(PLEASE NOTE: Transcribed automatically by Vimeo, mistakes are possible/likely. Our apologies.)

TRANSCRIPT - GR 04 15 22 "Everything You Wanted to Know About Hospice But Were Afraid to Ask"
***Joshua Barkley, MD*, from the University of Virginia**

UVA Chiefs

00:32:37Today we're gonna be given by Dr Joe partly because most of us aren't around department of medicine so Dr barkley graduated from the University of Maryland Medical School and actually came here and did his internal medicine residency training.

- 00:32:53After that he completed fellowships in palliative care medicine and health services research at Duke university and I have to be completed, that he joined the Faculty 2008 because it assistant professor and incense risen to the rank of associate Professor.
- 00:33:09And I think most in the room, and over zoom or you know, certainly the folks in the room, are familiar with Dr barkley his role as attending on the palliative care consulting service but also.
- 00:33:21They started the patient care.
- 00:33:25Service line which he is intimately involved, but both in terms of the clinical eating and then also the educational efforts for the advanced practice providers.
- 00:33:33Who are servants is also involved as the fellowship program director for palliative care medicine fellowship and it's really been.
- 00:33:44A big part of that ever since it was founded in 2013 and, finally, you know, Dr Barkley has a lot of research interests within the field, in particular, is an interest in.
- 00:33:56substance abuse and diversion within that palliative care medicine, you know patient community and then also have sort of an interest in a way that providers sort of interact with palliative care of patients and their.
- 00:34:12Their emotional states the way these patients, so today we're honored he's going to come and give us a real tour de force on hospice care what it means.
- 00:34:21What the Medicare benefit is and then you know the many barriers, I think this will be a both a fantastic review of the.
- 00:34:28literature, but also a really a great practical education, especially for the learners in the room, so with that I will.
- 00:34:36hand it over to Dr Barkley and for everyone in the room we've let this up here at the snap not actually the first slide but they're going to be some poll everywhere questions, so please get your full every word out and I'll hand it over to.
- 00:34:54Thanks so much I do want to try to get a sampling of what folks know so we can kind of gear, the discussion towards.
- 00:35:01everybody's level, so this is the pole at comm slash Joshua Barclay 135 if you could go there, so to get those out I'll have my first question will be in just a second.

- 00:35:13I just want to make one minor correction, which is that I'm no longer the program director on the associate program director Dr Timmons to get full credit to him is actually now the program director firstly.
- 00:35:27I this is going to be about hospice care and so I'm going to cover really a broad array of and a move fairly quickly i'll talk a bit about the literature that looks at kind of how we provide hospice care.
- 00:35:38What the benefit is, overall, what are some of the barriers that we have towards providing hospice care and hopefully answer most questions that people would have.
- 00:35:47These are my learning objectives and then talk about the hospice benefit and look at barriers overall to care.
- 00:35:55This is the poll everywhere so it's casual Barclay one.
- 00:36:00And the poll question is the next slide so just to prepare yourselves for that.
- 00:36:05So while we're kind of getting that up, I want to just talk about what are the terms that I'm going to use just so that everybody kind of knows what I'm speaking about.
- 00:36:12So the first is, is what is hospice So when I refer to hospice I'm talking specifically about the Medicare hospice benefit that really is the standard by which we provide hospice care.
- 00:36:23And so, there are other insurances or Medicaid or other things that may have different requirements, but by and large the hospice services that the hospice provide is geared based on the Medicare hospice benefit.
- 00:36:36 I'm going to talk a lot about something called gap so GI P stands for general Inpatient level of care so when you think about hospice a patient could qualify for hospice.
- 00:36:46But there are four different levels of hospice there's routine general Inpatient respite and continuous care.
- 00:36:53and general Inpatient or gap level of care is one of those levels and I'll talk about that as we move on further, but when you hear gap that's a specific level of hospice or.
- 00:37:03respite care is the same thing it's a specific level of hospice when I talk about Inpatient hospital there's a lot of confusion as to what Inpatient hospice is.
- 00:37:11 I'm specifically referring to hospice provided not in a patient's home setting so at some facility, not necessarily uva but just added any facility.
- 00:37:23A lot of people are curious about what this thing the cake unit is, and so, for those who don't know that right, there is the actual way that it is so.
- 00:37:32I wasn't gonna point but it.
- 00:37:36sorry about that, let me go back here.
- 00:37:42it's right here is that is the case unit.
- 00:37:46So that's the case unit CAC is the Center for advanced hospice care it's a unit run by hospice the Piedmont.
- 00:37:54hospice of the p by have a representative who came out a consultant, who said, you know cake is something you eat after dinner it's not a place that you get care.
- 00:38:02So hospice the Piedmont wants to change the name to the Center, but if you use the cake unit for the Center they will know what you're talking about.
- 00:38:10That is out of the transitional care hospital in contrast the hospice house that we talked about is over, on park street those are both run by hospice of the Piedmont, and then, when we talk about hospice conversions we're specifically talking about what happens if you've yet.

