

## Looking Ahead

Mark M Murray, President & CEO

The growth of the hospice movement over the past 30 years has been extraordinary. In 2010 (most recent figures available) an estimated 1.58 million patients, along with their family caregivers, received hospice services in the U.S. But, despite this growth there is still an ongoing lack of awareness about the full benefits of hospice. The consequences are that many patients in desperate need of hospice do not get enrolled soon enough.

Patients are often hesitant to inquire about hospice services. Sometimes there is an irrational belief that if we even talk about death and dying, it will somehow happen sooner. Some healthcare professionals, under the misguided impression that it will take away "hope," refuse to make a referral to hospice when studies have shown just the opposite is true. Most patients know when they are seriously ill and they expect their own trusted healthcare professionals to have an honest dialogue with them and to have it early enough to allow for informed decisions to be made. Neglecting to talk about hospice care could deprive the patient of essential support and symptom control – care they could be entitled to receive under federal law. Patient quality of life, and in some cases even life expectancy itself, is actually increased by discussing hospice care earlier. Research in 2007 discovered that hospice care not only improves the quality of life for patients with terminal conditions but may lengthen life as well. The study revealed hospice patients lived on average 29 days longer than patients with similar conditions who did not choose hospice.

For a program designed for six months, the average length of stay under hospice care remains staggeringly short. In 2010 the national average length of stay for a Medicare hospice patient was 69 days and the Median was 21 days. Nationally, about 30% of all hospice referrals die within a week and about 10% within 24 hours following admission.

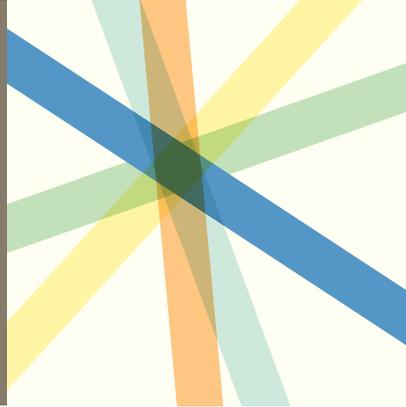
The Medicare Hospice Benefit provides for care when the physician's clinical judgment indicates that the patient might expire in six months or less if the disease runs its normal course. However, there is no time limit for how long a patient may be under hospice care as long as a physician continues to certify the terminal condition. For hospice care to truly benefit the patient and family there must be sufficient time. Less than three weeks is simply not enough. It's no wonder the most frequent complaint we receive from surviving family members is, "why didn't somebody tell us about hospice care sooner." Even though we are serving more patients each year and by numbers of patients served rank in the top 5% of all hospice programs in America, our hospice length of stay is just barely above the national average and our median is just 14 days, well below the national average. Late referrals are part of the problem. We respond immediately, many times within hours, to all referrals. It is depressing to note that during 2011, 1 in 12 referrals were so late the patient died before we could get there to explain our services and how we could help. This was the experience for more than 200 local patients and their families.

### Center for Hospice Care is a Mission-Driven Organization

The cost of charitable care, free care, write-offs, etc. amounts to over \$1 million each year. We rely on philanthropic donations to support our charitable care as well as fund our other non-reimbursed programs like community bereavement counseling for anyone who has lost a loved one (whether or not their loved one had a hospice experience),

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hospice & physician  
**team**  
newsletter



newsletter



Mark M Murray  
President & CEO

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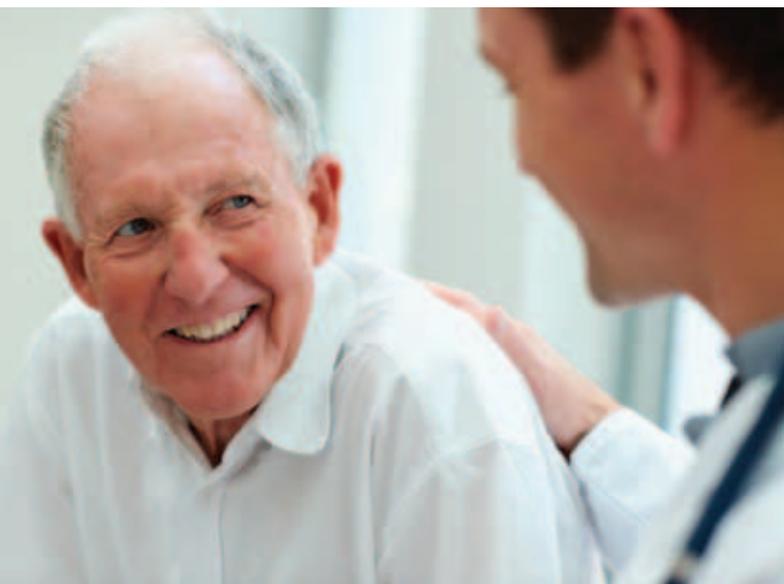


choices to make the most of life

# 96% of Physicians Favor Enhancing Quality of Life for Seriously Ill Patients over Extending Life as Long as Possible

Nearly all physicians believe this country should place a higher priority on providing palliative care to all patients who need and want it, and that it is more important to enhance terminally ill patients' quality of life than to try to extend it by any means, a nationwide survey released by National Journal has found.

