The word *hospice* derives from the Latin concept of *hospitium*, or hospitality.

**Abstract**

Hospice provides multidisciplinary care to dying patients with and without cancer. Most adults would prefer to be cared for in their home or that of a family member. This guide provides answers to the questions most commonly asked of physicians. Its goal is to facilitate a better understanding of what hospice does, who is eligible, physician roles, and how physicians can use hospice to help their patients.

**Introduction**

The idea that dying is a natural part of life conflicts with the medicalization of death to which we have become accustomed (McCue 1995). However, all would agree that it is inappropriate to treat only the dying patient’s disease. We would be remiss to ignore the family, social, cultural and spiritual dimensions of dying.

While disease-oriented care focuses solely on prolonging life, comfort and quality of life are at the heart of palliative care. Palliative care is the foundation for hospice services, although it can be provided in any setting where care is delivered to the terminally ill.

Most dying patients and their families want what hospice has to offer. A 1996 Gallup poll showed that, should they become terminally ill, 88 percent of adults would prefer to be cared for in their home or that of a family member (Gallup 1996).

Unfortunately, according to a more recent poll, 75 percent of Americans do not know that hospice care can be provided in the home, and 90 percent were unaware that hospice care can be fully covered by Medicare (NHPCO, Facts and Figures, 2000). Nearly 2.4 million Americans died in 2000; about 600,000 of them received hospice care. Close to 50 percent died in the hospital, 25 percent in a nursing home, and 25 percent in their own home or elsewhere. The National Hospice and Palliative Care Organization estimates that it served 29 percent of all Americans who died that year. Missouri has 72 licensed hospice programs, serving all counties but one (Oregon). In 2001, almost 17,000 Missourians were cared for in hospice, and more than 90 percent of hospice days were provided in patients’ homes.
The word hospice derives from the Latin concept of hospitium, or hospitality. It was popularized by nurse and physician Dame Cicely Saunders, who founded one of the first hospices, St. Christopher’s in London. Medicare, Medicaid (in 33 states), and most private insurance programs cover hospice services. Since the Medicare hospice benefit was introduced in 1983, millions of terminally ill Americans and their families have relied on interdisciplinary comprehensive palliative home care.

Hospice care is guided by an individualized plan developed by an interdisciplinary team, including a physician medical director, nurse, chaplain, social worker, and the patient’s attending physician, using a comprehensive case management approach. The goal is a care plan consistent with the preferences of the patient, designed to manage pain and other symptoms, and provide social support to the patient and their family.

To help inform physician readers of Missouri Medicine, here are some typical questions asked about hospice care.

**What services are provided under the Missouri Hospice Benefit?**

Under the direction of the attending physician, hospice provides:
- Registered nurses, often with special training in end of life care, furnish direct patient care and case management. The hospice nurse visits the patient as needed and is on call 24 hours a day for support of the patient and family.
- The medical social worker assesses needs and delivers social and instrumental support to the patient and family.
- The chaplain provides pastoral care assessment and spiritual support as desired by the patient and family members.
- The medical director supplies oversight and consultation to the multidisciplinary team and to the attending physician if desired.
- Trained hospice volunteers offer listening and companionship to the patient and family.
- Home health and homemaker services are also available, as are bereavement and dietary counseling.
- When included in the patient’s written plan of care, physical, occupational and speech therapy services must also be available.

One thing hospice does not supply is a 24-hour in-home caregiver. In fact, to be eligible for hospice, a dependent patient must have a designated caregiver.

**Does hospice provide drugs and medical equipment?**

Yes, as needed for palliation and management of the terminal condition. The patient is responsible for a 5 percent drug co-payment, not to exceed $5 per drug. Durable medical equipment such as commode chairs, walkers, and hospital bed are also supplied without charge as needed.

**Who is eligible for hospice?**

The short answer is: anyone who is dying. However, it is more complicated than that. Most private insurance programs and Medicaid have a hospice benefit plan with admission guidelines resembling those of Medicare.