- 00:38:26So first question here, so how much do you know about the Medicare hospice benefit, so that, so it looks like most people are saying I know a fair amount, but I need a little bit of help.
- 00:38:35With a significant number also sort of saying they don't know much about it, and then it looks like about a quarter, saying that they have some familiarity with it so let's talk a bit about it.
- 00:38:47So I do want to provide a quick warning here, which is that I think, to understand hospice you kind of have to get a little bit into the weeds.
- 00:38:54And so I am going to get a bit into the weeds of how hospice works and so just so that everybody knows if you can bear with me i'll point out sort of where some of the things that are particularly important are.
- 00:39:04So hospice was initially started in a long time ago in Malta, the modern hospice movement occurred with Dame cicely Saunders in England.
- 00:39:15Subsequent to that around the 1970s in the United States, we had our first established hospice and then in 1982 under the Reagan administration under a bill that was designed to lower health care costs, we had the Medicare at the monitor and Medicare hospice benefit.
- 00:39:32So some people may say why should I care about hospice you know this is this doesn't seem like something I need to really worry about so I'll talk a little bit about why it's important for our patients, so this is from a well established resource the onion and says, you know.
- 00:39:48The world death rate currently is holding steady at 100%, so this is something that all of our patients will ultimately have to deal with.
- 00:39:54But maybe a bit more for our patients in particular 51% of Medicare beneficiaries will ultimately access hospice at some point, they may not necessarily die on hospice.
- 00:40:05But they'll access the hospice benefit and from the standpoint of our patients, why do we care well there's fewer hospitalizations at the end of life.
- 00:40:12there's less intensive care unit at the end of life as well, we have improved symptom management and caregiver distress so I'm going to talk about five patients I'm sorry five articles here.
- 00:40:21kind of give you just a little bit of a sample of what's going on this is kind of a broad display of the literature, but we're partnering but it represents the preponderance of the literature.
- 00:40:33So one of the questions that often comes up is does hospice actually save money, and so, in this particular study they looked at a match cohort design between hospice and not hospice patients for cancer patients and found costs Asians.
- 00:40:46If you look across the literature some depending upon the patient population that we're seeing some patients do save money, some don't.
- 00:40:54At the very least, I would say hospices, is cost neutral and the preponderance of literature currently would sort of say that it does save some degree of.
- 00:41:04This was a study that we did here at uva it looks at care track patients, for those who don't know, we have the care track Program.
- 00:41:10In the clinic it's a longitudinal care program where we see patients, we follow them aggressively do aggressive symptom management have a lot of goals discussions.
- 00:41:20And this is over in the clinic with Dr black call Dr Paul Timmons Salerno.
- 00:41:25And Katie Merrill has see these patients and what we looked at was patients that were followed by this group versus those that weren't and what we found was that for those that.

- 00:41:35were, in fact, followed by the palliative group they had fewer hospitalizations in the last month of life, they had less debt and the hospital and increased hospice us as well.
- 00:41:47When we look at the family perspectives for patients that were enrolled in hospice what we see is that hospice patients were more likely to report pain.
- 00:41:56In this particular study but we're also more likely to report the use of pain medications.
- 00:42:01And we're also more likely to report that they received just the right amount of pain medications.
- 00:42:06That they've gotten help with dystonia that their end of life wishes were followed and they had excellent quality of life.
- 00:42:11So from the family's perspective, the patients get better care from the patient's perspective there is their wishes are tend to be honored.
- 00:42:19And then, in this particular study this looked at whether or not a patient had received a end of life conversation.
- 00:42:26or some type of goals of care conversation with a provider.
- 00:42:30And so, importantly, if they had received an end of life conversation with a provider, it was not associated with more worry or anxiety, it was not associated with higher rates of major depressive disorder.
- 00:42:41But it was associated with lower rates of ventilation resuscitation and higher rates of hospice enrollment.
- 00:42:47Now some people may say well geez if you got a goals of care conversation, you probably weren't doing well, or maybe you had a higher symptom burden.
- 00:42:55And they did see that in this study, so it is likely that many of these patients who had goals of care conversations that may have been triggered by a decline in their overall health so as we look at the literature, we do want to make sure that we're reading everything in context.
- 00:43:10In this particular study is looked at family caregivers and they looked again at cancer patients.
- 00:43:16And what we see is that patients who died in the hospital ultimately had a lower quality of life, they had more physical and emotional distress.
- 00:43:23and very for bereaved caregivers of those patients they had a higher risk of ptsd as well as something called pgd which is prolonged grief disorder.
- 00:43:34So for the patients that are in the hospital again, this may represent a higher symptom burden of those patients that may be why they're seeing some of these issues.
- 00:43:43But overall, when patients leave the hospital and go to other facilities, they have a better quality of life and their symptoms are better managed.
- 00:43:51So we talked a lot about the idea of patients wanting to be home, and we ask that question and wouldn't you rather be at home, rather than in the hospital and so i'll ask the question So what do patients actually want.
- 00:44:04So i'll put that forward here, so what attribute to patients rank is the most important at the end of life, if you kind of had to add to theorize.
- 00:44:28Alright, so it looks like most people thought maintaining dignity some said, free of pain some said presence of family so congratulations to that 3% that just kicked in should be highest rated on this particular study.
- 00:44:41was to be kept clean, so I do want to just kind of give a caveat that the study, if we look at the study design, this was done by Karen steinhauser.

- 00:44:50Who was one of my fellowship directors at Duke and what she did was she basically took a number of items 44 separate items and had people rank them as it either very important all the way down to not important at all on a.
- 00:45:03scale to later condensed it down to a three point scale either agree disagree or somewhere in between, and then she looked at those and saw where we saw a disagreement so.
- 00:45:13Our agreement or disagreement, so it is true that, for example, while I'm sitting here if you ask me, as an important for me to be here at uva are sitting at home drinking a beer.
- 00:45:22I probably would rate sitting at home drinking a beer is pretty high, but I would probably say being kept clean or free of pain is more important so.
- 00:45:30Study doesn't necessarily say where do you want to die just says what's important so as we look at this the items were divided into three groups where there was strong agreement.
- 00:45:39With all participants so that would be patient's family health care providers both physicians or non physician versus strong support by patients but less with physicians and items with broad variation.
- 00:45:53So what people felt was had they had strong agreement on was symptom issues preparation for end of life, achieving completion and having good relationships with healthcare providers so having good relationships with their team.
- 00:46:06was something that people really wanted to make sure they had at the end of life there were other ones that had broad sort of variation and included in that was the use of available treatments and dying at home.
- 00:46:18So I don't, I hope, people can see this, but basically i've put three kind of things that I thought were interesting so one is.
- 00:46:25The idea of using all available treatments, no matter what the chance of recovery, you can see, there was a fair amount of.
- 00:46:31discrepancy so patients are over here on the left side, where they about 50% of them felt they should they would want that that was important.
- 00:46:39Numbers a little bit less so, but health care providers clearly didn't feel like that was something that was really important at the end of life.
- 00:46:46there's a little bit surprising in terms of not being connected to these in the sense that many patients wanted that health care providers were a little bit less interested in that bad about 50%.
- 00:46:57With a large degree of ambivalence I was a little bit surprised about that, but if we look at home, you can see dying at home about 35% for patients, so not as high or not as high of importance on their scale.
- 00:47:09But a bit higher for health care provider, so I think it's a bit it matters a bit more to us than it does to families.
- 00:47:17If we look at the trends of where that's occurring, and this is a New England journal medicine New England Journal of medicine article for 2019.
- 00:47:25What we see is that more patients actually are dying at home we're really only seen somewhere around 25 to 30% with a large percentage of patients dying in the hospital.
- 00:47:36If we look across all the studies that we look at a systematic review, you can see that about half of patients want to die at home, but I think there are some important caveats to this.

