset of the culture of our veteran population,” she says. “When we think about assessing and managing pain, many veterans were trained to be stoic. Not to understand the role of stoicism in their lives is doing these patients a disservice. Not acknowledging their service to their country seems almost impolite,” Malloy says. “We need to remember the women, too, and ask about participation in combat. Non-VA facilities have a lot to learn about post-traumatic stress disorder (PTSD), which isn’t just an issue for veterans.”

Although ELNEC is now seeking funds to update its ELNEC for Veterans curriculum, Malloy invites hospices to contact her for more information about the curriculum or to obtain CD-ROMs of past training sessions: pmalloy@aacn.nche.edu. For a list of ELNEC-For Veterans trainers, see: http://www.aacn.nche.edu/elnec/trainers.

**COMPLIANCE UPDATES**

The next round of hospice PEPPER (Program for Evaluating Payment Patterns) reports are due to be released in mid-April. PEPPER gives providers data on their performance over three years on specific target areas that CMS believes could be at risk for improper payment, with comparisons to other hospices nationally, in the same state and for the same MAC jurisdiction. PEPPER target areas for hospices in 2015 include proportions of live discharges, lengths of stay greater than 180 days, continuous home care provided in an assisted living facility, and routine home care provided in an ALF, nursing facility or SNF....

A post-award protest of a RAC (recovery audit contractor) contract awarded by CMS to Connelly, LLC, means that RAC audits of hospices are delayed until the protest is resolved. The RACs have become notorious for other categories of providers, such as hospitals, based on their financial incentives to reject claims and then extrapolate to larger patient populations, but it appears that hospices, along with DME and home health care, won’t be subject to this brand of aggressive scrutiny until 2016 at the soonest.

**Using the Frame of Prognosis ...**

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— Pamela Malloy

The Kaplan Family Hospice House of Care Dimensions in Danvers, Mass. PHOTO COURTESY of Care Dimensions

Heather Wilson, PhD, CEO of Weatherbee Resources, has a different view on what she describes as a major paradigm shift from a focus on the patient’s primary hospice diagnosis to an “all-inclusive prognosis.” Her *April 2 blog post* on this subject has already generated a number of thoughtful comments, indicating that others share her concerns regarding the extraordinary financial, clinical, administrative and compliance implications of moving from a focus on the patient’s principal diagnosis to all things that might influence or contribute to the patient’s terminal prognosis.
Another new regulatory acronym, PQRS (Physician Quality Reporting System)—with its price tag of 2 percent reimbursement penalties for failure to comply—may have gotten the attention of some hospice and palliative care physicians recently. Although this reporting does not apply to hospice-employed physicians visiting hospice-enrolled patients, hospice and palliative care physicians and non-physician practitioners making Medicare-billable palliative care visits to non-hospice patients and deemed eligible professionals for PQRS by the government are required to participate in the reporting—if they wish to avoid payment reductions.

Initially physicians were rewarded for just reporting their PQRS quality data, regardless of how well or poorly they performed, but under the Affordable Care Act, CMS was directed to phase out incentive payments and instead start to apply penalties for non-participation. Recently, those physicians that failed to report the required data received warning letters from the government—which offered a few more weeks past the February 28, 2015 deadline for reporting their 2014 data.

Consultant Jean Acevedo of Acevedo Consulting, Inc., in Del Ray Fla., says that PQRS is part of a larger evolution toward value-based payments to physicians by the government. PQRS will also be used to measure data to calculate a performance-based physician payment adjustment known as the Value-Based Payment Modifier. Data can be reported by individual physicians or group practices or through qualified clinical data registries, each with its own specific reporting criteria.

The modifier clicks in this year, with potential penalties going into effect in 2017, Acevedo explains. “For palliative care services that have grown out of hospice programs, they may not know about these new requirements, especially given all of the other regulatory changes rolled out in recent months, and the tendency for these reporting programs to all sound alike.” But PQRS is here to stay, she says.

“We have worked with some fairly large palliative care programs and hospices that called us in a panic when they started getting these letters.” The problem is compounded by the fact that penalties are imposed based on lack of compliance from two years before, she said. “Be sure in 2015 to get educated about the program and successfully report your PQRS data so that you can avoid further impact down the road.”

Acevedo says her firm can work with providers on the PQRS requirements, but she also urges physicians to talk to their medical specialty societies, including the American Association of Hospice and Palliative Medicine, for resources to help with PQRS requirements. For more information on the PQRS requirements and compliance, contact her at: jacevedo@acevedoconsulting.com.

