Service Category Definition - DSHS State Services

Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of Hospice Care provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals with AIDS residing in the Houston HIV Service Delivery (HSDA).

Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course
Agency Requirements:	Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation. Provider must inform Administrative Agency regarding issue of long term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care. Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.

	Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
Staff Requirements:	All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart. Must comply with the **Houston HSDA Hospice Standards of Care**. The agency must comply with **the DSHS Hospice Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

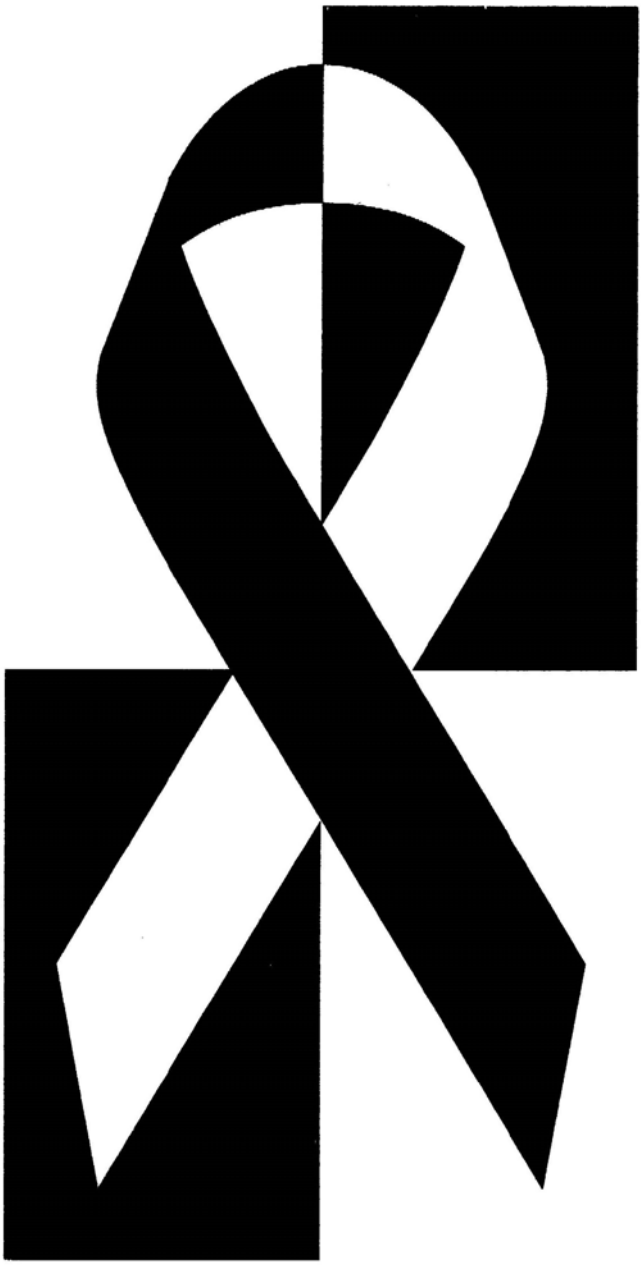
FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #3**	Date: **04/24/19**
Recommendations:	Financial Eligibility: **300%**
1.	
2.	
3.	



HOSPICE SERVICES
2018 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Tool Development

The TRG Hospice Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a population of 46 (CPCDMS) who accessed hospice services in the measurement year. The records of 39 clients were reviewed, representing 85% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Demographics- Hospice

2017 Annual

Total UDC: 51 Total New: 39

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	1	1.96%
25 - 44 years	17	33.33%
45 - 64 years	30	58.82%
65 years or older	3	5.88%
Unknown		0.00%
	51	100.00%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	9	17.65%
Male	42	82.35%
Transgender FTM	0	0.00%
Transgender MTF	0	0.00%
Unknown	0	0.00%
	51	100.00%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	19	37.25%
Black	24	47.06%
Hispanic	8	15.69%
Asian	0	2.63%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	51	100.00%

From 01/01/17 - 12/31/17

2018 Annual

Total UDC: 46 Total New: unk

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	1	2.17%
25 - 44 years	14	30.43%
45 - 64 years	28	60.87%
65 years or older	3	6.52%
Unknown	0	0.00%
	46	100.00%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	8	17.39%
Male	37	80.43%
Transgender FTM	0	0.00%
Transgender MTF	1	2.17%
Unknown	0	0.00%
	46	100.00%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	19	41.30%
Black	27	58.70%
Hispanic	11*	23.91%
Asian	0	2.63%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	46	100.00%

From 01/01/18 - 12/31/18

RESULTS OF REVIEW

ADMISSION ORDERS AND ASSESSMENT

Percentage of client records that document attending physician certification of client's terminal illness.