A recent Centers for Medicare and Medicaid Services (CMS) document states: “The certification of terminal illness in an individual who elects hospice shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness … Generally speaking, the hospice benefit is intended primarily for use with patients whose prognosis is terminal with six months or less of life expectancy” (CMS 2002).

In 2000, both nationally and in Missouri, about 60 percent of hospice patients had cancer as their terminal diagnosis. More than 80 percent of these patients were Medicare recipients. But patients can enter hospice with any terminal diagnosis, including chronic obstructive pulmonary disease, HIV/AIDS, congestive heart failure, renal failure, stroke, or advanced dementia. The American Academy of Hospice and Palliative Medicine has developed general and disease-specific guidelines for hospice enrollment (Standards and Accreditation Committee, 1996).
Do I relinquish care of my patients when they enter hospice?

No. During the provision of all hospice services, the attending physician remains in charge. He or she works cooperatively with the hospice interdisciplinary team, but remains responsible for the services provided, and bills accordingly (see “How Do I Bill?” following). It is important to both physician and patient to continue their relationship during this difficult time; not only does it provide comfort to the patient, but the physician can enrich his or her personal and professional expertise by guiding the hospice team. The attending physician orders the personalized medical care, which should be based on goals of palliation rather than treating the disease itself. Some primary physicians who refer patients to hospice may prefer not to oversee their care. Sometimes the subspecialist who has been caring for the patient – an oncologist, cardiologist or neurologist, for example – may continue as the patient’s physician under hospice. If the primary physician wants to stop being involved after hospice certification, the patient can be referred to a colleague, or cared for by the hospice medical director, who then acts as the attending physician.

How will hospice help me care for my patient?

We all recognize that as terminally ill patients approach death, they require more frequent and diverse help than we generally provide in our office or hospital practices. The hospice team is structured to furnish these complex and time-consuming services so we don’t have to. For the hospice patient with a problem, the first contact is the hospice nurse, who is available in person or on call at all times. The social worker and chaplain assess patients and caregivers on admission to hospice, and as needed after that. The multidisciplinary team, including the medical director, regularly reviews the patient and care plan. This review, including recommendations for physician orders, is forwarded to the attending physician. As the end nears, hospice services are intensified. The hospice nurse goes to the home at the time of death (if not already present) and facilitates the transfer of the body to mortuary services.

How can I be sure I am sending my patient to a good hospice?

To receive Medicare funding, each hospice must go through a certification process and an annual survey. In Missouri, the Department of Health and Senior Services also completes an annual survey and licenses hospices. In addition, the National Hospice and Palliative Care Organization has developed “Standards of Practice for Hospice Programs” that measures 10 domains of quality care. Hospices that participate in the NHPCO are members of the Quality Partnership Program. Of course, personal and professional references are valuable.

How is hospice different from good home health care?

Hospice and Medicare-sponsored home care share some of the same goals: maintaining function and helping the patient stay at home. Sometimes home health agencies also provide hospice services. Clients of Medicare-sponsored home care are expected to improve and service ends if and when the patient stabilizes and no longer needs skilled nursing or rehabilitative services. Most home health agencies do not have active medical director support. Most do not provide pastoral care, and none supply medications. Medicare-sponsored home health requires the patient be homebound, while hospice has no such requirement.

If my patient is in hospice, does that mean I can’t treat pneumonia?

The short answer is no. In making a decision about treating an acute illness, one should always compare that decision with the patient’s goals for care. Once a patient is in hospice, the goals of care shift from disease treatment to comfort and improving quality of life. If treating pneumonia accomplishes those goals, then such treatment

Immediately, and during the year after death, hospice provides bereavement services to the family.
period after admission to hospice, die within the six-month period after admission to hospice, What if my patient doesn’t die within the six-month period after admission to hospice?