- 00:47:45And i'll talk about the New York Times article that came out just last month that many of you all may have seen, I think one of the important pieces of this is that many of the patients who died in the hospital.
- 00:47:55Many of them were happy with the care that they received at for patients that are at home as death gets closer many of the families that reported.
- 00:48:03That they actually would have preferred to be at a facility, not necessarily the hospital.
- 00:48:08And so it's something to think about in terms of the resources that patients have that if they're at home, they may not have the resources that they need.
- 00:48:15To provide adequate care and that a facility actually might be a little bit of a better option, even though patients want to pass away at home.
- 00:48:24So this was a study that I did it looked at at vitas hospice of ethos is the nation's largest hospice provider, it is a private for profit entity.
- 00:48:34But it does have care facilities across the United States and what I found basically was looking at this, so for patients that went home.
- 00:48:42But ultimately required transfer out to a higher level facility what we found was the income was a predictor.
- 00:48:49Of the need for transfer out, but that the availability of something called continuous care, which is a higher level of care through hospice help to mitigate that effect.
- 00:48:58So what we see is that it probably is a level of resource utilization or need for resources that allows patients to stay at home.
- 00:49:07And the New York Times article that I had alluded to came out just last month.
- 00:49:13And so, in that article, they talked about with several families that need to acknowledge that there are needs caregiving needs that patients have at home that may prevent them from getting home.
- 00:49:23So, while a large percentage of our patients want to leave the hospital, one of the things that limits them is the fear of not having enough resources and there's really a call for increased financial support for dying patients.
- 00:49:35I do want to comment we're going to talk a bit about gap, the gap benefit you remember that's the general Inpatient benefit.
- 00:49:42I think one of the things when I talk to RON contrail of hospice and the Piedmont is the CEO of their company and other hospice providers, they are concerned.
- 00:49:50about the current status of Medicare and the fact that Medicare is increasingly auditing gap.
- 00:49:56And in fact ITO binoche is the CEO and director of the national hospice and palliative care organization and he specifically side of the idea of Medicare audits for decreased use of respite care continuous care and gap level care.
- 00:50:12So what does the Medicare hospice benefit like took this picture from a New Jersey hospice so I guess their conception of hospice is a fairly healthy looking guy.
- 00:50:24A good time.
- 00:50:27So hospice is it was enacted as a Medicare benefit 1982 there was a cost cutting benefit and I'll talk about some of the provisions of that from a cost perspective.
- 00:50:36It is a comprehensive care organization that is designed to provide good quality care at the end of life, it treats both patients and families.

- 00:50:45it treats patients and families before the patient dies, and then it has an A bereavement benefit, it does not seek to hasten the end of life it's simply allows them to have comfort in the place of their choosing and, as I mentioned, includes the whole family.
- 00:51:01So hospices generally for most people will be covered by their Medicare Part A, if they're if they qualify for Medicare Part A.
- 00:51:08But private insurance covers it most, but not all Medicaid VA benefits cover it as well, and the indigent care is generally provided free of charge by hospices, not all of them and then obviously anybody could pay cash as well.
- 00:51:23What are the services that are provided so I've put up here arrows next to the provider services that are required under the Medicare hospice benefit.
- 00:51:32So all hospices, have a medical director that oversees the care so if you're taking care of a patient and you need assistance, I mean, obviously.
- 00:51:40myself and my team are happy to help with that, but there is a medical director who is overseeing the care of every one of the hospice patients who can help out.
- 00:51:48There is a nurse case manager that has to see that is seeing every patient and seeing them on a regular basis.
- 00:51:55There is a social worker that does psychosocial support, as well as resource management and is required, they have counseling services in the form of bereavement support dietary support and spiritual support.
- 00:52:08In addition to that they also have a requirement that 5% of the care time that is provided for patients, has to be provided by volunteers.
- 00:52:18hospice works under the idea of that when they're you're admitted to hospice there's a there is a end of life diagnosis.
- 00:52:25medicare would like it to be then anything that you think about that is causing that patient to pass away in six months would be included under that end of life diagnosis.
- 00:52:35And so once that's once that is defined during the patient's enrollment process the hospice is responsible for all medical care.
- 00:52:42That is provided for that and the patient is agreeing that hospice is their provider for that diagnosis, so if you admit somebody with lung cancer.
- 00:52:50The hospice is responsible for providing all the medications related to their lung cancer.
- 00:52:55they're provided any medical equipment that they need any resources any labs or any imaging and we'll talk a bit about the funding of hospice and why that really plays into the roles of what hospice can and can't provide.
- 00:53:08So what do I talk about patients, what do I talk when I talk to patients, what do I tell them about hospice.
- 00:53:14But I tell them that number one the hospice workers are required to come in at least one out of every 14 days so some families say hey you know I.
- 00:53:21I don't want people coming into my house well hospice person has to check on them at least once every 14 days.
- 00:53:27The vast majority of patients will be seeing more frequently than that I usually would say a guidance will be maybe once every two days to three days somebody from hospice will be coming into their.
- 00:53:36house to check on them that level of services and the frequency of visits going to change based upon.

