

newsletter



Mark M Murray
 President & CEO

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Numbers of Patients Up in 2009, but Lengths of Stay Become Shorter

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Last year Center for Hospice Care (CHC) cared for 1,752 patients, an 11% increase from the prior year. Not since Elkhart General Hospital gave us their hospice program in early 2005 has the annual increase in patients served hit double digits. Yet the median length of stay dropped three days. Half of our patients admitted in 2009 died within 16 days. This isn't nearly enough time for our patients and their families to experience all of the covered services they are entitled to receive under a program designed for six months.

Our second seven-bed inpatient unit, the Elkhart Hospice House, was operational for the first full year in 2009. With the doubling of available beds, the numbers of patients experiencing Hospice House grew 106%. However, the average length of stay for these 576 patients dropped from eight days in 2008 to just six days last year. This indicates later referrals and patients coming to Hospice House with higher acuity levels. Unfortunately, there were several occasions where Hospice House referrals were so late that patients expired in the ambulance en route.

Shrinking lengths of stay have a negative effect on the average daily census. Even when the overall total numbers of patients are increasing, shorter lengths of stay create fewer patients per day. For any hospice program, the most staff intensive and expensive time during a patient's stay is at the beginning (acquiring medical records, interdisciplinary group meetings, admission visits, initial assessment visits by all disciplines, medication & DME setups, etc.) and at the end (emergency visits, death visits, removal of equipment arrangements, discontinuing pharmacy services, referring family to bereavement services, etc.). The middle is less intensive, more predictable, and less expensive. Yet Medicare pays the same fixed rate, around \$140 a day for a routine level of care, regardless if it's at the beginning, middle, or end. When the overall length of stay decreases, the "middle" becomes smaller and it's more difficult to recover the high costs of the beginning and end.

CHC received nearly 2,000 referrals during 2009. In hospice care time is obviously a vital dynamic for everyone involved. That's why we make every attempt to see patients the same day they are referred. Last year 8%, or about one in every 12 referrals, actually expired between the referral call and the admission. These patients didn't live long enough to receive even the first visit from CHC.

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choices to make the most of life

Completing the Circle of Care

Robin Zon, MD, FACP



Robin Zon, MD, FACP
Michiana Hematology Oncology

Dr. Zon is principal investigator for Cancer Control Studies with the Northern Indiana Cancer Research Consortium. She is currently Vice-Chair of the Hoosier Oncology Group, and was recently elected to serve on the Board of Directors for the world's leading professional organization representing physicians who care for people battling cancer, the American Society of Clinical Oncology.

Dame Cicely Saunders, the first medical professional to apply the term “hospice” to specialized care for dying patients, once said “You matter because of who you are. You matter to the last moment of your life, and we will do all that we can, not only to help you die peacefully, but also to live until you die.” And so the concept of hospice as a holistic, interdisciplinary approach to end of life care began in Great Britain during the 1960’s. By the 1970’s the hospice care movement started infiltrating the American healthcare system; and in 1982, the Medicare Hospice Benefit was passed, serving as the basis for the hospice model of care, and as a model for Medicaid and private insurance provision and reimbursement of this essential service.

As an oncologist, I find great joy in being able to cure patients from their disease, but I equally value the pivotal role I play in enabling patients with an incurable, terminal illness to continue to live their lives pain free, with dignity and quality, surrounded by loved ones in their last weeks of life. Hospice, a philosophy of care accepting death as the final stage of life, allows me as a physician to help patients live the remainder of their lives as fully as possible. In contrast to what some may perceive as “giving up” when a hospice referral is made, I believe that hospice plays a critical role in affording physicians, patients and families the opportunity to affirm life while focusing treatment on the patient’s and loved one’s needs, rather than the disease. Once a patient and I are partnered with hospice, the circle of care is complete.

Center for Hospice Care utilizes a team of professionals, including primary and specialist physicians, to care for the patient. Each team member offers support and cares for individuals based on their special areas of expertise. My years of experience working with patients and hospice has taught me that hospice care is best exemplified when referrals are made early, ideally weeks to months before the expected transition. The early intervention allows the team to fully evaluate and effectively implement a plan of care addressing palliative care issues, and assisting in spiritual care, respite care, and ultimately bereavement care for surviving loved ones.

