Unity

LEADERS IN HOSPICE AND PALLIATIVE CARE

Common Hospice Misconceptions

MYTH	FACT
Hospice is only for patients who have pain management issues.	Hospice is a rich Medicare entitlement that provides your patient the following at no cost: • 24/7/365 coverage by an interdisciplinary team • Weekly and PRN RN visits in the home • Nurses Aide service • Social work and pastoral care • Bereavement services leading up to and for 13 months or longer following death • Durable medical equipment and oxygen as needed related to diagnosis • Medications related to admitting diagnosis • Trained, community volunteers to assist with patient/family needs
Cancer is the only qualifying disease for hospice.	Hospice is appropriate for any patient with a progressive, life-limiting illness. Hospice should be considered for any patient with: • Cancer • Dementia • HIV/AIDS • Pulmonary Disease (Emphysema, Fibrosis, COPD) • Renal Failure • General Terminal Illness • Heart disease • Liver Disease • Kidney Disease • Stroke or Coma • Neurological Disease (ALS, Muscular Dystrophy, Parkinson's, MS)
My patient should be referred to hospice when death is imminent.	Experts agree that hospice is most beneficial when provided for a minimum of three months. Research shows oncology patients who received early care lived 2.7 months longer, had fewer depressive symptoms and experienced higher quality of life. Brief exposures to hospice at the end-of-life do not allow patients and families to take full advantage of the benefits.
My patient doesn't want to talk about hospice until death is imminent.	Talking honestly and upfront about a patient's prognosis and end-of-life goals and desires increases patient and caregiver satisfaction. Research shows that patients who were counseled about end-of-life decisions and referred early to hospice, reported less emotional distress, as did their caregivers. Use Unity's script to help introduce hospice care to patients and families.
Hospice is giving up hope. My patient will die quickly.	Research published in the *Journal of Pain and Symptom Management* found that hospice patients lived longer on average than patients who opted for more conventional treatment. Receiving hospice care does not mean giving up hope or that death is imminent. Hope for a cure is replaced with a new type of hope: Hope for comfort, pain and symptom relief, days filled with peace, joy and the sharing of special moments and memories.
My patient must be homebound in order to receive hospice.	Unlike home health care, hospice care is appropriate at the time of a terminal diagnosis, regardless of the patient's physical condition. Many patients continue to lead productive and rewarding lives outside the home. Homebound status is not a determining criteria for hospice eligibility.
Hospice care is the same as home health care.	Hospice care and home health care are dramatically different. Comfort vs. Cure: For most home health care providers, the goal is to make the patient well. With hospice care, the staff and family recognize that the patient will not get well. They focus on comfort and support rather than cure. Interdisciplinary Team Approach: In hospice, all members of the care team – primary care physician, nurses, social workers, chaplain, nursing assistants, volunteers and hospice physicians – work together to coordinate care. Family Focus: The patient and family is at the center of hospice care. A personalized care plan is developed to meet both the patient's and family's needs and wishes concerning treatment and lifestyle. Grief Support: Hospice care does not end when a patient dies. Hospice support staff and volunteers maintain contact with the family for at least one year after the death of a patient. Hospice care can be delivered in any setting, including a residential home, skilled nursing facility, assisted living or facility. Unity also provides in-patient hospice care at area hospitals.

MYTH	FACT
If my patient is admitted on a hospice program I can no longer see him or her in my clinic.	As an attending physician not employed by the hospice, you can continue office visits with your patients for both services related to and unrelated to the terminal diagnosis and still receive reimbursement. For care related to the hospice diagnosis, use a GV modifier on your claim. For care not related to the hospice diagnosis, use a GW modifier on your claim. You can also bill for care plan oversight in increments of 30 minutes as supported by documentation, submitted once per month. Use *Unity's Care Plan Oversight Monthly Tracker* tool for documentation.
As a primary physician, I must transfer control of my patient to hospice.	Because of the close relationship that primary care physicians have with their patients, they are in a unique position to provide end-of-life care, which includes recognizing the need for and referring to hospice when appropriate. Research shows that care is enhanced when the primary physician maintains control of the patient's care until his or her death. Research also shows that patients and families feel abandoned when primary care physicians refuse to provide care. Unity teams work closely with primary physicians. The continuation of the patient-physician relationship is a high priority. **Attending Physician's Role** • Maintain primary responsibility for the patient's care • Write basic admission orders • See patient for office visits • Collaborate with the hospice team to manage symptoms • Complete and sign the death certificate **Unity's Medical Team Role** • Regulatory work to be done by hospice employed providers • Collaborate with Unity field staff and patient's attending physician to recommend: - Medication and dosages - Symptom control treatment options • Communicate with patients and family as needed
As an attending physician, I will lose out on Medicare reimbursements when my patient is admitted to hospice.	Medicare reimburses physicians and nurse practitioners for qualified time spent overseeing the care of patients receiving hospice services. Hospice Care Plan Oversight (CPO) exists because CMS recognizes the importance of on-going physician engagement in patient care. CPO can add up quickly: if you are providing CPO for ten hospice patients a month, it adds up to $12,618 per year (based on 2014 Medicare rate).
My patient cannot receive artificial hydration or nutrition while on hospice.	There are many instances where artificial hydration or nutrition are appropriate. Each patient situation is carefully evaluated to determine the best treatment plan possible.
I'm at risk for Medicare penalties if my patient outlives his/her 6 month prognosis.	A referring physician is at no risk for Medicare penalties for a life-limiting prognosis. Unity hospice physicians are responsible for ongoing certification that is "unlimited" as long as the patient continues to demonstrate decline.
My patient needs a DNR to be eligible for hospice.	Hospice does NOT require a DNR order or an ICD deactivation for admission. Unity's interdisciplinary team will continually educate the patient and family regarding disease progression and goals of end-of-life care, including code status.
Once my patient elects hospice care, he or she cannot return to traditional medical treatment.	Patients always have the right to reinstate traditional care at any time, for any reason. If a patient's condition improves or the disease goes into remission, he or she can be discharged from a hospice and return to aggressive, curative measures, if desired. If a discharged patient wants to re-enroll in hospice care, Medicare, Medicaid, and most private insurance companies and HMOs will allow unlimited readmissions.
My patient needs Medicare or Medicaid to afford hospice services.	Although hospice is a no-cost benefit of Medicare and Medicaid, most private insurance plans, HMOs, and other managed care organizations also offer this benefit. In addition, through community contributions, memorial donations, and foundation gifts, Unity is able to provide patients who lack sufficient resources with full hospice services. Unity has never turned anyone away due to inability to pay.

Call Unity 24/7 at **920.338.1111** or **800.990.9249** to request a free patient informational visit or assessment for hospice eligibility.