	Yes	No	N/A
Client records that evidenced a Hospice Certificate Letter.	38	1	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**97%**	**3%**	-

Percentage of client records that have admission orders

	Yes	No	N/A
Client records that showed evidence of an admission order.	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

Percentage of client records that have all scheduled and PRN medications, including dosage and frequency

	Yes	No	N/A
Client records that evidenced all medication orders	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

CARE PLAN AND UPDATES DOCUMENTAITON

Percentage of client records that have a completed initial plan of care within 7 days of admission.

	Yes	No	N/A
Client records that evidence a completed initial plan of care within 7 days of admission	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

Percentage of client records that have a completed plan of care reviewed and/or updated at least monthly.

	Yes	No	N/A
Client records that evidenced a completed plan of care that was updated at least monthly.	12	0	27
Clients in hospice services that were reviewed.	12	39	39
Rate	**100%**	**0%**	**69%**

Percentage of client records that document palliative therapy as ordered by the referring provider

	Yes	No	N/A
Client records that showed evidence of palliative therapy as ordered.	33	3	3
Clients in hospice services that were reviewed.	36	36	39
Rate	**92%**	**8%**	**8%**

SERVICES

Percentage of client records that had bereavement counseling offered to family members upon admission to Hospice services

	Yes	No	N/A
Client records that showed evidence of bereavement counseling	3	27	9
Clients in oral health services that were reviewed.	30	30	39

Rate	**10%**	**90%**	**23%**

Percentage of client records that had dietary counseling

	Yes	No	N/A
Number of client records that evidenced dietary counseling	0	1	38
Clients in oral health services that were reviewed.	1	1	39
Rate	**0%**	**100%**	**97%**

Percentage of client records that had spiritual counseling

	Yes	No	N/A
Client records that evidenced spiritual counseling.	36	2	1
Clients in oral health services that were reviewed.	38	38	39
Rate	**95%**	**5%**	**3%**

Percentage of client records that had mental health counseling offered to family members upon admission

	Yes	No	N/A
Number of client records that evidence mental health counseling offered	0	0	39
Clients in oral health services that were reviewed.	39	39	39
Rate	**0%**	**0%**	**100%**

HOMELESSNESS

Percentage of client records that show the client was homeless on admission. (CPCDMS)

	Yes	No	N/A
Client records that showed evidence of homeless on admission.	9	30	-
Clients in hospice services that were reviewed.	39	38	-
Rate	**23%**	**77%**	-

SUBSTANCE ABUSE

Percentage of client records that showed the client had active substance abuse on admission. (CPCDMS)

	Yes	No	N/A
Client records that evidenced active substance abuse on admission.	3	36	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**8%**	**92%**	-

PSYCHIATRIC ILLNESS

Percentage of client records that showed the client had active psychiatric illness on admission (excluding depression). (CPCDMS)

	Yes	No	N/A
Number of client records that evidenced active psychiatric illness	3	36	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**8%**	**92%**	-

DISCHARGE

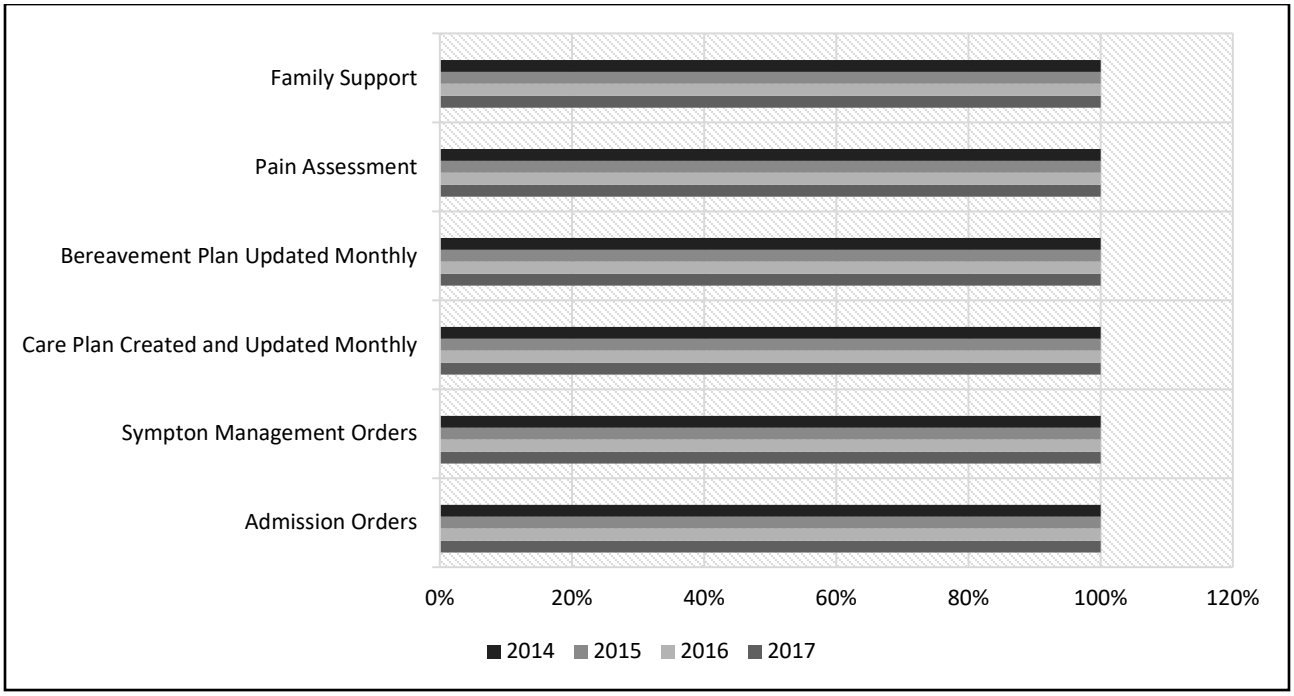
Percentage of client records that evidence all refusals of attending physician referrals by hospice providers with evidence indicating an allowable reason for the refusal