There is evidence demonstrating that referral to hospice measurably lowers the rate of hospitalization and emergency care while improving an individual’s quality of living. Fortunately, hospice expenses are paid by Medicare, including 100% of costs of medication and medical equipment related to the terminal illness. For many of my patients, this benefit has relieved a tremendous financial burden, especially as certain medications, including those prescribed for pain control, can be very costly and unaffordable for some families. Additionally, Center for Hospice Care offers a service under the home health care license, offering comprehensive specialized care for families and patients who have a life expectancy of greater than six months while allowing individuals to pursue treatment, including enrollment in clinical trials. As hospice recognizes the need of patients and caregivers to have a stable connection to their programs and services, the same team is assigned to the patient regardless of which service is being utilized.

I am often asked why I refer patients to hospice care. The question really is why wouldn’t I refer an individual to hospice? Evidence clearly demonstrates the advantage of interdisciplinary care for individuals along the entire spectrum of cancer care, ranging from cancer prevention, diagnosis, treatment as well as palliation and end-of-life care. I consider hospice services to be necessary in completing the circle of care for patients with a terminal illness. This community is fortunate to have Center for Hospice Care providing dedicated services with a commitment to assisting patients to “live until you die.”

Reaching Center for Hospice Care couldn’t be easier.

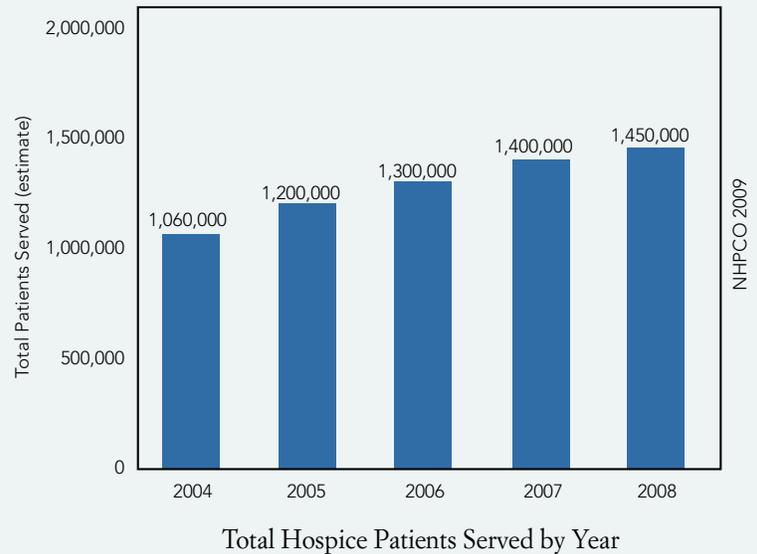
Just call **1-800-HOSPICE**

Hospice Stats at a Glance

How many patients receive care each year?

In 2008, an estimated 1.45 million patients received services from hospice. This estimate includes:

- 963,000 patients who died under hospice care in 2008
- 276,000 who remained on the hospice census at the end of 2008 (known as “carryovers”)
- 212,000 patients who were discharged alive in 2008 for reasons including extended prognosis, desire for curative treatment, and other reasons (known as “live discharges”).



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Of those patients who actually lived long enough to be admitted, 19% – about one in every five admissions – expired within two days of entering our hospice program.

Extraordinarily late referrals and dwindling lengths of stay in hospice care were not events exclusive to CHC last year. This scenario was reported by hospice programs all across the country. Some areas have been hit harder than others. Oklahoma has recently seen ten programs go out of business. In particularly competitive areas, many hospices have merged with other programs hoping to spread costs and financial risks over a larger patient census.