Many physicians are reluctant to refer patients to hospice, concerned that they might be underestimating their length of life. In 2000, the average length of service was 48 days, and the median was 25 days (NHPCO, Facts and Figures). Three months after enrollment, three months later, then at two-month intervals thereafter, the hospice must certify that the patient continues to meet hospice criteria and can benefit from hospice services. It is unusual but not impossible for patients to live for years after enrolling in hospice.

Physicians dislike predicting when a patient’s life will end, and research has shown they are not very good at it (Christakis, 1998, 2000). Unfortunately, 33 percent of patients served by hospice died in seven days or less, sometimes only hours after referral, thus preventing the patient from receiving the benefits that the hospice team can offer.

Physicians whose patients live longer than six months in hospice do not risk charges of Medicare fraud or abuse.

What if my patient wants to opt out of hospice, recovers, and doesn’t need hospice?

At any time, the patient can opt out of the hospice program and go back to receiving usual Medicare benefits. Should the need arise, the patient could re-enter hospice when appropriate.

Useful Websites for Information on Hospice Care

- National Hospice and Palliative Care Organization  www.nhpco.org
- Missouri Hospice and Palliative Care Association  www.mohospice.org
- Medicare - Hospice  www.hcfa.gov/medicare/hospiceps.htm
- American Academy of Hospice and Palliative Medicine  www.aahpm.org
- Midwest Bioethics Center - for information on medical ethics and end-of-life care  www.midbio.org
- American Medical Association’s Institute of Ethics program “Education for Physicians on End-of-Life Care” (the EPEC project)  www.ama-assn.org/ama/pub/category/2743.html
- Last Acts - a coalition of more than 300 organizations representing health care providers and consumers nationwide  www.lastacts.org

What happens if my patient or the family needs a break, or if symptoms cannot be controlled at home?

For overwhelmed caregivers, the hospice can provide several days of respite services, usually by placing the patient in an area nursing home with which the hospice contracts. If symptoms cannot be managed at home, the patient can be admitted to a hospital for intensive symptom management. This hospital is paid a negotiated rate by the hospice, and no break in service is required. Since the hospice team is skilled in home-based symptom management and can intensify services when necessary, it is unusual for a patient to require hospitalization.

If the patient is already in the hospital, how can hospice get involved?

It is often during hospitalization that it becomes obvious that the patient’s goals of care should shift from disease-oriented treatment to palliative care, and focus on quality of life and comfort. If the patient is not likely to die in the hospital, then hospice can provide...
a helpful transition of care to home or another setting, with no break in care plan or service. Attending physicians and hospitals should be encouraged to work with local hospices to encourage such smooth transitions.

Can hospice provide care for nursing home residents?

Because both Medicare-sponsored skilled nursing care and hospice are benefits paid for by Medicare Part A, no patient can receive both services simultaneously. Any non-Medicare nursing home patient, as long as he or she meets hospice criteria, can receive hospice benefits. Specialty-trained hospice staff and volunteers can provide many services beyond those usually offered in the nursing home. The delivery of end-of-life care occurs within the guidelines of both the nursing home and hospice. The coordinated plan of care must designate which care and services will be provided by the nursing home and which by the hospice, in order to best respond to the needs of the patient (Keay and Schonwetter 1998). Payment of room and board remains the responsibility of the patient, the family, or Medicaid for eligible residents. While 28 percent of Missouri deaths occur in nursing homes (Teno J., 2000), only a small percentage of elderly nursing home residents are enrolled in hospice (Oliver et al, J Palliative Care, in press).

How do I bill for caring for patients in hospice?

Attending physicians for hospice patients bill Medicare B through their usual carrier, simply adding the modifier - GV to the appropriate CPT code. Physicians who are caring for problems unrelated to the hospice diagnosis use the - GV modifier when they bill Medicare. Consulting physicians who are addressing needs related to the hospice diagnosis are effectively contracting with the hospice and bill the hospice agency itself.

How can I find a hospice in my community?

Hospices that serve your area can be found at the website of the Missouri Hospice and Palliative Care Association (www.mohospice.org). Representatives of most hospices will be happy to come to your patient’s home to answer questions and provide information.

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References