

**THE FUTURE IS NOW:
HOSPICE AND CONCURRENT CARE FOR
VETERANS**

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DISCLOSURES = NONE

CONCURRENT CARE

How do you feel about it?



**CHANGES TO ALLOW
PATIENTS MORE FLEXIBILITY**

**HOSPICE
AND PALLIATIVE
CARE PROVIDERS**

**CURRENT
MEDICARE
HOSPICE BENEFIT**

**NOT SURE IF CONCURRENT
CARE IS REALLY CONFUSING**

OR BEST THING EVER

YOU GET HOSPICE!

**AND YOU GET
LIFE-PROLONGING TREATMENTS!**

OBJECTIVES

- Define concurrent care and identify settings in which concurrent care is being offered.
- Learn how the Hospice Benefit for Veterans who receive care through the Veterans Health Administration differs from the Medicare Hospice benefit.
- Articulate strengths and challenges related to the provision of, and communication around, concurrent care.
- Identify potential strategies for making the most of concurrent care opportunities and avoiding common pitfalls.

WHAT IS CONCURRENT CARE?

“Concurrent curative care means receiving curative care to eradicate disease or normalize the underlying health condition, while simultaneously receiving hospice care for physical symptoms and psychosocial needs at end of life”

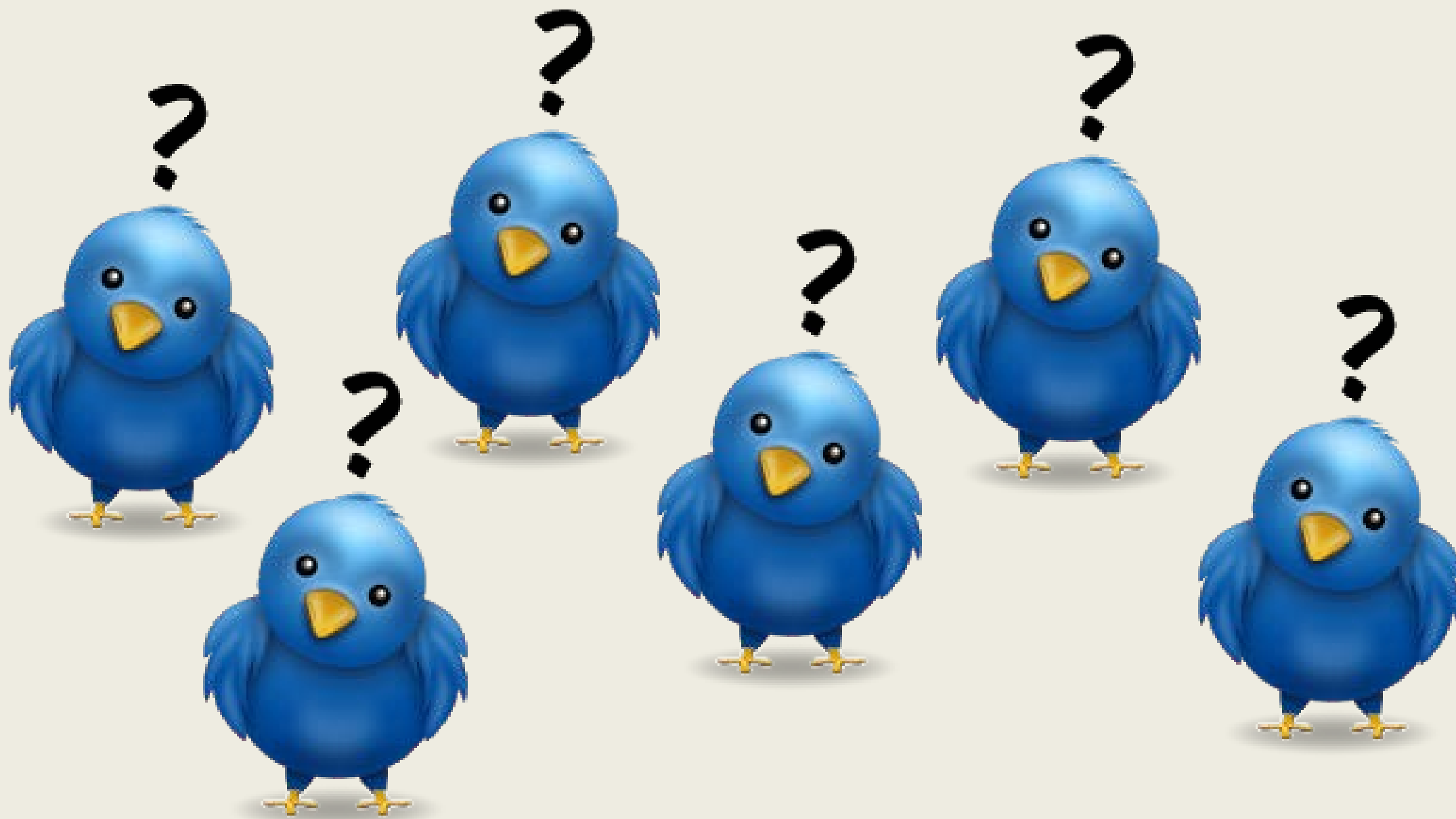
Lindley, L. C. (2011). Health care reform and concurrent curative care for terminally ill children: A policy analysis. *J Hosp Palliat Nurs*. 13(2), 81-88.