- 00:53:43How how acute the patient is and how sick, they are and what their care needs are.
- 00:53:48I do tell patients that that I do want to make sure this is the case, because we talked about the idea of a nurse will come out to the House.
- 00:53:55So I do tell patients that there is not somebody there 24 hours a day example I usually give is if a patient has a bowel movement in the middle of the night, the hospice worker is not going to come out and clean that up.
- 00:54:05they're going to need to be able to do those things now there is a nursing assistant, who will help with bathing.
- 00:54:10and other things like that, but the family is going to be one of the main units of caregivers under the hospice services.
- 00:54:16The hospice is available 24 seven that's usually going to be a phone call initially.
- 00:54:21And it may take an hour for them to call back so it's hospice is not 911 so the hospice can come out if need be, but it may take several hours before they get out there, usually what they would do is provide.
- 00:54:34guidance on the phone to the patient and do a lot of anticipatory guidance, when we look at models of care there's home based primary care.
- 00:54:43And hospice care yeah it really functions really on the idea of proactive management so hospice when a patient roles in hospice they're generally going to have a symptom management kit.
- 00:54:53And so they're going to be seen patients are going to look at them longitudinally they're going to see progression of care and they're going to hope to try to act in a proactive manner.
- 00:55:03So we talked a bit about the idea of levels of care, and this is a fairly important piece, so I just need to focus in on this.
- 00:55:09So there are four levels of care and I kind of liken this to when we think about patients coming into the hospital.
- 00:55:15A patient might be admitted to the floor, it might get a bit into an intermediate care unit they might get moved up or it might be on telemetry.
- 00:55:21It might get the icu there's different levels of care to just because you were qualified for Inpatient care doesn't mean that you qualify for icu level of care.
- 00:55:31same is true with hospice you get admitted to routine care there's general Inpatient or gap there's respite and continuous care.
- 00:55:38nationally, this is the trends for hospice So you can see that, like 98% of the days on hospice are done at the routine level of care very little under gap is to just 1.2% little very even less under respite even less under continuous here.
- 00:55:56So what is gap hospice and what is what's the big deal about that so gap hospice is designed general and patient hospices, designed to dream.
- 00:56:04Huge symptom issues it's designed for short term to something on the order of days like maybe in the neighborhood of three to five days.
- 00:56:13it's designed for aggressive pain management sudden deterioration or symptom issues that require frequent evaluation and adjustment.
- 00:56:21It is not designed for, and this is specifically from Medicare, it is not designed for actively dying patients who don't meet that criteria.
- 00:56:30And it's not designed for a caregiver crisis, in which case the rest of benefit would be more appropriate.

- 00:56:35So an example of a patient that needs tip would be a patient that has been terminally activated.
- 00:56:40Another example would be somebody who is to where you would go see the patient, you make an adjustment with their medications you go back and see them again make another adjustment you're adjusting their medications throughout the day.
- 00:56:52Those be good examples of kind of gap type patients or patients that need frequent reevaluation assessment, ultimately, it is the hospice agency that makes the decision as to whether the patient needs gap criteria it does.
- 00:57:05I do want to say that if you feel like there's a patient that you feel like does meet that criteria.
- 00:57:11And you feel like the hospice is saying no please let us know from the palliative care team, because we frequently talk with them, we do peer to peer evaluations, we talked with them, and so I think that there for many patients, we can advocate for that.
- 00:57:26I mentioned the issue of hospice care and scrutiny of gap and respite days, so the top is actually a quote from a health and human services document.
- 00:57:36which they said cms staff have expressed concerns about the possible misuse of gap, such as care being billed for it, but not provided long ways to stay and beneficiaries receiving care unnecessarily.
- 00:57:47So when I talked with the medical directors of hospice they actually are pretty concerned about this, you can see the trends nationally over the course of time, where the percentage of gap days is actually trending down.
- 00:58:01respite care for those who have patients in the outpatient setting.
- 00:58:05respite care is something that can be done to provide respite for families, the patient is admitted to a facility, the hospice pays for the facility costs, this is up to five days generally.
- 00:58:15And then the patient goes back to the family's home once that period is over, so this is actually a really great benefit and one that's used very infrequently.
- 00:58:27Continuous care is sort of the least profitable thing so i'll just spend very little time on this, but basically it allows for very aggressive care.
- 00:58:35Within the patient's home for a brief period of time, it does require that the hospice has providers in the home for at least eight hours in a 24 hour period.
- 00:58:44and very few times do we ever do this here in Charlottesville so if it's something that you're thinking about you can let me know or talk to the hospice Agency but it's pretty rare.
- 00:58:55Alright, this is actually, I think, a very important slide, so I do want to just if.
- 00:59:00It just to bring everybody's attention to, because I think it explains a lot about how hospice is reimbursed and how they.
- 00:59:07Think about their services so for patients admitted to routine homecare the hospice is provided a a capitated payment and it's a daily payment that they receive, they may not see the patient in that day, they may see the patient for 24 hours and that day.
- 00:59:23I take so if it's 24 hours they would probably qualify for continuous care, but but they could see the patient and do very intensive work versus not.
- 00:59:31And should still get billed about the same so for the first 60 days they get they reimburse at $203 a day because longer length of stay or are associated with less cost.
- 00:59:44After 60 days they get a reduced rate for respite care they get a rate of about 473 and they generally would go to a contract facility.