This situation is gaining some national coverage from the likes of Kaiser Health News who recently published an article on declining hospice utilization stating, “Suddenly, many hospices are admitting fewer patients. Others are increasingly caring for people for just days or hours before they die. The result...patients are missing out on critical end-of-life care.” The article included some of the most popular theories for why this is happening. Some blame our challenging economic times. People who are unemployed may be putting off seeking medical treatment until they are diagnosed with late stage disease. Another common theory is that fewer patients exist within the usual trajectory toward hospice. With censuses down in many healthcare settings, some providers may be hanging on longer to the patients they have. It’s also been suggested that extended care facilities have empty beds because unemployed caregivers are available to provide for their loved ones at home making such facilities unneeded for some in this situation.

Throughout 2009 we also had the looming unknown specter of Healthcare Reform and the truly unfortunate and inaccurate descriptions of impending “death panels.” The media coverage surrounding this may have caused some patients and families to become even more suspicious of the healthcare delivery system.

Fearing lesser care and less choice, they presumably steered clear of “comfort care” until the very last hours. Appropriate end of life care may have been delayed until all family members were convinced that “everything that could have been done was done,” even though the outcome was the same. Whatever it is, we hope and trust that end-of-life care has not permanently become “brink-of-death-care.” There is evidence that our patients and families feel the same way.

There is an interesting data element from last year on the Family Evaluation of Hospice Care (FEHC) survey within the answer to a specific question regarding the timing of hospice referrals. The FEHC is a national 61 question post-death survey designed to yield actionable information that reflects the quality of hospice care delivery from the perspective of family caregivers. Hospices submitting FEHC data to the National Hospice and Palliative Care Organization receive reports for each question that include individual hospice results plus state and national aggregate averages for comparison. For the question regarding “The patient was referred to hospice at the right time,” we saw contrasting results over the last two years. CHC families agreed their loved ones were referred at the right time in 2008 and our scores on this were higher than scores for Indiana and the nation. However, of the more than 400 surveys returned last year, more family members disagreed that their loved ones were referred at the right time and CHC fell below both the state and national aggregated score for this question. It seems our anxieties about late referrals are also the concern of CHC family members.

Through 30 years and more than 19,000 patients, the most frequent complaint we receive is, “Why didn’t somebody tell us about CHC sooner?” Lately, we’ve been hearing this more than ever. If you have thoughts or ideas about how the timeliness of referrals to our care might be improved, please contact me at mmurray@centerforhospice.org.



Center for Hospice Care

choices to make the most of life

Time for a New Look...

Different name, same mission

In 30 years, we have cared for 18,969 patients and their families. We have written thousands of care plans, visited thousands of homes, held thousands of hands, and taught thousands of patients and families about death and dying.

In 2009, The Center for Hospice and Palliative Care (now Center for Hospice Care) invested time, money, and energy into scientific market research throughout the communities we serve. We conducted focus groups, facilitated a telephone survey to 300 households, and called on area physicians to get a better understanding of our community's hospice knowledge.

What We've Learned

- While there is an awareness of hospice and that hospice is available in our community, people were unable to name our agency (Center for Hospice and Palliative Care). In fact, only 9% of respondents were able to state our name correctly.
- The word, "palliative," is confusing.
- People don't know when hospice care is appropriate.
- Those in our community don't know who can call hospice or how hospice care is paid for.

- Many think the "H" in our logo stands for hospital.
- Respondents to our survey didn't realize that many hospice programs are available in our area and that you have the right to choose which hospice program provides your care.
- The fact that hospice is a six-month Medicare benefit surprised most of our respondents.
- Many didn't realize hospice care is for *all* life-limiting diseases, not just cancer.

Change Opens the Door to Opportunities

The name change to Center for Hospice Care makes sense. It is a change we feel will help us do a better job reaching our vision of being the premiere hospice and palliative care organization for all end-of-life issues.

Did you know that the National Hospice and Palliative Care Organization states that approximately seven out of ten deaths are hospice appropriate? Keeping that in mind, Center for Hospice Care could be serving an additional 149 patients on any given day. Think of how many more patients and families could be experiencing the benefits provided by hospice care during the last months of life.

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1/1 1 *****AUTO**SCH 5-DIGIT 46601
 Dr. Douglas N. Macgregor
 515 N Lafayette Blvd
 South Bend IN 46601-1003

111 Sunnybrook Court
 South Bend, IN 46637

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