CMS Change Request 9091, issued on March 6 as Manual System Transmittal 39, does apply directly to hospices, with penalties for failure to report required quality data, although NHPCO’s Judi Lund Person says this information should not be news to hospices.

When, exactly, the penalties will be exacted, and whether any failure in reporting results in the full penalty for the agency, remain to be seen. But according to the new regulations, “for fiscal year 2014, and each subsequent year, if a hospice agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that year,” even if it results in a negative inflationary payment update for the hospice.

CMS will be providing Medicare Administrative Contractors with a Technical Direction Letter identifying those agencies that failed to meet the requirements, and the MACs will update the quality indicator in the Provider Outpatient Specific File for each identified hospice agency. Hospices that received their notification of certification on or after November 1 of the previous year are excluded from these payment penalties for the subsequent fiscal year.

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— Jean Acevedo

Next Month Hospice Compliance Letter will continue the discussion regarding related / unrelated and Part D medications.
A temporary injunction filed in the 10th Judicial Circuit Court in Polk County, Fla., by Compassionate Care Hospice of Central Florida seeks a “cease and desist” order against the state Agency for Health Care Administration (AHCA)’s attempts to shut the hospice down on the grounds that its hospice license has expired. AHCA says it did not receive the application renewal paperwork by the expiration date of February 21, 2015, and without so much as a courtesy notice ordered the hospice in a March 9 letter to “immediately cease operations and transfer all patients.” The hospice, which has also filed a civil suit against the state, says it submitted its renewal application in December.

If the state’s order were implemented, the hospice, which serves 250 patients in three Florida counties, would have to go all the way back to a certificate of need process, which could take years and essentially, according to the hospice’s lawyers, would be its death sentence. “My greatest concern is that these patients are provided due process,” the hospice’s attorney, Geoffrey Smith, told the Lakeland Ledger newspaper. In late March, it was reported that the hospice has gone back to serving patients, and AHCA had backed off from its demands that the provider close immediately, agreeing that the hospice can seek a stay from the District Court of Appeals while continuing to serve patients. Compassionate Care Hospice is a national company with two other licenses in the state of Florida.

Paul Ledford, President and CEO of Florida Hospices and Palliative Care, tells HCL that his association will take a closer look at the issue to see if there might be a legislative remedy or grace period for applications that get lost due to simple clerical errors at either end.

Care Dimensions, a hospice program based in Danvers, Mass., in partnership with local Regis College, has received a Massachusetts Healthcare Workforce Transformation grant to develop a hospice nurse residency program and online learning modules for hospice clinical staff. “Hospice requires specialized skills and experience that many nurses are not exposed to,” says the hospice’s president and CEO, Diane Stringer. “This training grant will allow us to introduce and mentor new nurses to hospice care and develop online training tools for clinical staff so they can access support whenever and wherever they need it.”

The residencies start on August 1, 2015 and February 1, 2016, and are offered for six months to new nursing graduates and for three months to experienced nurses who are new to hospice and palliative care. The nurses will be employed at Care Dimensions and may be offered full-time positions on completing their residency. For more information, contact Alissa Brownson: ABrownson@caredimensions.org.

UPMC (the University of Pittsburgh Medical Center), announced that it will integrate Pittsburgh-based Family Hospice and Palliative Care, the largest non-profit hospice and palliative care provider in Pennsylvania, into its Community Provider Services affiliate. Family Hospice will continue to operate under its own name in 23 Western Pennsylvania counties, with combined hospice operations managed by the UPMC Home Nursing Agency.

The merging partners cited pressures on hospice providers, including increased competition from for-profits and increased regulatory scrutiny, as drivers of the affiliation. They also pointed to the organizations’ historical collaborative relationships.

“The Family Hospice organization through its governing board has been looking at how to expand its role and mission in the market that it serves for quite some time,” UPMC’s Deborah Brodine told the Pittsburgh Business Times. Subject to due diligence and regulatory approvals, the affiliation is expected to close by mid-year, bringing hospice and palliative care to a broader population in its service area...

At press time, another hospice affiliation was announced, with Midwest Palliative & Hospice Care-Center, Glenview, Ill., joining two other Chicago-area non-profit hospices, Horizon Hospice & Palliative Care and JourneyCare, to form the premier palliative and end-of-life care provider in its region.