- 00:59:52For your VIP care for the paint when we do conversions the hospice is receiving about $1,000 a day and the vast majority of that gets sent over to uva to help cover the cost of care so hospice recoups a very small amount of the cost for gap care.
- 01:00:10For hospice has two caps and these were designed as cost saving measures, so the average cost of a patient for hospice.
- 01:00:18And not exceed for 2022 cannot exceed $31,297 per patient if the hospice exceeds that amount of money per patient, they have to give that money back to Medicare.
- 01:00:31In addition to that there's an Inpatient caps of the total Inpatient days for gap or respite for a hospice cannot exceed 20% and if it does exceed 20% the hospice does not get the higher level of Inpatient benefit, rather they get reimbursed at the routine care so they lose that money.
- 01:00:51So people often asked, could we just have a uva and patient hospice the answer to that would be not based on that Medicare criteria.
- 01:01:00So where are the requirements we talked a bit about this, so you have to have a prognosis of less than or six months if the disease falls its usual course.
- 01:01:08need to have a hospice diagnosis you'd have agreement on the focus being palliative goals of care.
- 01:01:15And so I want to talk a little bit about the admitting diagnosis so many parent got rid of the ability to use what's called failure to thrive.
- 01:01:23or disability unspecified so you have to name a specific diagnosis and then the patient agrees that that is the hospice will be the provider for that diagnosis and the patient also our excuse me in the hospice agrees to cover the costs associated with that treatment.
- 01:01:40So who receives hospice care we see what we see is that it is a pretty much.
- 01:01:45A Caucasian person benefit, we do not actually see that hospices, provide a lot of services to minority patients, and you can see, this is national hospice data from.
- 01:01:59And so for many different reasons there's not anywhere near the amount of uptake of hospice services in minority communities.
- 01:02:10When we talk about the idea of disease trajectories and I understand that there are there are problems with the use of these models.
- 01:02:17But, in general, I think it could help to identify why people use hospice services, so we look at cancer, which is the sort of Orange line at the top.
- 01:02:25What we see is that generally patients with cancer solid org and malignancies develop a.
- 01:02:31burden of disease and when they get to a certain point they're oftentimes did inflection on their functional status.
- 01:02:37And what we see is that there's a rapid decline and this often allows more predictability in terms of getting patients to hospice.
- 01:02:44When you compare it to an end, organ dysfunction like end stage heart failure and stage respiratory disease, a lot of times these patients are coming in, we do a lot of great work and getting them.
- 01:02:54buffed back up and then back out sort of very close to where they were before.
- 01:02:58And it makes it much harder for us to know if we're in sort of the first decline or the 20th decline or later on, that makes it harder to predict when they may go to hospice.
- 01:03:08In contrast, patients with frailty or dementia oftentimes may just sort of potter along for a long period of time using minimal resources, then ultimately pass away.

- 01:03:18So when we look at hospice diagnoses a few uses hospice we do see that that hospice is largely a cancer cancer diagnosis type of service, but we do see increasing usage dementia has an increased use of hospice and some of that is driven by for profit hospice agencies.
- 01:03:39We look at length of stay for hospices, and you think about kind of the the rate of reimbursement on the far right, we see all patients, you can see that.
- 01:03:48The kind of Gray bar, there is the medium length of stay so most hospice patients are staying on hospice really for only about 15 days, so the hospice is really.
- 01:04:00Providing a lot of services, if you think about the average patient going home hospice is putting a bed in their bedside commode oxygen they're sending out a nurse a social worker cna support.
- 01:04:12A chaplain and they're all doing intake work and the patient, then passes away after about 10 days most hospices, would say that they need about five days in order to recoup their initial cost and the patient.
- 01:04:24When we look at this we do see that for dementia and Parkinson's disease those patients do have a much longer length of stay and as we've seen the increase rise in for profit hospices, we do see.
- 01:04:35Increased enrollment of dementia patients, which are generally sort of lower demanding patients with longer lengths of stay.
- 01:04:44alright.
- 01:04:45So another question so you're seeing a patient with metastatic lung cancer, which is still rolling hospice patients been receiving dialysis for 10 years, which has preceded his diagnosis of cancer, he says, Dr will they give up on maybe give up my dialysis.
- 01:05:04I don't see the results.

Unknown Speaker

01:05:26yeah

UVA Chiefs

01:05:28Well, I apologize, I thank you for participating on that so let me just go to the answer here.

- 01:05:36So one of the main issues that we have for interventions.
- 01:05:41That the reimbursement for hospice is limited right so hospices, have decreased ability to pay for more expensive.
- 01:05:48treatments in dialysis is one of them, we think about the hospice diagnosis, sometimes we are able to go and separate it out, so if the patient has.
- 01:05:56lung cancer as their hospice diagnosis, sometimes they're able to go and have end stage renal disease separate and that would just be covered by Medicare, but that is not always the case, and so it's useful to talk to the hospice medical director.
- 01:06:10i'm going to use the use of transfusions as a little bit of a surrogate to help to understand this, so when we look at patients with leukemia especially transfusion dependent leukemias.