	Yes	No	N/A
Client records that evidenced appropriate refusal	6	0	33
Clients in hospice services that were reviewed.	6	39	39
Rate	**100%**	**0%**	**85%**

Percentage of client records that showed completed discharge documentation

	Yes	No	N/A
Client records that evidenced completed discharge documentation.	39	0	-
Clients in hospice services that were reviewed.	39	38	-
Rate	**100%**	**0%**	-

HISTORICAL DATA



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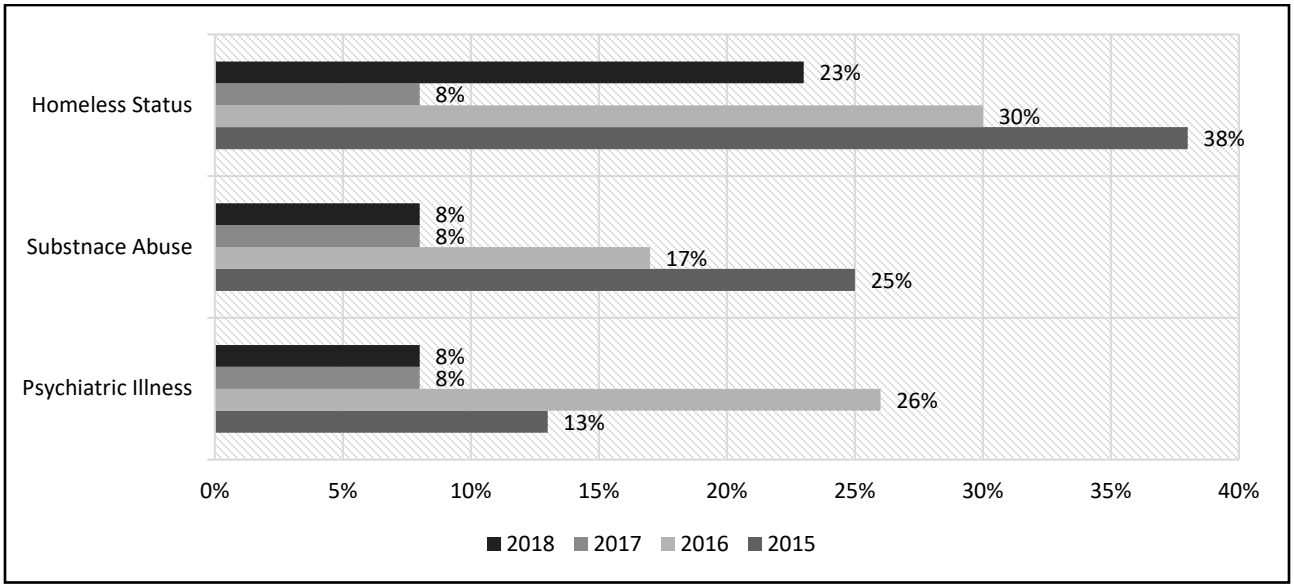

CONCLUSION

The review showed that Hospice Care continue to be delivered at a high standard. Seven of the thirteen Standard of Care data elements were scored at 100% compliance, including care plan, health assessment and discharge. Of the client records reviewed, 23% (9) of records indicated the client was homeless on admission. This is a significant increase from 8% in 2017. Additionally, 8% (3) of records reviewed showed evidence that the client had active substance abuse on admission (decrease from 17% in 2016); 8% (3) of records reviewed showed evidence of active psychiatric illness on admission (excluding depression). This is a decrease from 26% in 2016. Demographically, the client's served in the age bracket 45 and up, is increasing with (58%) clients in 2016 to (67%) clients in 2018. All other demographics have remained consistent.