Results of the poll of 500 board-certified physicians were presented this past November at a Washington, DC, policy summit as the third and final part in the series entitled, "Living Well at the End of Life: A National Conversation." The presenter was Brent McGoldrick, senior vice president and general manager of FTI Consulting, the firm that conducted the survey for National Journal.



## KEY FINDINGS INCLUDE:

- 96% of physicians believe it is more important to enhance the quality of life for terminally ill patients than to attempt to extend life by any means.
- 96% think that patients and their families should be educated about palliative and end-of-life care and the options available to them.
- 94% agreed that palliative care should be made available to all seriously ill patients, should be offered alongside curative treatment, and should be fully covered by health insurance and Medicare.
- 79% think the nation's health care system spends too much in an attempt to extend the lives of terminally ill patients.

However, the data revealed some noteworthy hesitations about palliative care and barriers to its full adoption, McGoldrick pointed out.

Similar to patient groups, many physicians (42%) are concerned that emphasizing palliative care could interfere with cure-directed treatment. This concern was found less frequently among those physicians most familiar with palliative care, showing that more education is needed to explain that palliative care is not an either/or choice.

A dramatic "generation gap" found in physicians' early education and training in palliative and end-of-life care indicates encouraging progress in the last 15 to 20 years, said McGoldrick. Among physicians younger than 39 years, 73% reported having received at least some training in palliative care and end-of-life care counseling in medical school, compared with only 25% of respondents aged 40 years or older. Further, 60% of all respondents say they have pursued continuing medical education in this area.

Physicians are aware of the limitations of their training; while 49% feel somewhat prepared to discuss palliative care, only 35% say they feel very prepared. And only 30% feel very prepared to counsel patients on end-of-life care options.

## BARRIERS TO PALLIATIVE CARE

Physicians identify the following as barriers to the implementation of palliative care:

- Patients are not adequately informed and don't ask (91%).
- Patients are reluctant to accept palliative care because it means admitting they may not recover (84%).
- Health insurance companies and Medicare do not reimburse adequately for consultations (82%).
- There are insufficient palliative care physicians and services (78%).
- Patients lack the resources to afford the care (78%).

## PHYSICIAN COMMUNICATION AND COMPENSATION

Two areas of crucial importance to physicians wishing to improve delivery of palliative care are training in the end-of-life conversation and compensation for such discussions, according to summit panelist Ezekiel J. Emanuel, MD, chair of the Department of Medical Ethics and Health Policy, University of Pennsylvania, Philadelphia. Patients don't want to ask about end-of-life care, he noted, but neither do physicians want to initiate these discussions.

"You resist that conversation as long as possible," he said. "It's emotionally draining, it takes time, it's difficult, you have no way of knowing how the patient and family are going to react. That is enormously difficult.

"Figuring out how to start that conversation is the most important thing we can do to try to transform this. That requires education in better communication skills specific for end-of-life care." Also needed, said Emanuel, is improved training in addressing and managing specific symptoms, as well as better research and the development of more effective interventions.

Emanuel feels strongly that physicians must be compensated for the time needed for end-of-life conversations, just as they are compensated for taking a patient's history.

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## Physician First

by Robert B. Kolbe Jr. MD



Robert B. Kolbe Jr. MD

I have been a strong supporter of hospice services since I started my practice in 1985. I began my career in family medicine and in 1992 I added geriatrics. More than 30% of my patients are elderly and many have been the recipients of hospice care. Hospice care has also been a valuable addition to my nursing home practice.

I am the medical director at two area facilities and have patients in two other facilities as well. Staff, patients, and their families greatly appreciate the additional service

hospice care provides. I view it as another set of hands caring for my patient(s). The benefits of hospice care include added clinical care with the hospice nurse, social services, financial help for medications, and spiritual care. This allows my patients to remain in their home as long as possible.

A service from Center for Hospice Care (CHC) that has become increasingly beneficial to my practice is palliative care. I have been able to ask CHC's board certified palliative care doctors to see my patients in consultation. This makes my job easier with regards to caring for my terminal patients. CHC's medical directors have reviewed my medications and made suggestions of when to discontinue or change. Their interactions with my patients and family members are very supportive and serve as a second opinion. This helps my patients and their family members better understand and accept the terminal illness. I believe this leads to a transparent and honest relationship with my patient. It provides some insight into what's going to happen in the future. This greatly alleviates the patient's sense of abandonment as well.