- 01:06:22About half of hospice was would say they would not cover any transfusions at all.
- 01:06:28And about another quarter of those would say it's only on a limited basis, and so, when we look at the use of transfusions and hospice we see that when compared to solid tumors or patients that are not transfusion dependent.
- 01:06:40The hospice use and length of stay for patients with.
- 01:06:43Who are transfusion dependent is much less the thought would be that this is because the hospice is limiting that and that the issue is, is that the hospice is just not able to provide for the cost of that.
- 01:06:54So, to try to help to adjust for that there are a number of different models and i'll talk about them here.
- 01:07:00So one is the Medicare care choices model, so this was something that came out in the last few years and it's a model that allows.
- 01:07:06Patients to stay on hospice did provide services from a nurse social worker chaplain and volunteer support but medications were covered by patients Medicare part D dmv was covered by the.
- 01:07:21team Medicare and then the respite care was only provided within the patient's home, and so the hospice got paid Substantially Less money was just a monthly fee.
- 01:07:32Of the hundred and 41 hospices, that involved in this model, none of them are here in Charlottesville so it's not something that we have the ability to really look at and a number of them ultimately.
- 01:07:44bailed on this, however, for the hospices, that did continue, there was a substantial cost savings and it was also much more likely that those patients would ultimately enroll in hospice.
- 01:07:54So this may be a a model that we see as time moves on, where patients could take advantage of some of the benefits of hospice but not have the restriction in terms of the care that they provide, so they could get some benefits of hospice but, for example, still get chemotherapy.
- 01:08:11One service that we do have here in Charlottesville is home base palliative care so hospice the Piedmont.
- 01:08:17And hospice of the Shenandoah which is Augusta health both operate a home based palliative care.
- 01:08:23it's primarily a nurse practitioners that have been service that patients are generally speed seen.
- 01:08:28About once a month they're seeing in their home setting they can be seen in a skilled nursing facility as long as a skilled nursing facility.
- 01:08:35allows the hospice agency to be to see the patients and they do take on the role of medication prescribing so that is an option as well, so this is a really good service it's.
- 01:08:46hospice the pea pod is expanding this up into call pepper So if you have patients that are in Culpeper Augusta county Albemarle Charlottesville, this is a great resource for them.
- 01:08:58So what is a typical hospice agency, when we think about what are the ones around here so typically they have a median census of about 32 patients or a average of about 67 patients.
- 01:09:10The one I have on this slide is a bit misleading so hospice of the Piedmont told me they have about 300 patients total but that includes their entire catchment area, which includes called pepper Charlottesville Albemarle and Augusta county.

- 01:09:23legacy says that in their Charlottesville office they have about 70 patients but legacy actually includes the entire state as well.
- 01:09:30So, from a statewide perspective, they have about 300 patients, so that kind of gives you an idea about when they're each of those patients is giving about $200 a day that kind of gives their pool of money for all care.
- 01:09:42And again, noting that, when I was a fellow quite some time ago, the majority of hospices, were not for profit.
- 01:09:49Whereas now about 70% are for profit agencies in general, the service menu is basically the same between for profit nonprofit agencies, because it's dictated by.
- 01:09:59medicare requirements, the main difference is sort of patients selection so hospice of the Piedmont is a bit more willing to take on indigent patient or other patients like that that have.
- 01:10:09additional services where for profit agencies are more based out of skilled facilities were a nurse could go in see 10 patients in that facility and therefore maximize his or her time.
- 01:10:22Alright last I think this was going to work here so, is it require the patient sign a durable dnr.
- 01:10:41Alright, so about a third for all of them.
- 01:10:45So for hot for the hospice benefit itself for the Medicare hospice benefit, you cannot require that a patient be dnr dni.
- 01:10:54However, there are benefits that we do get sometimes give to patients that are outside of the Medicare hospice benefit.
- 01:11:00So, for example, the cake unit, the hospice house or uva conversions are outside of the benefit, and therefore we do have requirements for patients that they have to meet certain criteria, but they are just signing on to hospice, it is not required.
- 01:11:16And so, so, in fact, about 13% of the hospice admissions or full code those patients are more likely to revoke hospice.
- 01:11:24I will tell you that it makes no sense to me for a patient to go on hospice and be full code, but I have admitted many patients to hospice as full code patients.
- 01:11:34Usually, what happens is that the hospice nurse and the social worker continue to talk with them and eventually the patient makes that transition, but it is not an absolute requirement.
- 01:11:47So what about Inpatient hospice so it can be provided a number of different venues Jen, it is not covered by.
- 01:11:55routine hospice care so under gap or respite that room and board is covered for the duration of those therapies.
- 01:12:02But under routine hospice, it is not provided there's generally a room and board fee that is usually around $250 a day, but it can be.
- 01:12:11done on a sliding scale for those wondering a patient cannot use both the hospice benefit and their skilled care of benefit, at the same time Medicare does not allow that.
- 01:12:22which has given rise to the idea of this what's called skilled palliative, which means that the patient goes to the a skilled Facility under their skilled care of benefit with a palliative focus that does preclude their ability to access hospice simultaneously with that benefit.
- 01:12:39All right, this is the hospice house, which is a beautiful facility.

- 01:12:44I I would encourage you guys, as you drive by just to take a look at it's really nice, the only thing I'll put as a little bit of a star for this facility.
- 01:12:51Is that they do not have nursing care there anymore they've removed their nurses it's just MED techs at this point so if a nurse needed to see a patient in the hospice house.
- 01:13:01The hospice nurse would come in from the field, but this is a very nice facility, this is the cake unit so it's out of the transitional care hospital this.
- 01:13:12The upper right picture, there was their family room, which was shut down during coven and they're looking to reopen that, but the patient care rooms are really nice, and this is the Shenandoah House which is out at on the campus of Augusta medical Center.
- 01:13:28So the hospice house is generally a short, excuse me a longer term facility it's an eight bed unit it's for lower acuity patients.
- 01:13:37The hospice unit, the cake unit, the Center is a shorter stay unit higher acuity gap type patients and then the Shenandoah house is generally for gap type patients.
- 01:13:49So what about hospice at uva so I'm kind of round out my presentation with a discussion of hospice conversions.
- 01:13:58So as a part of Medicare conditions of participations in order condition of participation in order for us to have.
- 01:14:05Patients in here in the hospital, they have to meet gap criteria, these are patients that are discharged.
- 01:14:13From their usual Bennett hospital benefit and then readmitted under hospice care under gap care.
- 01:14:20I will tell you that I think that if I was a family member, I would prefer to be out at the at the cake unit, the reason being is it's quieter it's a nicer place.
- 01:14:28Patients are not being pushed to ultimately leave.
- 01:14:32If they no longer have God if they're no longer qualify for gap care, so I think if we can get patients to the cake unit that will be better.
- 01:14:39But primarily for patients that are too unstable and transfer the conversions are are a good option.
- 01:14:45It is limited to those agencies that we have contracts with that's hospice the Piedmont legacy and a medicine legacy has come on recently and has been doing a great job and hospice sippy has liaisons here as well.
- 01:14:58i'm often asked like what are the benefits, why would we want to do this, and so I think there are three so one is is that this allows for patients to stay here it relieves a lot of the pressure to look to see if we can discharge the patient.
- 01:15:10So it's a benefit for the family, especially for patients that have had a rapid decline and are too unstable for transfer.
- 01:15:17The other benefit that I often talk about is that if a patient ultimately survives.
- 01:15:23And we're looking to transfer them this provides a very nice option for continuity of care and the final one is is the bereavement services, and so I did contact, or we did discuss with hospice of the Piedmont what their overall use of the bereavement services has been an.
- 01:15:42Patients received some degree of support from hospice to Piedmont, so this is a benefit that is used for patients that don't qualify for hospice Michelle Nice in our social worker has been contacting them to help out with bereavement support.