MAYO CLINIC

Healthy Lifestyle

End of life

Hospice care might be an option if you or a loved one has a terminal illness. Understand how hospice care works and how to select a program.

By Mayo Clinic Staff

If you or a relative has a terminal illness and you've exhausted all treatment options, you might consider hospice care. Find out how hospice care works and how it can provide comfort and support.

Hospice care is for people who are nearing the end of life. The services are provided by a team of health care professionals who maximize comfort for a person who is terminally ill by reducing pain and addressing physical, psychological, social and spiritual needs. To help families, hospice care also provides counseling, respite care and practical support.

Unlike other medical care, the focus of hospice care isn't to cure the underlying disease. The goal is to support the highest quality of life possible for whatever time remains.

Hospice care is for a terminally ill person who's expected to have six months or less to live. But hospice care can be provided for as long as the person's doctor and hospice care team certify that the condition remains life-limiting.

Many people who receive hospice care have cancer, while others have heart disease, dementia, kidney failure or chronic obstructive pulmonary disease.

Enrolling in hospice care early helps you live better and live longer. Hospice care decreases the burden on family, decreases the family's likelihood of having a complicated grief and prepares family members for their loved one's death. Hospice also allows a patient to be cared for at a facility for a period of time, not because the patient needs it, but because the family caregiver needs a break. This is known as respite care.

Most hospice care is provided at home — with a family member typically serving as the primary caregiver. However, hospice care is also available at hospitals, nursing homes, assisted living facilities and dedicated hospice facilities.

No matter where hospice care is provided, sometimes it's necessary to be admitted to a hospital.

For instance, if a symptom can't be managed by the hospice care team in a home setting, a hospital stay might be needed.

If you're not receiving hospice care at a dedicated facility, hospice staff will make regular visits to your home or other setting. Hospice staff is on call 24 hours a day, seven days a week.

A hospice care team typically includes:

- **Doctors.** A primary care doctor and a hospice doctor or medical director will oversee care. Each patient gets to choose a primary doctor. This can be your prior doctor or a hospice doctor.
- **Nurses.** Nurses will come to your or your relative's home or other setting to provide care. They are also responsible for coordination of the hospice care team.
- **Home health aides.** Home health aides can provide extra support for routine care, such as dressing, bathing and eating.
- **Spiritual counselors.** Chaplains, priests, lay ministers or other spiritual counselors can provide spiritual care and guidance for the entire family.
- **Social workers.** Social workers provide counseling and support. They can also provide referrals to other support systems.
- **Pharmacists.** Pharmacists provide medication oversight and suggestions regarding the most effective ways to relieve symptoms.
- **Volunteers.** Trained volunteers offer a variety of services, including providing company or respite for caregivers and helping with transportation or other practical needs.
- **Other professionals.** Speech, physical and occupational therapists can provide therapy, if needed.
- **Bereavement counselors.** Trained bereavement counselors offer support and guidance after the death of a loved one in hospice.

Medicare, Medicaid, the Department of Veterans Affairs and private insurance typically pay for hospice care. While each hospice program has its own policy regarding payment for care, services are often offered based on need rather than the ability to pay. Ask about payment options before choosing a hospice program.

To find out about hospice programs, talk to doctors, nurses, social workers or counselors, or contact your local or state office on aging. Consider asking friends or neighbors for advice. The National Hospice and Palliative Care Organization also offers an online provider directory.

To evaluate a hospice program, consider asking:

- Is the hospice program Medicare-certified? Is the program reviewed and licensed by the state or certified in some other way? Is the hospice program accredited by The Joint Commission?
- Who makes up the hospice care team, and how are they trained or screened? Is the hospice medical director board certified in hospice and palliative care medicine?

- Is the hospice program not-for-profit or for profit?
- Does the hospice program have a dedicated pharmacist to help adjust medications?
- Is residential hospice available?
- What services are offered to a person who is terminally ill? How are pain and other symptoms managed?
- How are hospice care services provided after hours?
- How long does it take to get accepted into the hospice care program?
- What services are offered to the family? What respite services are available for the caregiver or caregivers? What bereavement services are available?
- Are volunteer services available?
- If circumstances change, can services be provided in different settings? Does the hospice have contracts with local nursing homes?
- Are hospice costs covered by insurance or other sources, such as Medicare?

Remember, hospice stresses care over cure. The goal is to provide comfort during the final months and days of life.

