



## New Research Finds Patients Do Live Longer Under Hospice Care

*Hospice Patients Lived an Average 29 Days Longer Reports NHPCO*



A new study published in the March 2007 issue of the *Journal of Pain and Symptom Management* reports that hospice care may prolong the lives of some terminally ill patients.

Among the patient populations studied, the mean survival was 29 days longer for hospice patients than for non-hospice patients. In other words, patients who chose hospice care lived an average of one month longer than similar patients who did not choose hospice care.

Sponsored by the National Hospice and Palliative Care Organization, the study was conducted by NHPCO researchers in collaboration with the highly regarded consulting and actuarial firm, Milliman, Inc.

Researchers selected 4,493 terminally ill patients with either congestive heart failure (CHF) or cancer of the breast, colon, lung, pancreas, or prostate. They then analyzed the difference in survival periods between those who received hospice care and those who did not. Data came from the Centers for Medicare and Medicaid Services and represented a statistically valid five percent sampling from 1998-2002.

Longer lengths of survival were found in four of the six disease categories studied. The largest difference in survival between the hospice and non-hospice cohorts was observed in CHF patients where the mean survival period jumped from 321 days to 402 days. The mean survival period also was significantly longer for the hospice patients with lung cancer (39 days) and pancreatic cancer (21 days), while marginally significant for colon cancer (33 days).

“There’s an inaccurate perception among the American public that hospice means you’ve given up,” said J. Donald Schumacher, NHPCO president and

CEO. “Those of us who have worked in the field have seen firsthand how hospice can improve the quality of and indeed prolong the lives of people receiving care. Benefits of hospice have been reinforced by positive stories like that of Art Buchwald who seemed to thrive under the care of hospice.”

Researchers cited several factors that may have contributed to longer life among patients who chose hospice. First, patients who are already in a weakened condition avoid the risks of over-treatment when they make the decision to receive hospice care. Second, hospice care may improve the monitoring and treatment patients receive. Additionally, hospice provides in-home care from an interdisciplinary team focused on the emotional needs, spiritual well-being, and physical health of the patient. Support and training for family caregivers is provided as well. This may increase the patient’s desire to continue living and may make them feel less of a burden to family members.

“There is a perception among some healthcare providers that symptom relief in hospice, especially the use of opioids and sedatives, could cause patients to die sooner than they would otherwise. This study provides important information to suggest that hospice is related to the longer, not shorter length of survival – by days or months – in many patients,” said Dr. Stephen Connor, NHPCO’s vice president of research and international development, and lead author of the study. “This additional time may be valuable to patients and families to give more time for resolution and closure.”

Co-author Bruce Pyenson, an actuary at Milliman in New York, added, “We believe this study helps support the growing quality movement within healthcare. For some patients, hospice care is not a choice about cure, it is a choice for the best care.”





# Report from Washington: Hospice in the Crosshairs

By Mark M. Murray, President/CEO

“It’s like a whack-a-mole game,” according to former CMS Administrator, Tom Scully. Scully was speaking at the National Hospice and Palliative Care Organization’s (NHPCO) National Public Policy Forum in April. He said whenever anything pops up with this much growth, CMS is going to take a mallet and whack it down. He was talking about hospice.

I recently spent a week in our nation’s capital attending an NHPCO Board of Directors meeting, Public Policy Forum, Council of States, and alongside eight other CHAPC staff, the annual Management Leadership Conference. Throughout the week the message was clear: hospice is in the crosshairs. It’s not just because of extraordinary growth over a very short period of time, but also because of suspected fraud and abuse among some unscrupulous hospice providers. Most providers are ethical and strive to adhere to Medicare regulations when it comes to patient care and billing for that care. But as it is within all realms of life, there are those who choose the shortcut and endeavor to take advantage.

In the past few months, the Committee on Energy and Commerce Oversight announced their plans to review alleged billing fraud in various Federal health care programs, and “hospice benefit fraud” is on this list. The current 2007 work plan for the Office of Inspector General includes looking at hospice payments to nursing homes, and, hospice plans of care and appropriate payments. In remarks before the Federation of American Hospitals, Acting CMS Administrator, Leslie Norwalk stated that CMS is “concerned about what we’ve been seeing in regard to hospice” with average lengths of stay varying “tremendously in various parts of the country.” She went on to express concern about the rise of Alzheimer’s disease as a hospice diagnosis and warned that, “Hospice is not intended to be used as a nursing home.”