WHAT DOES CONCURRENT CARE FOR
PATIENTS ON HOSPICE *REALLY* LOOK LIKE?

Does “concurrent care” happen when...

- ...a patient with ESRD receives 2 weeks of HD for goal of attending her daughter’s wedding in 10 days?
- ...the hospice team supports closer management of heart failure to relieve symptoms like SOB?
- ...a hospice patient with prostate cancer has a “check-in” visit with a oncologist of 8 years?
- ...a hospice patient with a prognosis of 3-4 months wants to undergo previously scheduled cataract surgery?
- ...a patient with terminal lung cancer wishes to continue HD?

HOSPICE IS LESS BLACK AND WHITE THAN
THE MEDICARE CONDITIONS OF
PARTICIPATION MIGHT LEAD US TO BELIEVE



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CALLS FOR CHANGES IN THE MEDICARE HOSPICE BENEFIT

- In our dichotomous system — one that forces patients to choose between the goal of comfort or cure — this means that most of them will forgo palliative care.
Watcher, R. (2018, April 19) The Problem with Miracle Cures, NYT.

A change in hospice benefits that (financially) supports patients whose terminal illness is ESRD, allowing them to continue to receive hemodialysis and hospice care, could be both cost saving and improve their care at the end of life.
Schwarze, Schueller & Jhagroo (2018) Hospice Use and End-of-Life Care for Patients with End-stage Renal Disease, JAMA, Internal Med, 178 (6), 799-801.

“Finding ways to increase the use of hospice and palliative care — such as through concurrent care — will be a significant step toward addressing the public health problem of the burden of advanced life-limiting illness.”

Harrison & Connor (2016) First Medicare Demonstration of Concurrent Provision of Curative and Hospice Services for End-of-Life Care. AJPH. 106, 8, 1405-1408.



**IF THIS IS THE ROAD AHEAD,
WHERE CAN WE FIND A MAP?**

THE FUTURE IS NOW: WHERE CONCURRENT CARE IS HAPPENING

- Medicare Demonstration Project – Medicare Choices Model
 - First Medicare hospice demonstration in 35 years
 - “A new option for Medicare beneficiaries to receive supported care services from selected hospice providers, while continuing to receive services provided by other Medicare providers, including care for their terminal condition.”
 - 5 year demonstration. CMS invited over 140 Medicare-certified hospices to participate in the Model
 - Cohort #1 started Jan 1, 2016, Cohort #2 started Jan 1, 2018.
 - Outcomes and results pending

THE FUTURE IS NOW: WHERE CONCURRENT CARE IS HAPPENING

- Pediatric Concurrent Care under the ACA – Medicaid/CHIP only
- “Section 2302 states that a child who is eligible for and receives services for hospice care must also have all other services provided, or have payment for services that are related to the treatment of the child’s condition.”
- Same 6-month prognosis criteria applies.
- Impacts not well studied. Lindley (2016) found that a similar county-by-county policy in California did not increase Hospice enrollment, but did increase length of stay.

Mann, C., CMS. (September 9, 2010) Re: *Hospice Care for Children in Medicaid and CHIP*. Retrieved Feb 7, 2019 from <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10018.pdf>

Lindley, LC. (2016) The effect of Pediatric Palliative Care Policy on Hospice Utilization Among Medicaid Beneficiaries. *J Pain Symptom Management*. 52(5) 688-694.

THE FUTURE IS NOW: WHERE CONCURRENT CARE IS HAPPENING

- The Veterans Health Administration
 - The VA Comprehensive End-of-Life Care Initiative (CELCI)
“enabled Veterans enrolled in the VA to access hospice without having to forgo all active, disease-modifying cancer treatment – often referred to as the ‘terrible choice’ facing Medicare beneficiaries.”