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Jan. 30, 2019

Original article: https://www.mayoclinic.org/healthy-lifestyle/end-of-life/in-depth/hospice-care/art-20048050

National Hospice and Palliative Care Organization

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

FACTS AND FIGURES

HOSPICE CARE IN AMERICA

2017 EDITION

(REVISED APRIL 2018)

TABLE OF CONTENTS

INTRODUCTION

About This Report

NHPCO Facts and Figures: Hospice Care in America provides an annual overview of hospice care delivery. This overview provides specific information on:

- Hospice patient characteristics
- Location and level of care
- Medicare hospice spending
- Hospice provider characteristics
- Volunteer and bereavement services

Currently, most hospice patients have their costs covered by Medicare, through the Medicare Hospice Benefit. The findings in this report reflect only those patients who received care in 2016 through the Medicare Hospice Benefit and the hospices certified by the Centers for Medicare and Medicaid Services (CMS) to care for them.

What is hospice care?

Considered the model for quality compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's family as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice facilities, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients with any terminal illness or of any age, religion, or race.

How is hospice care delivered?

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. This interdisciplinary team, as illustrated in Figure 1, usually consists of the patient's personal physician, hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and speech, physical, and occupational therapists, if needed.

FIGURE 1. INTERDISCIPLINARY TEAM

What services are provided?

The interdisciplinary hospice team:

- Manages the patient's pain and other symptoms
- Assists the patient and family members with the emotional, psychosocial, and spiritual aspects of dying
- Provides medications and medical equipment
- Instructs the family on how to care for the patient
- Provides grief support and counseling
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time
- Delivers special services like speech and physical therapy when needed
- Provides grief support and counseling to surviving family and friends

Location of Care

The majority of hospice care is provided in the place the patient calls home. In addition to private residences, this includes nursing homes and residential facilities. Hospice care may also be provided in freestanding hospice facilities and hospitals (see Levels of Care).

Levels of Care

Hospice patients may require differing intensities of care during the course of their disease. While hospice patients may be admitted at any level of care, changes in their status may require a change in their level of care.

The Medicare Hospice Benefit affords patients four levels of care to meet their clinical needs: Routine Home Care, General Inpatient Care, Continuous Home Care, and Inpatient Respite Care. Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the interdisciplinary team, medications, medical equipment and supplies.

- Routine Hospice Care (RHC) is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care at their residence.
- General Inpatient Care (GIP) is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has a registered nurse available 24 hours a day to provide direct patient care.
- Continuous Home Care (CHC) is care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
- Inpatient Respite Care (IRC) is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long term care facility that has sufficient 24 hour nursing personnel present.

Volunteer Services

The U.S. hospice movement was founded by volunteers and continues to play an important and valuable role in hospice care and operations. Moreover, hospice is unique in that it is the only provider with Medicare Conditions of Participation (CoPs) requiring volunteers to provide at least 5% of total patient care hours. Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services that support patient care and clinical services ("clinical support")
- Engaging in a variety of activities such as fundraising, outreach and education, and serving on a board of directors ("general support")

Bereavement Services

Counseling or grief support for the patient and loved ones is an essential part of hospice care. After the patient's death, bereavement support is offered to families for at least one year. These services can take a variety of forms, including telephone calls, visits, written materials about grieving, and support groups. Individual counseling may be offered by the hospice or the hospice may make a referral to a community resource. Some hospices also provide bereavement services to the community at large.

WHO RECEIVES HOSPICE CARE

How many Medicare beneficiaries received hospice care in 2016?

1.43 million Medicare beneficiaries were enrolled in hospice care for one day or more in 2016*. This includes patients who:

- Died while enrolled in hospice
- Were enrolled in hospice in 2015 and continued to receive care in 2016
- Left hospice care alive during 2016 (live discharges)

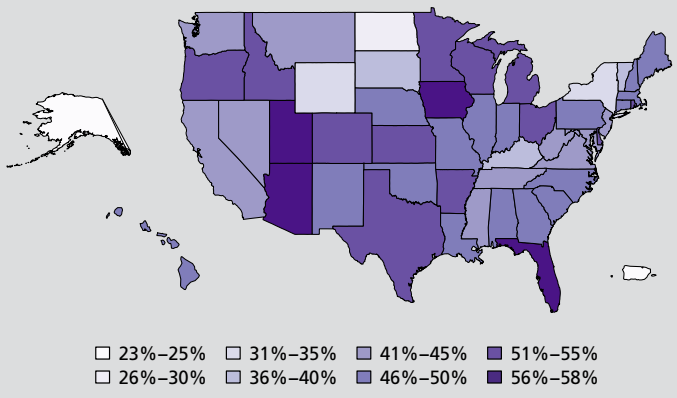
**includes all states, Washington D.C., and Puerto Rico.*

What proportion of Medicare decedents were served by hospice in 2016?

Of all Medicare decedents in 2016, 48% received one day or more of hospice care *and* were enrolled in hospice at the time of death.

As illustrated in Figure 2, the proportion of Medicare decedents enrolled in hospice at the time of death varied across states from a low of 23% (PR) to a high of 58% (UT).