I would highly recommend that my colleagues continue using hospice care and increase the use of palliative care medicine consultations. I really appreciate the added attention and care given to my patients. I also like the availability of a medically trained caretaker who is present with the patient more than I can be. The dying process is made more comfortable for all involved. Afterwards, grief counseling is very helpful. This holistic approach to patient care, and the intimacy created during the dying process becomes part of the family story. I have found no one disappointed with this care.

## Numbers Receiving Hospice Care Improving

Center for Hospice Care has increased the number of patients in their service territory receiving expert end-of-life care by nearly 25% since 2007. However, only two-thirds of hospice-eligible patients received hospice care in 2010. The data demonstrates the need to continue educating the community about the choices Center for Hospice Care offers that allow patients and families to make the most of life. For patients with a life-limiting illness, hospice emphasizes quality of living by providing expert care and compassionate support.

Since 2007, the average length of time patients in Center for Hospice Care's service area received expert hospice care was approximately 75 days, slightly above the national average of 67 days. While many patients are able to receive the full benefit of hospice care during the final months of a life-limiting illness, other patients access end-of-life care too late. In 2011, more than 30% of Center for Hospice Care's patients received hospice care for less than seven days. A patient with any life-limiting, progressive illness and a life expectancy measured in months may be appropriate for services at Center for Hospice Care. The sooner you get Center for Hospice Care involved, the more we can do to provide choices to make the most of life.

*This information is from the State Hospice Profile, using 2010 Medicare statistics*

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our free annual children's "Camp Evergreen," and our innovative art counseling program, just to name a few. To help sustain our long term future, many people are taking a proactive approach by choosing to make giving to CHC part of their estate planning.

CHC will be facing challenges in the future. Hospice Medicare reimbursement cuts which began in 2009 will continue through at least 2019 with additional cuts to hospice planned. Consequently we cannot underestimate the importance of philanthropy to the ongoing financial viability for our special community programming and our charity care. You can help sustain CHC through your continued support and by encouraging others to offer their support. Our benefactors help ensure that all people in our communities who are nearing the end of life do so with dignity and compassion and that the survivors are cared for as well.

After 32 years, we believe nowhere in our community are there professionals and volunteers more proficient or more experienced at providing high quality, patient and family-centered care at the end of life. There is no question that we are the leading local experts in caring for people facing serious, advanced and life-limiting illnesses. However, in order to maintain our standing as the specialists, we must bravely respond to our challenges.

Changes are coming for healthcare in America. Hospice care is included in these transformations. As a result, changes are coming for CHC, as they must naturally do, if we wish to achieve even higher levels of success. We will need to continually monitor our business plans, evaluate current and new programs, and adapt to an ever shifting economic environment. We will need to invest in new infrastructure, new facilities and consolidate some of our locations into a campus setting in order to ultimately reduce costs and increase efficiencies. We will need to develop new tools for ensuring the provision of quality, evidence-based, ethical, effective, and efficient end-of-life care. We will need to learn how to thrive in an environment that is much different from that of even two years ago. This will require dedication and commitment. I believe we can do this. As a result, as the stewards of our mission, we may need to make bold choices for our future. We will need to harness imagination and creativity to strengthen CHC for the coming generations who are yet to enter our care. But I also believe our collective welcome of new directions must be anchored to the strongest values of our original establishment. In the face of change, what we can never take for granted is what matters most -- the promises and obligations we make to our patients and families. As with everything we do, it all ultimately comes down to the care at the bedside.

We are all here because we are committed to *Improving the Quality of Living*, and the decisions we make for our future will be reflective of it.

## Core Indicators for Hospice Care

# Dementia

**Non-Alzheimer's dementia** has been one of the most common diagnoses among Medicare hospice patients in recent years.

**Dementia is a primary indicator for hospice care. According to Medicare guidelines, core indicators of hospice eligibility for dementia include:**

- Unable to walk without assistance
- Urinary and fecal incontinence
- Speech limited to a few words
- Unable to dress without assistance
- Unable to sit up or hold head up
- Complications: pneumonia, UTI, sepsis, pressure ulcers
- Difficulty swallowing/eating
- Weight loss

If your patient exhibits these signs and symptoms, call Center for Hospice Care at 800.HOSPICE (467.7423) or fax a Referral to 574.243.3705.

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# palliativecarecenter

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Mishawaka, IN 46545

Hours: Tuesday and Thursday 2 - 4 p.m.  
Phone: 574.243.3712

Physician referral only.

For an inservice on Palliative Care, call 574.243.3712 or email [info@centerforhospice.org](mailto:info@centerforhospice.org)

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Center for  
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choices to make the most of life

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