- 01:16:00When we look at this particular study to see who accesses bereavement support what we see is that for patients with very short length of stays.
- 01:16:08The family actually has a higher number of counseling sessions used, and so, for those patients where there's a very rapid decline, this is a real issue for a family, the bereavement support services can actually be very good.
- 01:16:22So last slide my final recommendation so hospice provides really a comprehensive approach I think it's a really good or a good.
- 01:16:31resource, especially for home hospice it helps to prevent patients from needing to come back to the hospital and provides a lot of resources.
- 01:16:39There are limitations that we oftentimes are able to work with those limitations, either through discussions of goals of care and looking at other resources that the patients, make it.
- 01:16:48And so you know we're happy to get any consultation help or consultation requests 1539 we're happy to just answer questions or do a console but just you know calling earlier oftentimes gives us a bit more options so with that oh.
- 01:17:05it's really questions.
- 01:17:13i'll start up I'm.
- 01:17:16Using the over the called the respite care pathway, often in our hospital.
- 01:17:23We don't have a contract with any of our agencies that do for respite care here.
- 01:17:30Is that something that you know say we good consultant to evaluate efficient emergency department, who did roll the office and represented the ED.
- 01:17:39there's an acute medical sounds like it's mostly the patient just needs respite care that we not admitted to the hospital, but other locations in the area that we can refer them to or because I feel like that's not something I was aware would potentially be an option for patients.
- 01:17:57yeah usually patients that are presenting a year into some issue, but it could be a caregiver crisis there.
- 01:18:03Were there was a crisis in the home and the caregiver was suddenly gone so the question pertains to respite care and can we use that so patients already access hospice.
- 01:18:13Then, then by all means definitely ask the question, it will be up to the hospice agency to be able to facilitate arrange that.
- 01:18:22For some patients the question would come in as if they're not on hospice could we admit them directly to respite care.
- 01:18:29And so I would say that, in general, Medicare sort of frowns upon that idea of kind of admitting somebody directly to respite care.
- 01:18:35However, there are a number of hospice agencies that are willing to do that.
- 01:18:40And I have done some patients before So if you have a patient where you're like you know boy the family just needs like five days to kind of get their stuff together.
- 01:18:49And a lot of times, if you talk with the hospice agency, they might might be willing to do a directed mission.
- 01:18:57The other option would be so you know hospice is a pretty much kind of ideal setup for this right, because they have a they have two facilities and so oftentimes those patients can go directly there.
- 01:19:07But if you have a patient where you're the you know the attendees on them you're the primary care doctor and you're noticing that this is an issue.

- 01:19:14It would be good to talk with the hospice agency and say hey can we get this family and the respite care are seeing a patient into respite care, let the family kind of decompress and then send them back home.
- 01:19:25yeah I'm.
- 01:19:27struck by that I needed there it is 30 degree of disparity and legalization of hospice care is there and associated trend and coincidences and the white.
- 01:19:40circles, but in fact just that, or is it.
- 01:19:45Like more includes trying i'm kind of comfort care models.
- 01:19:54yeah I mean that's a really big discussion, and I think it's really one that's worthy of a lot of investigation, so one of the main people that is looking into this is.
- 01:20:04Kimberly Johnson who's at Duke who was actually my research mentor and so I've talked with her quite a bit and she's published a ton on this particular.
- 01:20:13think that there's a there, she has actually really parse the data out quite well and I had looked at some of her data I think a lot of it has to do with.
- 01:20:22With the perception of sort of what does what does hospice look like and what is care look like.
- 01:20:27I think one of the things that we talked about, or one things that she had talked a lot about is the idea of disparities that have existed throughout.
- 01:20:34for hundreds of years and especially for those patients, were they were unable to access care for so long and that they're finally at the end of life and they're finally in a hospital and getting care.
- 01:20:44And so, would they really want to go and continue or would they want to not get care now or have different focuses of care.
- 01:20:51She had looked at kind of what resources were available and found that when patients have high access to resources.
- 01:21:00That it actually their their perceptions of hospice for actually much better.
- 01:21:05I think that that some of the data that I had looked at also looked at whether income was a predictor and so for patients with lower levels of income or patients that lived in an area with a much higher area deprivation index were much less likely to be favorable towards hospice.
- 01:21:23But I think it's a it's a very big issue that we face, and I think it's one that from a national academies standpoint, a lot of work is going into.
- 01:21:32But it is an area where there are wide disparities, and so I think a lot of it has to do with the fact that for patients who are affluent or otherwise.
- 01:21:42and have gotten care their entire throughout their gotten good care throughout their lives that there they then are much more receptive to hospice and, but I do think it's an area that we really need to work on.
- 01:21:55question.
- 01:21:58Okay, one right here so having you out so.
- 01:22:04fast, efficient versus in the hospital meeting gap criteria traveling exhibition of eternal activation of patients and.
- 01:22:14For people who are going to be terminally activated for like brain damage or other reasons, you might be candidate for like donor.