Speaking of nursing homes, there is now knowledge at the federal level of hospices billing for general inpatient care within nursing homes when the facility doesn’t meet the Medicare Conditions of Participation for that level of care. There is knowledge of hospices offering and some nursing homes soliciting a guaranteed number of “continuous care” days, which could be seen as an inducement under the anti-kickback laws exposing both the hospice and the nursing home to potential

liability. They not only know the “what,” but they are learning the “who” directly from the data that’s been sent to them.

One of the most shocking conference presentations came from Terri Deutsch, a CMS health insurance specialist, who performed data mining on Medicare hospice claims looking at ICD-9 codes. She discovered hospice providers listing the following as the primary terminal conditions: tuberculosis reaction, strep throat, family history of breast disease, and prickly heat, just to name a few of the most outrageous.

For unprincipled hospice providers, a Medicare program that automatically pays more than 90% of submitted claims without anyone actually looking at them – claims requiring no detailed clinical information at all – must have been a dream come true. Previously, hospice was an industry flying under the radar and siphoning just a petite fraction of the overall Medicare budget. This, along with a perceived reputation as the “white horse” of compassion and dignity, the hospice business must have appeared financially charming. However, conventional wisdom says the party may be coming to an end for some. Times are changing.

Consider these facts:

- Medicare spending on hospice has risen to \$10 billion per year, about the size of the entire federal food stamp program. Hospice expenditures are no longer an inconsequential sliver of a much larger budget pie.
- There are now more than 4,100 hospice sites operating in the U.S. Within a two year period, 500 new hospice programs have opened their doors.
- Of the last 1,000 hospice provider numbers issued by Medicare, 80% have been at the request of for-profits.
- Rapid and sustained growth in the number of hospice providers has been noted by representatives in Congress, especially in the past 2 years.
- Both the House of Representatives and Senate have indicated they intend to review practices and providers in search of possible fraud within the hospice community.

*Hospice is in the crosshairs. It’s not just because of extraordinary growth over a very short period of time, but also because of suspected fraud and abuse among some unscrupulous hospice providers.*



We understand the wheels of federal government turn slowly and much of this “enhanced oversight” process is just now getting underway. The real “whacks” won’t likely begin until after the 2008 election. Still, here at The Center for Hospice and Palliative Care, Inc., we are supportive of all efforts to eradicate the few bad players, improve the quality of care, enhance reimbursement oversight, unlock access barriers, and allow an industry to grow appropriately – as it should – to care for those who need us today and for the millions of baby boomers that will want and need what hospice has to offer tomorrow.

All hospice programs will go through some pain because of the tactics of a few bad providers. But we believe it will be worth it in the long run. Cleaning up this part of our national healthcare system and eliminating the “drive-by hospices” must be done. After this takes place, perhaps everyone in hospice can get back to concentrating exclusively on what we really need to be doing: taking care of the patients by providing comprehensive, quality hospice care. That’s the real business of hospice.



## Structured Approach to ICU Family Conferences Reduces the Stress of Bereavement



The use of a communication strategy for discussing a change in treatment plan with relatives of patients dying in the intensive care unit (ICU) has been found to reduce symptoms of stress, anxiety, and depression among bereaved family members, report the authors of a study published in *The New England Journal of Medicine*.

As compared with customary end-of-life ICU conferences, the proactive strategy “resulted in longer meetings in which families had more opportunities to speak and to express emotions, felt more supported in making difficult decisions, experienced more relief from guilt, and were more likely to accept realistic goals of care,” write the authors.

Investigators conducted a randomized controlled trial of the effects of a proactive end-of-life communication strategy, using a system known by the mnemonic VALUE, which was developed by co-investigator Randall Curtis, MD, of the University of Washington, Seattle. Participants were relatives of 126 patients dying in 22 ICUs in France. Those in the intervention group were also given a brochure on bereavement.

