Supporting life and living with hospice care

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Areas of Discussion

• State of the Industry
• Prognostication
• Quality Metrics and Reporting
• Hospice Industry Future

State of Industry

• There are approximately 6,100 hospices in operation
• 78.9% of hospices had 500 or fewer admissions
• The majority of hospices are independent freestanding agencies

State of the Industry

• 84% of patients where 65+
• Today Cancer accounts for less than half of all hospice admissions

State of the Industry

• The median length of stay is 17.4
• The average length of stay is 71.3
• The largest portion of patients died within 7 days of admission (35.5%)

Prognostication
Prognostication Study

- 343 Physicians to Predict Survival Rate
- 468 Patients Referred to Hospice
- Only 20% of predictions were accurate (as defined as within 33% of actual survival)
- Overall, doctors overestimated by a factor of 5.3!

Christakis NA, Lamont EB. Extent and Determinants of Error in Doctor’s Prognoses in Terminally Ill Patients: Prospective Cohort Study. BMJ. 2000; 320:469-472.

Prognostic Communication

Step 1: Initiating Discussion
- Establish a compassionate relationship with patient and family.
- Initiate conversation about end-of-life care.
- Share general thoughts about end-of-life preferences.

Step 2: Clarifying Prognosis
- Be direct, clear, and honest.
- Use simple, understandable language.

Step 3: Identifying End-of-Life Goals
- Facilitate open discussions about desired medical care.
- Recognize that as death nears, most patients share similar goals: maximizing time with family and friends, minimizing hospitalizations and interventions, ensuring comfort, and maintaining dignity.

Step 4: Developing an Ending Plan
- Provide guidance in implementing end-of-life plans.
- Make arrangements for appropriate treatment.
- Clearly communicate options.
- Ensure timely palliative care, when appropriate.

Prognostic Points

Baseball, Apple Pie... Immortality?

Data Demonstrates Society’s Discomfort with EOL Care

- Percentage of doctors who are not aware of the existence of their patient’s EOL documents
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Prognostic Communication

Step 2: Clarifying Prognosis

There is a national inclination to express about bad news, to discuss the consequences of a patient’s condition, and to share this information. However, the American Medical Association has acknowledged that this is often misunderstood. These conditions are not fully aware of their prognosis; they tend to underestimate their survival, which influences their prognostic decisions regarding end-of-life treatment.

Patients and families often require repeated explanations in order to understand a medical problem. Communication is enhanced with such repetition. With all medical discussions, it is best to use simple, everyday language and to avoid technical wording. Most patients need understanding new information when it is presented at a rate of eight to eight grade level. Stating terms of high anxiety, concentration, and comprehension may be further limited. It is important to keep it simple.

I want to be certain that I have clearly explained your medical situation. Can you give your understanding about what I am about to say?

Prognostic discussions are broken by epidemiologic shortages, statistics speak for groups, not for individuals. Should we focus on the small number of patients who exhibit the average, or those who fall below the average curve? Can we be a source of both truth and hope to our patients?

Most people with multiple diagnoses who are at your stage of the disease, continue to live very well for 2 to 3 years, that time is the average patient and known outcome. Please remember that outcomes are not always what the literature may suggest. Sometimes it is better than average, but it is also possible that you may do worse.
Prognostication Points

- Appropriate prognostic information is essential for informed advance planning decisions
- Hospice Care is most beneficial in months not days

Quality Metrics and Reporting

- Increased regulatory scrutiny
- Increased documentation and reporting requirements...resulted in:
  - CMS, under the Affordable Care Act, requiring hospices to collect and submit patient data-designed to measure and assure quality
  - In less than 2 years, CMS has implemented 2 nationwide mandated reporting initiatives
    - Hospice Item Set – 7 (HIS7)
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- CMS has been collecting this data and plans to use this data to drive quality improvement and assurance in the hospice industry
  - Results could impact reimbursement (“high” performers get more; “low” performers get less)
  - Results could be publicly reported
  - Inform consumers on “best products” available
  - Encourage “low-performing” hospices to make improvements

Hospice Item Set 7 (HIS7) - Background

- CMS Mandated quality reporting requirement
  - effective 07/01/2014
- Nationwide data gathering initiative
- Currently evaluates 7 elements of patient care
  - CMS refers to them as “Care Processes”
  - Will likely expand in upcoming years
- Available for public consumption after few years of data collection
  - Consumers, along with CMS, will be able to compare facilities against one another, along standardized quality measures, to help inform choice and reimbursement
- Data is submitted on every admission and every discharge
  - Failure to participate results in 2% reimbursement reduction in 2016
  - Currently quality of numbers has no direct reimbursement impact

Hospice Item Set 7 (HIS7) - Overview

<table>
<thead>
<tr>
<th>Care Process</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF #1641</td>
<td>Treatment Preferences</td>
</tr>
<tr>
<td>NQF #1647</td>
<td>Beliefs/Values Addressed</td>
</tr>
<tr>
<td>NQF #1634</td>
<td>Pain Screening</td>
</tr>
<tr>
<td>NQF #1637</td>
<td>Dyspnea Screening</td>
</tr>
<tr>
<td>NQF #1639</td>
<td>Dyspnea Treatment</td>
</tr>
<tr>
<td>NQF #1617</td>
<td>Patients Treated with an Opioid who are Given a Bowel Regimen</td>
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</tbody>
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Hospice CAHPS - Background

- Consumer Assessment of Healthcare Provider and Systems
  - Has been in healthcare for a while, just now reaching hospice industry
- Mandated Quality Reporting Initiative
- Survey mailed to primary caregivers of deceased hospice patients
  - Mailed several months following the death of a hospice patient
  - Gathers information on the perceived experiences of hospice care received
  - Survey results are then submitted to CMS for analysis
  - Survey results are also used internally for quality assurance and improvement
- Dry run (pilot phase) began January 1, 2015
- Effective Start Date April 1, 2015

Hospice CAHPS – Current Status

- It has been a year since CAHPS was implemented nation wide
- We have not heard or seen any feedback from CMS regarding the data
- We have been utilizing CAHPS data internally, for QA/QI purposes
- Ex. Questions:
  - How often did you get help from the team during evenings, weekends, etc?
  - Did the team give you the training needed to care for your loved one?
  - How often did your loved one need help with constipation?
  - In your opinion, was your loved one referred to hospice too late, at the right time or too early?
Hospice Item Set 7 (HIS7)/ Hospice CAHPS Process Overview

Phase 1 - Submit Data
- Collect and store data
- Validate and submit data

Phase 2 - Organize Data
- Clean and organize data
- Admit Patient
- Pull assessment data

Phase 3 - Disseminate
- Disseminate results for public consumption

Hospice Industry Future
- Fewer “facility” patients
- Less reimbursement
- Fewer hospice organizations
- Integration with palliative care teams/ healthcare systems
- Key metrics
- IT & data analytic capabilities essential to viability

Conclusion
- Hospice Needs and Focus areas are evolving rapidly
- Improved Prognostication vital to improving “value” in healthcare
- Increased Quality Measurement and Standardization
- Industry consolidation and alignment part of hospice evolution