FIGURE 2. GEOGRAPHIC VARIATION IN THE PROPORTION OF MEDICARE DECEDENTS WHO DIED WHILE RECEIVING HOSPICE CARE IN 2016



What are the characteristics of Medicare beneficiaries who received hospice care in 2016?

Patient Gender

In 2016 more than half of hospice Medicare beneficiaries were female.

Female	58.6 %
Male	41.4 %

Patient Age

In 2016 about 64% of Medicare hospice patients were 80 years of age or older.

TABLE 1. PERCENTAGE OF PATIENTS BY AGE

Age Category (Years)	Percentage
< 65	5.3 %
65 - 69	7.7 %
70 - 74	10.0 %
75 - 79	12.8 %
80 - 84	16.7 %
> 84	47.5 %

*Patient Race**

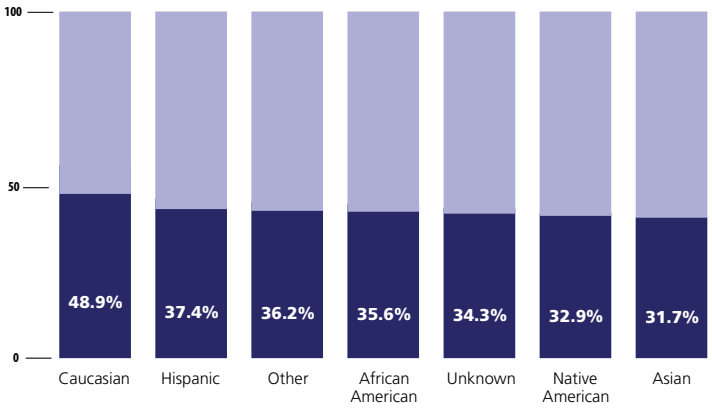
In 2016 a substantial majority of Medicare hospice patients were Caucasian.

TABLE 2. PERCENTAGE OF PATIENTS BY RACE*

Race	Percentage
Caucasian	86.5 %
African American	8.3 %
Hispanic	2.1 %
Asian	1.2 %
Other	1.0 %
Native American	0.4 %
Unknown	0.4 %

** Categories correspond to those used by CMS in the Hospice Limited Data Set*

TABLE 3. DEATH/SERVICE RATIO BY RACE*



**Percentage of Medicare decedents totaling 100% (within each race category) who died under hospice care by race (death/service ratio within each race category)*

Principal Diagnosis

The principal hospice diagnosis is the diagnosis that has been determined to be the most contributory to the patient's terminal prognosis. In 2016 more Medicare hospice patients had a principal diagnosis of cancer than any other disease.

TABLE 4. PERCENTAGE OF PATIENTS BY PRINCIPAL DIAGNOSIS

Principal Diagnosis	Percentage
Cancer	27.2 %
Cardiac and Circulatory	18.7 %
Dementia	18.0 %
Respiratory	11.0 %
Stroke	9.5 %
Other	15.6 %

HOW MUCH CARE IS RECEIVED?

*Length of Service**

The average length of service (ALOS) for Medicare patients enrolled in hospice in 2016 was 71 days. The median length of service (MLOS) was 24 days.

** LOS calculation is based on the total days of care for patients who received care in 2016. Days of care have been combined for patients who had multiple episodes of care in 2016. Days of care occurring in other years are not included.*

*Days of Care**

In 2016 hospice patients received a total of 101 million days of care paid for by Medicare.

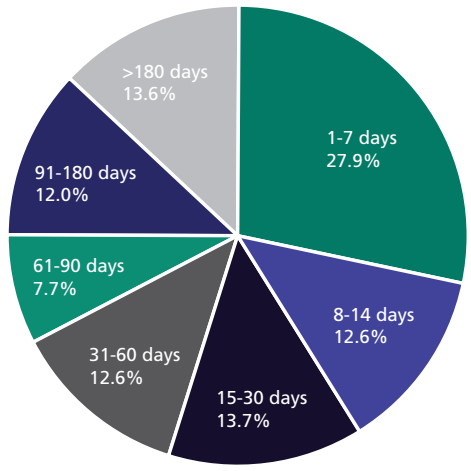
In 2016, a greater proportion of Medicare patients (27.9%) were enrolled in hospice a total of seven days or fewer compared to all other length of service categories.

TABLE 5. DAYS OF CARE CATEGORIES BY PERCENTAGE OF PATIENTS*

Total Days of Care	Percentage of Patients
1 – 7	27.9 %
8 – 14	12.6 %
15 – 30	13.7 %
31 – 60	12.6 %
61 – 90	7.7 %
91 – 180	12.0 %
> 180	13.6 %

**These values are computed using only days of care that occurred in 2016. Days of care occuring in other years are not included. Days of care have been combined for patients who had multiple episodes of care in 2016.*

FIGURE 3. PROPORTION OF PATIENTS BY DAYS OF CARE IN 2016



In 2016 over half (54.2%) of patients were enrolled in hospice for 30 or fewer days.