Mor, V., et al (2015). The Rise of Concurrent Care for Veterans with Advanced Cancer at the End of Life. *Cancer*, 122, 5, (782-790).

**Department of
Veterans Affairs**

Memorandum

Date: **AUG 24 2016**

From: Acting Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Providing Hospice Care and the Importance of Associated Coding

To: Network Director (10N1-23)
Chief Medical Officers (10N1-23)

1. To promote improved coding of workload and to address possible confusion about the definition of "hospice", this memorandum provides interim guidance on the definition of hospice as it pertains to administrative accounting and workload (e.g., Decision Support System stop code 351 for hospice care, and treating specialty "1F" for hospice in an acute care setting). Hospice includes the following core elements:

a. Veteran has a life-expectancy of less than 6 months given the normal

1. To promote improved coding of workload and to address possible confusion about the definition of "hospice", this memorandum provides interim guidance on the definition of hospice as it pertains to administrative accounting and workload (e.g., Decision Support System stop code 351 for hospice care, and treating specialty "1F" for hospice in an acute care setting). Hospice includes the following core elements:

a. Veteran has a life-expectancy of less than 6 months given the normal course of disease, as determined by a Department of Veterans Affairs (VA) physician;

- i. The focus of care is on comfort and quality of life, though this does not exclude disease modifying interventions;
- ii. The Veteran makes an informed decision to receive hospice care; and
- iii. Hospice services are delivered by an interdisciplinary team with expertise in this area.

Note that the codes specific for hospice care, such as 351 and 1F, are to be used only for Veterans meeting all four of the core elements of hospice care.

2. The Office of Geriatrics and Extended Care (GEC) Services is working on updating related policies and administrative documents to more uniformly define hospice, as outlined in this memorandum. In conjunction with these efforts, GEC



CASES: HOW DOES IT PLAY OUT?

Three Categories of Concurrent Care
Cases to Consider

“FULL” CONCURRENT CARE

- 83 yo male veteran with metastatic melanoma
 - Initial Dx 2/2014
 - Mets to lung, bone, soft tissue 9/2015
 - Mets to brain 8/2016
 - Intracardiac mass 10/2018
 - XRT @ 3/2014, 8/2016, 5/2017
 - Dabrafenib & Trametinib through 8/2017
 - Pembrolizumab q21 days 8/2017 - present

“FULL” CONCURRENT CARE

- Minimal Sx's or functional decline through most of his Dz/Tx history
- Mild fatigue, weakness, cognitive changes, and HAs began July 2018
- Concurrent care hospice recommended at that time by VA providers
- Pt demonstrating very slow decline and tolerating Tx without burden
- Pt open to hospice only if allowed to continue immunotherapy
- Goals of remaining at home (ALF) as long as possible, well managed Sx's when they occur, live as long as possible with acceptable QOL
- Admitted to hospice 7/2018
- Pt continues to receive palliative immunotherapy q21 days with minimal AE's or Tx burden

“FULL” CONCURRENT CARE

- Pt continues to live independently and achieve his QOL and care goals aligned with his values
- Has required increased utilization of hospice team members over time. Now seeing RNCM, chaplain, massage, MSW, music, and aide
- Increasing HA frequency and severity; Progressive weakness, fatigue, anorexia, and somnolence
- Ongoing d/w Pt regarding continued immunotherapy with goal of stopping when burden outweighs benefit

“FULL” CONCURRENT CARE

STRENGTHS

- Veteran receives earlier involvement of holistic ID team to provide support and care in the home setting
- Veteran not required to make an “all or nothing” decision regarding Tx; Developed a POC that met his goals and values
- Veteran has been able to achieve goals of living independently with acceptable QOL
- There is time to build a relationship between Pt and hospice team to better assist with appropriate POC as disease progresses

CHALLENGES

- Longer LOS
- Pursuit of palliative Tx complicates prognostication
- Communication is vital and more difficult
 - With Pt
 - With VA providers
- Veterans particularly loyal to VA provider input
 - Pt less trusting of hospice team
 - More difficult to help guide POC discussions

“PARTIAL” CONCURRENT CARE

- 85 year-old Veteran with a history of TIA's who is living in a memory care unit. She has been receiving hospice services for 5 months for Cerebral Vascular Disease resulting in Vascular Dementia.
- POAHC was visiting, and noticed that her mother was lethargic, fatigued, and had a high pulse rate. She suspected an A-fib “episode” like she had in the past and requested treatment.

