

Q&A

The Medicare Hospice Benefit: Quality Compassionate Care at the End of Life

Janet Lieto, DO, CMD

Since its inception, the Medicare Hospice Benefit (MHB) has helped millions of Americans and their families receive quality end-of-life or palliative care that provides comfort, support, and dignity. However, in 2003, only 43% of Medicare beneficiaries eligible for hospice care actually received hospice services.¹

Most hospice programs are run by nonprofit organizations, while some are affiliated with hospitals, nursing homes, or home health care agencies. To be admitted into a hospice program, a patient must have a referral from a physician and a life expectancy of 6 months or less. Most hospice care is provided in the home by a caregiver; however, short stays in an inpatient hospice unit are designed for aggressive pain and symptom management that cannot be managed in an ambulatory setting.² Patients must also sign a statement choosing hospice care using the MHB, rather than curative treatment and standard Medicare-covered benefits for their hospice diagnosis, and enroll in a Medicare-certified hospice program to be eligible for hospice benefits.³

In this article, Janet Lieto, DO, CMD, answers some important questions for health care professionals who provide hospice care or care-related services.

Q: What is the main benefit for patients involved in hospice?

A: The main benefit is easy access to an interdisciplinary team that will help develop a comprehensive care plan to address all their needs. When a patient enrolls in hospice, a member of the hospice team discusses the medical history, symptoms, and life expectancy with the patient's physician. They then develop a new plan of care for the patient in light of the patient's expectations. The patient is no longer doing everything possible to live as long as he or she can; rather, they are looking to maintain a quality of life. Patients develop new concerns and needs, which may include physical or symptom management, psychosocial issues, or spiritual unrest. Sometimes patients may not understand their needs, but a good interdisciplinary hospice team is trained to recognize, assess, and treat these needs.



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Q: How does a patient's enrollment in hospice help them, their families, and their physician?

A: Hospice enrollment helps achieve a quality of life during the last stage of life. The patient is the center of the interdisciplinary team and can make his or her own decisions about care after being educated by the hospice team. The team helps the patient in the difficult transition from a curative care plan to a palliative care plan. During this period, the patient and family are constantly processing the patient's changing disease, symptoms, and needs. A supportive hospice team can help them make decisions about the best plan of care for the patient.

However, hospice goes beyond the obvious of having an RN and physician available to manage physical symptoms, such as pain, dyspnea, and agitation. The hospice social worker helps the family with psychosocial needs, placement issues, advanced care plans, and coordination of services. A spiritual advisor helps the patient and family deal with the question of "What is the meaning of all this?" After the death of the patient, a bereavement counselor helps the family cope with their loss.

Physicians benefit by having an interdisciplinary hospice team available to care for all the patient's needs. If a patient is homebound and the primary doctor cannot make home visits, the hospice medical director will see and manage the patient at the primary doctor's request. The patient will be provided with durable medical equipment if needed.

Q: How are providers reimbursed for hospice services?

A: The MHB is unique within the Medicare program because the Centers for Medicare and Medicaid Services (CMS) reimburse hospices directly for services provided to patients. Patients may be billed for up to 5%—up to \$5 for each prescription—for outpatient drugs for pain relief and symptom control. MHB does not cover services for conditions unrelated to the hospice diagnosis or services that are not called for in the hospice care plan or arranged for by the hospice program. Details of coverage of hospice services and how to process hospice claims can be found in the Medicare Benefit Policy Manual, available on the CMS Web site (www.cms.hhs.gov).⁴

Q: What is the biggest barrier to entering hospice at the right time? When is the right time?

A: The biggest barrier to entering hospice at the right time is the misunderstanding of the hospice benefit in the medical, as well as the lay community. Our society is death-phobic, focusing on youth and long life. The public believes that a person enters hospice to die, when in reality, patients enter hospice to create the best quality of life in the time they have left.

The right time to enter hospice is when the patient's plan of care changes from curative to palliative and the patient has a prognosis of less than 6 months. Every patient needs to work with their doctor or health care provider to determine when that time is. Health care professionals must feel comfortable initiating conversations about end-of-life issues to help overcome this barrier.

Q: How can physicians eliminate these barriers?

A: Physicians need to understand the MHB and offer it to patients who could benefit from

the program. Physicians should develop relationships with hospices in their area so they feel comfortable in picking up the phone and asking about benefits, diagnosis, and services.

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Physicians need to feel comfortable in communicating and coordinating care for their patients with the hospice team.

Q: What can long-term care (LTC) facilities do?

A: LTC facilities need to educate staff so they can identify patients who would benefit from hospice. They also need to feel comfortable with the hospice agency that they work with. Facilities should realize the importance of bereavement care for patients' families, as well as the LTC staff who have become the patients' second family.

Q: How does hospice work with LTC facilities, especially assisted living facilities (ALFs)?

A: When I posed this question to my interdisciplinary team working in an ALF, the reply was, "Very carefully!" ALFs are a unique setting that can truly benefit from a hospice team. ALFs advocate for hospice in their chronically ill patients whose goal is to die in their ALF apartment. The hospice team becomes an extra set of eyes and ears for the ALF staff and is helpful in coordinating symptom management for the patients. The hospice social worker becomes an integral resource, as many ALFs do not employ social workers to help patients and families deal with the psychosocial aspects of hospice. Families do not want to move failing loved ones out of an ALF that has become their home. In addition, the hospice can provide spiritual support for patients, families, and ALF staff who may have concerns.

Q: What drew you to hospice? Is this an opportunity for physicians?

A: As a fellowship-trained, board-certified geriatrician, function and quality of life have been important motivators for patient care. This quality of life can occur at the end of life, and I felt obligated to ensure that my patients dealt with end-of-life issues proactively so they would not suffer. I had the privilege of caring for patients in a continuing care retirement community, where patients progress from independent living to assisted living and then to a nursing home setting. My patients taught me that the loss of independence and function is a horrible part of aging and that death is inevitable. Most patients do not want to suffer or be a burden to their families. The elderly generation has a strong sense of spirituality and expectation that “the best is yet to come” when they pass. How best to meet their end-of-life needs than with coordination from a hospice program?

There are many opportunities for a physician to work with a hospice agency. Physicians’ col-

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Q: What role will hospice play over the next 10 years?

A: With our rapidly growing elderly population, society must meet the challenge of how to cope with death and dying in a humane and cost-effective manner. One study estimated that end-of-

life care consumed 10% of the total health care budget and 27% of the Medicare budget.⁵ In this study, the use of hospice services resulted in savings of 46.5% during the last month of life and 17% during the last 6 months of life due to the decreased use of inpatient hospitalizations and increased use of do-not-resuscitate orders. Another study demonstrated that much of the success of hospice programs was related to constantly monitoring the patient’s changing needs and involvement of the family in the emotional and spiritual support of the patient.⁶

From an operating performance perspective, Harrison and colleagues recently observed that hospitals with a hospice program had a higher return on assets and higher occupancy rates.⁷ From an organizational perspective, they also showed that hospitals with a hospice program were larger, had more clinical services, and shorter lengths of stay.⁷

In facing the ultimate challenge of death and dying, it is hoped that with increased education and awareness about end-of-life care, patients, families, and health care professionals will better understand hospice programs and palliative care services. With better understanding, it seems certain that more and more seniors will take advantage of the Medicare Hospice Benefit as they approach the end of life. **MPM**

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