TABLE 6. DAYS OF CARE OVER MULTIPLE YEARS BY PERCENTAGE OF PATIENTS*

Total Days of Care	Percentage of Patients
1-60	61.6 %
61-180	18.3 %
181-365	10.7 %
>365	9.4 %

**These values are computed using all days of care that occurred in 2016 and, for patients who received care in 2014 and 2015 as well as in 2016, days of care from those years are also included.*

Patients with a principal diagnosis of dementia had the largest number of days of care on average in 2016.

TABLE 7. DAYS OF CARE BY PRINCIPAL DIAGNOSIS*

Principal Diagnosis	Mean # Days of Care	Median # Days of Care
Cancer	46 days	19 days
Cardiac and Circulatory	79 days	30 days
Dementia	104 days	54 days
Respiratory	71 days	21 days
Stroke	77 days	22 days
Other	62 days	16 days

**These values are computed using only days of care that occurred in 2016. Days of care have been combined for patients who had multiple episodes of care in 2016. Days of care occurring in other years are not included.*

Deaths

In 2016 1.04 million Medicare beneficiaries died while enrolled in hospice care. Close to half of the deaths occurred in a home and almost a third in nursing facilities.

TABLE 8. LOCATION OF DEATHS

Location of Death	Percentage
Home	44.6 %
Nursing Facility*	32.8 %
Hospice Inpatient Facility	14.6 %
Acute Care Hospital	7.4 %
Other	0.7 %

** Includes skilled nursing facilities, nursing facilities, assisted living facilities, and RHC days in a hospice inpatient facility.*

Discharges and Transfers

In 2016, live discharges comprised 16.8% of all Medicare hospice discharges.

TABLE 9. DISCHARGES BY TYPE OF DISCHARGE*

Type of Discharge	Percentage
Deaths	83.2 %
Live Discharges - Patient Initiated	
Transfers (change in hospice provider)	2.1 %
Revocations	6.4 %
Live Discharges - Hospice Initiated	
No longer terminally ill	6.6 %
Moved out of service area	1.3 %
Discharged for cause	0.3 %

**Calculations are based on total number of discharges which includes patients who were discharged more than one time in 2016.*

Level of Care

In 2016 the vast majority of days of care were at the Routine Homecare (RHC) level.

TABLE 10. LEVEL OF CARE BY PERCENTAGE OF DAYS OF CARE

Level of Care	Percentage of Days of Care
Routine Home Care (RHC)	98.0 %
Continuous Home Care (CHC)	0.2 %
Inpatient Respite Care (IRC)	0.3 %
General Inpatient Care (GIP)	1.5 %

RHC by Location of Care

56.5% of RHC days of care occurred in a private residence, 42.5% in a nursing facility and 1.0% in a hospice inpatient facility, an acute care hospital, or an unspecified location.

Location of Care

In 2016 most of days of care were provided at a private residence.

TABLE 11. LOCATION OF CARE BY PERCENTAGE OF DAYS OF CARE*

Location	Percentage of Days of Care
Home	55.6 %
Nursing Facility*	41.9 %
Hospice Inpatient Facility	1.3 %
Acute Care Hospital	0.5 %
Other	0.8 %

** Includes skilled nursing facilities, nursing facilities, assisted living facilities, and RHC days in a hospice inpatient facility.*

HOW DOES MEDICARE PAY FOR HOSPICE?

Medicare paid hospice providers a total of 16.9 billion dollars for care provided in 2016.

Spending per Patient

The average spending per Medicare hospice patient was $11,820.00.

TABLE 12. MEDICARE SPENDING PER HOSPICE PATIENT

First Quartile	Median	Third Quartile
$1,904.00	$5,384.00	$16,110.00

Spending by Days of Care

In 2016 just under half of Medicare spending for hospice care was for patients who received 180 or fewer days of care.

TABLE 13. MEDICARE SPENDING BY DAYS OF CARE

Total Days of Care*	Percentage of 2016 Medicare Payments for 2016
1-60	19.2 %
61-180	25.1 %
181-365	26.5 %
>365	29.2 %

**Includes days of care that occurred in 2014 and 2015 as well as 2016.*

Spending by Diagnosis

In 2016 close to 25% of Medicare hospice spending was for patients with a principal diagnosis of dementia.

TABLE 14. MEDICARE HOSPICE SPENDING BY PRINCIPAL DIAGNOSIS

Principal Diagnosis	Percentage of Medicare Payments
Cancer	19.6 %
Cardiac and Circulatory	20.2 %
Dementia	24.9 %
Respiratory	10.9 %
Stroke	10.4 %
Other	14.0 %

Spending by Level of Care

In 2016 the vast majority of Medicare spending for hospice care was for care at the Routine Home Care level.

