The Medicare Hospice Benefit
Helping People With Advanced Illness and Their Families Have More Care, Better Quality of Life, and Less Stress

Medicare Rights Program Volunteers
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Background on the Hospice Benefit

• Created by Congress in 1982
• The Hospice Benefit resides in Medicare - Part A
• For people who have an advanced illness, are terminally ill with the likelihood of having less than 6 months to live
• Provides comprehensive, all-inclusive services, managed by Certified Hospices and an interdisciplinary team, 24 hours, 7 days a week
• Help individuals spend their last 6 or more months of their life in the comfort of their homes

Background on Hospice

• Hospice can be explained as the best set of benefits for someone with an “advanced illness”
• The benefits are comprehensive, continuous and can be longer term
• Someone may be on hospice for a year or longer as long as they are declining
Background on Hospice

• To be eligible for Hospice, the patient would have to have completed/or decided to forgo curative courses of treatment and choose "palliative care"
• Most chronic/serious illnesses have an advanced stage (as determined by clinical indicators) where Hospice is the most appropriate care option
• A Do Not Resuscitate Order is not required
• A Hospice patient can resume curative, heroic or more aggressive/active treatment of their illness by "revoking" from Hospice at any time. They can resume hospice at another time

Disease Trajectories Towards End-stage

Functional Decline for Cancer; Organ Failure; Dementia

Provided in Variety of Settings

• Home
• Hospitals (Patients who require intensive symptom management or actively dying)
• Skilled Nursing Facilities (if long term care resident)
• Assisted Living Facilities
• Group homes
Coverage

- Hospice services are covered 100% by Medicare, generally with no co-pays or deductibles
- May not use if on the Skilled Nursing Facility Rehab Benefit
- Hospice is a “carve out” for Medicare Advantage Plans. The Hospice is covered under general Medicare, with the patient using the Medicare Advantage Plan for unrelated medical needs
- There are 2 “90 day benefit periods”, and unlimited 60 day benefit periods. At the beginning of each benefit period a physician (or the Hospice Medical Director) must certify and write a narrative that the patient is still declining with a likely 6 months prognosis (at that point).

Discharge from Hospice

- Research has shown that people can get better (their prognosis improves) on Hospice – examples: dementia, cardiac disease and lung cancer
- Patients that improve may be “decertified”
- Patients may return to Hospice at a later time if they decline again.
- They come onto their next benefit period

Palliative Care

- Palliative Care is expert and intensive management of symptoms (such as but not limited to pain or respiratory distress) for optimal quality of life
- Palliative care addresses the physical, emotional, spiritual, psycho-social needs of the patient and their family
- Hospice Palliative Care must be provided through an interdisciplinary team including a Physician/Medical Director, Nurses, Home Health Aides, Social Workers, Chaplain, Nutritionist, Bereavement Counselors, and Volunteers
- The patient's primary physician stays involved, the hospice physician covers symptom management as requested
- Hospices have policies about what palliative treatments they do or do not cover
What the Hospice Provides

- Interdisciplinary team services – MD, Nurses Aides, Social Workers, Chaplain, Nutritionist, Counselors, Volunteers
- Around the clock/7day a week availability of nurses and on-call medical staff to make home visits, adjust medications and address patient/family needs.
- Durable medical equipment (delivered without any red-tape) and supplies

What Hospice Provides

- Medications, available/delivered 24 hours/7days, to manage symptoms of the illness (comfort packs in home). No co-pays or deductibles. Hospices have formularies. Intravenous medications may or may not be covered.
- Lab Work
- Other palliative treatments (like radiation/transfusions) according to the hospice’s policies
4 Levels of Care

The patient may be off and on different levels of care as their needs change:
1. Routine Home Care – most common
2. Continuous Care – for intensive nursing needs/periods of crisis (usually 8 -12 hour shifts of RN or LPN)
3. Respite Care – 5 days in a facility to relieve the caregiver or if caregiver has a vacation
4. General Inpatient Care – For intensive symptom control; provided for short term.

Bereavement Follow-up

- Anticipatory grief-work
- Identifying high risk individuals
- Involvement for 13 months after the death
- Bereavement mailings
- Bereavement groups
- Bereavement counseling

Myths about Hospice

- That Hospice is a place
  Hospice goes where ever the patient is, mostly to their home
- That the concept of Hospice is depressing
  Hospice is about Living!!! Hospice does not focus on dying, unless the patient or family brings it up. Rather Hospice is about regaining control and wellbeing. The patient is relieved and more comfortable. Generally their mood lifts when they can air their concerns and fears.
Myths

• That hospice is only for the last phase—it means that death is near
  Not so, the people that benefit the most are those who come on Hospice early, when we can really focus on living with quality of life. Many people say they wished they had been referred to Hospice earlier. However at any stage hospice can be beneficial

• That hospice means giving up
  There is a time when treatment may no longer be beneficial, creating a hardship and prolonged suffering for the patient. Hospice can be a time of shifting gears in a positive sense. Hospice means taking control over the time one has and achieving ones goals and wishes. There is a lot that can be done with spending precious time with family members, reviewing life, and strengthening relationships

Hope Systems

• Hospice does not mean giving up hope. Hope can shift as things change
  Such as from hope for a cure, hope to go to a son’s graduation, to hope for excellent pain management, or hope for a peaceful death

• Hope that is not grounded in reality, as to what can realistically be accomplished, can lead to depression and anxiety

Personal Inventory

• What kind of treatment do I want – Is there a time when I would want to shift gears—how will I know when that time is

• What would I want to spend my time on if my life is limited;

• Is there something that would be left undone if I were to die today

• What legacy do I want to leave my family

• What are my wishes for when I am dying or what would be a “good death”
Family Inventory

- What can Hospice help the family accomplish – what is needed to manage
- How will care-giving be managed as things change- balancing the patient’s need for care, maintaining jobs, caring for children, managing the household? etc.
- How is communication in the family
- Are there relationships that need repairing

What will happen when the patient dies

When is the right time for Hospice

*It is important to raise the option of Hospice with the Physician*

- When the patient is going in and out of the hospital - and not getting better – several hospitalization in a year indicate likely shorter prognosis
- When the medications are not controlling symptoms as well
- When the burdens of treatment are greater than the benefits,
- When the disease continues to spread despite treatment
- When the medications/treatments lead to less improvement in quality of life
- Look realistically at the possible outcomes of the treatments
- Consider that “time bank” and how one wants to use it

*Request a Hospice Assessment to get more information – see if your loved one would be eligible in order to maximize your “Benefits”*