### Compared with controls, participants in the intervention group:

- Experienced longer conferences (median, 30 minutes vs 20 minutes)
- Spent more time talking (median, 14 minutes vs 5 minutes)
- Had a significantly lower median score on instruments measuring for posttraumatic stress disorder (PTSD) at 90-day follow up, with a lower prevalence of PTSD-related symptoms (45% vs 69%)
- Had less prevalence of clinically significant symptoms of anxiety (45% vs 67%) and depression (29% vs 56%)

### The longer, more structured conferences allowed families to:

- Ask questions and address concerns
- Discuss the patient’s values
- Express emotions
- Alleviate feelings of guilt
- Arrive at a more realistic expectation of the outcome

“This study is groundbreaking in its demonstration of a statistically and clinically significant improvement in symptoms of anxiety, depression, and PTSD among family members, and it shows that expanding the focus of critical care to include family-centered outcomes is appropriate and desirable,” write the authors of an editorial accompanying the report.

The increasing use of critical care in this country has led to a rise in the number of Americans who die in the ICU, as well as to the increased number of patients who survive with desirable outcomes, point out Craig M. Lilly, MD, University of Massachusetts Medical School, Worcester, and Barbara J. Daly, PhD, RN, Case Western University, Cleveland, noting that “nearly every American family will be affected by the loss of a loved one in an ICU, and the effect of this loss can be mitigated by high-quality care.”

Lilly and Daly conclude: “**All providers of critical care should receive training that will allow them to offer the kind of support that they would want if they had a family member who was facing death in an ICU.**”



*Source: “A Communication Strategy and Brochure for Relatives of Patients Dying in the ICU,” *The New England Journal of Medicine*, February 1, 2007; 356(5):469-478. Lautrette A, Darmon M, Megarbane B, Curtis R, et al. Saint-Louis Hospital and Paris 7 University, Assistance Publique-Hopitaux de Paris, Lariboisiere Hospital, Paris, France; School of Medicine, University of Washington, Seattle. “The Healing Power of Listening in the ICU,” *ibid.*, pp. 513-515. Lilly CM, Daly BJ; University of Massachusetts Medical School, Worcester; Case Western University, Cleveland.*

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### VALUE: Guidelines for an End-of-Life Family Conference

*V*alue and appreciate what family members say

*A*cknowledge the family members’ emotions

*L*isten

*A*sk questions that allow you to

*U*nderstand the patient as a person

*E*licit questions from family members

— Lautrette, et al,

*The New England Journal of Medicine*

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## Fewer Concerns with Physician Communication, Greater Use of Hospice Linked to Presence of ADs

Bereaved family members express fewer concerns regarding communication about medical decisions and report fewer unmet needs for information about the dying process when their loved ones have completed an advance directive (AD), reports a team of Rhode Island researchers in the *Journal of the American Geriatrics Society*.

The team analyzed survey responses gathered 9 to 15 months post-death from relatives of a nationally representative sample of 1587 adults who died non-traumatic deaths in 2000. Nearly 71% of decedents had completed a written AD, a rate higher than reported in previous studies, the authors note.

Completion of an AD was associated with:

- Greater use of hospice
- Less likelihood of terminal hospitalization
- Less use of life-sustaining treatment during the last month of life
- Fewer concerns with physician communication
- Feeling more informed about what to expect throughout the dying process

“Despite this increase in the use of ADs, persistent and important concerns remain with how we as a society care for frail, older, dying persons,” warn the authors. “With the demographic projections of the ‘baby boomers,’ the ability to provide competent, coordinated, and compassionate care to older adults throughout the course of illness and the dying process is becoming increasingly urgent.”

*Source: “Association between Advance Directives and Quality of End-of-Life Care: A National Study,” Journal of the American Geriatrics Society; February 2007; 55(2):189-194. Teno JM, Gruneir A, Schwartz Z, Nanda A, Weile T; Center for Gerontology and Health Care Research, Brown Medical School; Department of Community Health, Brown University; Division of Geriatrics, Rhode Island Hospital; and Miriam Hospital, Providence, Rhode Island.*

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