TABLE 15. MEDICARE SPENDING BY LEVEL OF CARE

Level of Care	Percentage of Medicare Payments
Routine Home Care	92.3 %
Continuous Home Care	1.3 %
Respite Care	0.3 %
General Inpatient Care	6.1 %

WHO PROVIDES CARE?

How many hospices were in operation in 2016?

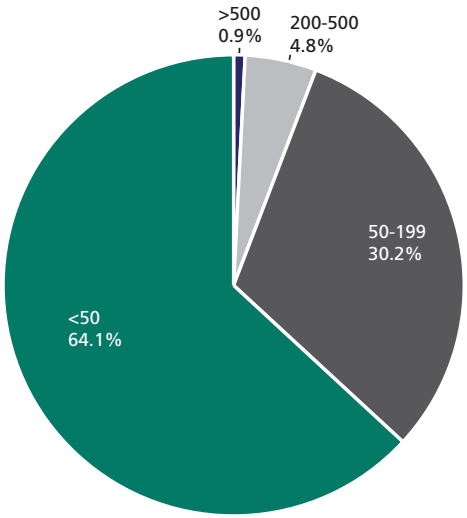
Over the course of 2016, there were 4,382 Medicare certified hospices in operation.

Hospice Size

One indicator of hospice size is average daily census (ADC) or the number of patients cared for by a hospice on average each day.

In 2016 the mean ADC was 63 and the median 31. The majority of hospices had an ADC of less than 50 patients.

FIGURE 4. AVERAGE DAILY CENSUS



Tax Status

67.0% of active Medicare Provider Numbers were assigned to hospice providers with for-profit tax status and 29.0% with not-for-profit status. Government-owned hospice providers comprised 3.9%.

Patient Volume

Admissions

In 2016 hospice providers performed a total 1.2 million unduplicated admissions* of Medicare hospice patients.

** Unduplicated admissions include patients who were part of the census at the end of 2015, carried over into 2016, discharged in 2016 and readmitted within the year.*

Volume of Deaths

In 2016 the highest number of hospice providers served 50 or fewer patients who died while enrolled in hospice care.

TABLE 16. VOLUME OF DEATHS

Total Deaths in 2016	Percentage of Hospice Providers
0 – 50	33.1 %
51 – 100	17.8 %
101 – 200	18.2 %
201 – 500	18.6 %
501 – 1000	8.1 %
>1000	4.1 %

Volunteers

In 2016 the majority of volunteer time was for direct patient care and the majority of volunteers were designated as direct care volunteers.

TABLE 17. VOLUNTEER TIME*

Type of Volunteer Sevice	Percentage of Volunteer Time
Direct Patient Care	42.7 %
Clinical Support	29.9 %
Non Clinical	27.4 %

**2015 and 2016 combined*

DATA SOURCES

The primary data source used for the findings in this report is CMS hospice claims data included in the hospice standard analytical file Limited Data Set (LDS). The NHPCO National Data Set (NDS) is the data source for the Volunteer and Bereavement statistics. The FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements is the source for the Tax Status statistics. MedPAC's March 2018 Report to Congress is the source for hospices in operation and tax status statistics.

Hospice Limited Data Set (LDS)

The hospice standard analytical file contains final action claims submitted by hospice providers. Once a beneficiary elects hospice, all hospice related claims are included in this file. Selected variables within the files are encrypted, blanked, or ranged.

The LDS file includes:

- the level of hospice care received (e.g., routine home care, inpatient respite care),
- terminal diagnosis (ICD-9/10 diagnosis),
- the days of service,
- reimbursement amounts,
- hospice provider number and beneficiary demographic information.

Federal Register 82: 36638

Aug. 4, 2017 (42CFR418) "FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements"

This document, prepared by CMS, contains certain descriptive information about hospice in 2016.

NHPCO National Data Set (NDS)

The NDS is a voluntary data collection initiative that gathers information on a wide range of hospice operations. NDS summary results provide useful information to hospices for defining strategic goals, setting operational targets, and improving care delivery.

Medicare Payment Advisory Committee (MedPAC)

MedPAC is an independent congressional agency established to advise Congress on payments to providers participating in the Medicare fee-for-service program. MedPAC also performs analysis on other issues related to Medicare including access to and quality of care. MedPAC publishes its recommendations in two reports released in March and June each year. Information on number of hospices in operation (pg 7) and tax status (pg 8) was taken from the MedPAC March 2018 Report to Congress.

SUGGESTED CITATION:
NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA:
National Hospice and Palliative Care Organization, Rev. ed. April 2018.

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