PARTIAL CONCURRENT CARE

- Caregivers on the memory unit initially dismissed the request, reminding the daughter that the patient was on hospice
- After finally contacting hospice, the hospice RN affirmed that “hospice philosophy” does not include “active treatment”
- Further consideration from the IDG prompted review of the patient’s treatment history and a gentle reminder that this 85 year-old woman had VA benefits
- She was taken to the VA for treatment of her A-fib

“PARTIAL” CONCURRENT CARE

STRENGTHS

- Traditional hospice philosophy and knowledge of regulations is alive and well!
- Concurrent care for a non-related hospice diagnosis is always an option regardless of Veteran status
- Collaboration between physicians/clinicians offers a holistic and balanced perspective to symptom management at end-of-life
- The IDG provides a broad view of patient situations and allows for discussion to offer symptom management through a variety of treatment options and concurrent care

CHALLENGES

- Change in condition (weakness/ fatigue) are minimized because of patient’s hospice election
- Because Lois was on hospice, the staff on the memory care unit told the family she was “not allowed” to go to the ER
- Revoking hospice benefit is the hospice “go to” when seeking “active” treatment
- How much is too much treatment?

“POSSIBILITY” OF CONCURRENT CARE

70 year-old Veteran with undifferentiated sarcomatoid malignancy of R posterior neck

- Diagnosed May 26, 2018
- Plan: surgical resection then adjuvant chemo
- Radical excision July 5, 2018 (+residual microscopic disease)
- Planned for systemic chemo (and maybe XRT--needed to clarify metastatic disease or no)
- Discharged home w/adequate pain control on oral opioids

“POSSIBILITY” OF CONCURRENT CARE

- Readmitted 7/24/18 for increasing pain and vomiting, pain quickly controlled, discharged home
- Started XRT 7/26/18
- Readmitted 7/31/18 for severe pain
 - Mass had grown so much that XRT mask wouldn't fit
 - Pt declined life-prolonging chemo, interested in life-prolonging immunotherapy if indicated
 - Pt desired home hospice to help manage PCA
 - Discharged home 8/8/18 w/hospice and PCA, pain well controlled

“POSSIBILITY” OF CONCURRENT CARE

- Presented to oncology clinic on 8/15/18 to start pembrolizumab, but had increase in pain not controlled w/PCA, weakness, dysphagia
- Decided to hold on infusion and admit to VA Inpatient Hospice Bed for EOL care (prognosis of days)
- Died 8/20/18

“POSSIBILITY” OF CONCURRENT CARE

STRENGTHS

- Veteran (and family) immediately receive the support and care they need
- Families for whom life-prolonging treatments are a source of hope can be told they are still available
- We can hope for what the veteran hopes for, while also preparing for other outcomes

CHALLENGES

- Are we enabling other specialists – or ourselves – to avoid truly difficult conversations?
- Does a goal of continuing life-prolonging therapies alter focus to an extent that precious time is spent injudiciously?

WHAT PULLS US TOWARD CONCURRENT CARE

- Patient-Centered, not Regulation-Centered, Care
- It allows us to support patient decisions that are based on education and information.
- It allows for services and support in a era of changing and increasing prognostic uncertainty.
- It speaks to our values as people passionate about end of life care and individualized care plans.

WOULD CHANGING PAYMENT STRUCTURES REALLY BE ENOUGH?

- Increases in concurrent care in the VA between 2006 and 2012 were **not** found correlate with earlier enrollment with hospice prior to death.
- Reimbursement policies don't do anything to change the culture and values that drive patient and clinician behavior.

Mor, V., et al (2015). The Rise of Concurrent Care for Veterans with Advanced Cancer at the End of Life. *Cancer*, 122, 5, (782-790).

Mrig and Spencer (2018) Political economy of hope as a cultural facet of biomedicalization: A qualitative examination of constraints to hospice utilization among U.S. end-stage cancer patient. *Social Science and Medicine*, 200, 107-113.

RECOMMENDATIONS TO NAVIGATE
CONCURRENT CARE CASES

ONE DOES NOT SIMPLY

***DO* CONCURRENT CARE**

RECOMMENDATIONS

- Accept that you are never done communicating.
- It is necessary to establish clear expectations for the Hospice Agency and the system that is providing additional care.
- Know that a concurrent care plan changes to another kind of plan at some point.
- For working across systems, have good contacts with whomever is within the other system, be it VA or otherwise.

QUESTIONS AND DISCUSSION