- 01:22:24To be donors are they still able to enroll and hospice at least those benefits or not so that's a huge question and I'll answer it as succinctly as possible, right now, while they're still being evaluated for transplantation we do.
- 01:22:41enroll them in hospice but if they do not meet criteria so, for example, if they did they were in line for a donation after cardiac death and they do not pass away quickly enough.
- 01:22:51We then oftentimes can enroll them afterwards, but it is an issue because many times afterwards they don't meet.
- 01:22:59gop criteria, so it is something for us to think about beforehand, I think it's worth talking about, but as of right now, we do not enrolled in the hospice before we do the excavation and if they are a donation after cardiac death.
- 01:23:14Is fish and.
- 01:23:18chips.
- 01:23:21Yes, no.
- 01:23:23Questions deductible hospice offer quote unquote transitions service for patients and families to hospice services prior to 4 million.
- 01:23:34So so transition the transitions program is actually a trademark name but it's kind of one of those things were telling clean X.
- 01:23:42So I'll just use it, the transitions program historically has been that that a volunteer from the hospice agency goes out and sees patients.
- 01:23:51On a on a regular basis, so if a patient That said, you know I don't really want hospice but I'd be willing to accept somebody coming out to my house periodically to check on me, so that when I then decline, they would directly rather than.
- 01:24:04That is available through some agencies, so, for example, legacy hasn't been.
- 01:24:10filled out of it.
- 01:24:12For some of them for many of those agencies it's just a volunteer coming out, and so it doesn't have a huge benefit to the patient for some it's a nurse it's going out and just periodically checking on them so some of the Agency is still do that yes.
- 01:24:27Second question, it seems there are some circumstances hospice skilled nursing facility Can you clarify the be an option at are probably with consultations available.
- 01:24:41So hospices generally can go into scale up facilities, without any trouble the issue when I talked to.
- 01:24:48For example, RON control from hospice one of the issues that they face is that the skilled facility from a financial standpoint would much rather have the patient under skilled palliative.
- 01:24:59Then a patient who's just a long term care patient and their facility and so actually they what hospice of the p talked about us it for some of the facilities they've had difficulty getting in.
- 01:25:10But in general a patient who was at a skilled Facility under long term care could have hospice without any difficulty and I do know that many of the hospice agencies that we have are.
- 01:25:21Seeing patients and taking care of patients in a scale up facility in general, it means that the patient would have to pay room and board unless they had something like Medicare long term care insurance.
- 01:25:32So, but in general they could be seen.
- 01:25:35And then the second question, I think, was it was there a way for them to be seen, so one way would be through the home based palliative care Program.

- 01:25:42The home base palliative care team can go out and see those patients and then the question was is could there be consultations and the answer to that is yes.
- 01:25:50So, for example, one of them very strong things that we do quite a bit is that Patrick Morocco, who is the medical director.
- 01:25:58Of hospice the Shenandoah is that his group actually is the medical director of a number of skilled facilities.
- 01:26:03And the Augusta area, and so they do palliative consultations for many of those facilities so if you're looking at discharging a patient to that area then it's worth kind of investigating as to whether or not the.
- 01:26:17Augusta home health and palliative could go out and see that patient as a console from a palliative perspective if they're not going to be involved in hospice.
- 01:26:30tech stack is a these workers able to administer palliative medications but a nurse President, so how does little a gallon.
- 01:26:38it's my understand that they could administer the routine medications but if there was a situation where the patient was worse we're having escalating symptoms that nurse would have to come in.
- 01:26:50And then, Dr P address the concerns that hospice the eth is designed to save money.
- 01:26:59So I think that one of the things to look out with when we think about the conversions, and this has been a question that's come up.
- 01:27:05is, I think that for every patient that we see where we're thinking about a conversion, the question has to be is does this provide value added, so I think that for many of the times, where we're talking about.
- 01:27:15I think the classic example that I would refer to as there's a family that's coming in the family says, I want to i'd like to go and.
- 01:27:22activate my loved one, I want to do it now and that way there's just not time to bring somebody in, and I would say, doing a conversion is not value added.
- 01:27:31So I think every time we see a patient we think about doing a conversion, the question that first should be as does this add value to my patients care.
- 01:27:39And I would encourage people to say you know what are the benefits that we might see so some of these patients may not survive to leave the hospital.
- 01:27:46But some of them, but there may be some benefit to the family, especially if they've had a rapid decline.
- 01:27:51In terms of bereavement support, so I think one of the key things is looking this does this provide.
- 01:27:56An overall benefit the other piece of it is, is that we may not necessarily do the conversion, but a patient may live a longer period of time, and we might be looking at a transfer to the cake unit.
- 01:28:06Or we might look into other areas, so I think oftentimes having the discussion, especially if we have the discussion earlier on, may be helpful.
- 01:28:13So it is true that there is a benefit to us in the sense that once that patient is discharged to hospice we do for some, but not all metrics do get a reprieve, but I think that the key question has to be you know, is there, value added for doing that conversion.

- 01:28:34Nice, yes, see either the you know kind of best practices for us when we think about discharging our patients and during the index hospitalization maybe where they enroll in hospice and trying to.
- 01:28:47You know understanding that inevitably some patients will come back, but to try to reduce the frequency with which patients kind of bounce back to the hospital.
- 01:28:57Having hospice involved really helps to reduce the frequency with which people come back I think that's one of the key pieces because they really are designed to help to provide the services.
- 01:29:07that people need and escalate if they need to, so I think that's one of the key pieces, I think, addressing code status, obviously, is a key piece I think preemptive counseling so that people know what to expect.
- 01:29:18When they're going out with hospice anticipatory medication use, I think that they have the medications that they need.
- 01:29:24can also be helpful, and I think that, then when people come back looking at what our resources that we can use and engaging the hospice to see are there ways that we might be able to either prevent the admission or get them admitted under their tip.
- 01:29:46Thank you guys so much for your time.
- 01:30:10thanks for having us.