

# *Two Words for Hospice Leaders: Prove It*



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### INTRODUCTION

*Hospice providers “know” it:* They offer extraordinary, high-quality care to those patients and families they have the opportunity to serve; and there are many more individuals who deserve, but don't receive, the benefit of hospice care. There isn't a provider that hasn't heard, “Hospice caregivers are truly angels.” Even CMS has referred to hospice as the jewel in the Medicare crown. Yet the appreciation for hospice has been built on relatively little “hard” data. With accelerating growth in consumer awareness of hospice, ongoing increase in the number of hospice providers, rapid growth in hospice utilization across settings, and an accompanying rise in Medicare hospice expenditures, tolerance for the shortage of data is fading fast. Consumers, regulators, payers, policy-makers, advocates, healthcare partners across the continuum, and hospice provider executives all need more data. Hospice leaders must increase their capacity to capture, report, and analyze data, both to direct their own strategic efforts and to demonstrate quality and value to their many constituents. Hospice can offer substantial value to the healthcare system, through the highest quality care and ever-stronger organizations. *2008 is the year to prove it.*

### WHY NOW?

Hospice has long experienced the changing healthcare environment more as a relative outsider than as an integral, influential part of the system. Hospice has been sustained by the Medicare hospice benefit, but not fully embraced and promoted as a central component of government healthcare strategy. That has meant that some who would have benefited from hospice care went un-served, but also that hospice has not been a direct target of cost reduction or regulatory oversight efforts. That is changing fast. Healthcare is under unprecedented scrutiny, and end-of-life care is, for many reasons, on the “RADAR” screen. Changes are being considered. Without proof of its value, hospice is challenged. Urgent, organized action toward meaningful hospice data is demanded.

### CURRENT HEALTHCARE TRENDS

Important healthcare trends will have a growing impact on hospice. (1) Healthcare is increasingly consumer-driven. Comparative quality data are increasingly available and influential. Can “Hospice Compare” be far off? (2) Pay-for-performance (P4P) and “value-based” reimbursement models that reward providers with demonstrated high quality are being developed and tested in a variety of settings, with home care implementation near. (3) Disease management (DM), an evidence-driven, integrated approach to care provision for targeted chronic diagnoses, is becoming a focus. Hospice and palliative care should excel under all of these changes, and they all demand data.

### GOVERNMENT ACTIVITY

The Medicare hospice benefit has grown to have significant, and increasing, impact on the healthcare system, yet the Conditions of Participation (CoPs) and reimbursement model haven't been changed since the early 1980s. There is growing pressure to evaluate cost and utilization of the benefit. As the primary purchaser of hospice services, the government seeks a better understanding of the types, frequency, and quality of hospice services provided – proof of the value of hospice. Yet relevant data is lacking. Several parallel efforts are moving forward (with varying degrees of coordination) to accelerate the development of better hospice data and, at the same time, analyze the limited available data.

- **The QAPI CoP:** The proposed CoPs, to be final in May 2008, introduce the Quality Assessment and Performance Improvement CoP and require data to drive all aspects of agency and patient care management.
- **CMS CR 5567:** A change request to Medicare billing procedures, requires the reporting of weekly patient visit data on Medicare hospice claims. This is the second phase of a CMS effort to increase the data submitted through hospice claims. Note: At publication time, the new reporting is optional and becomes mandatory on July 1, 2008. There is active negotiation with CMS for a delay and refinement of this requirement.
- **MedPAC:** The Medicare Payment Advisory Council is actively gathering data and reviewing hospice. Of current concern is the Medicare hospice reimbursement cap. Recommendations for further investigation include hospice finances (revenue vs. costs) and longer-term reforms to payment the payment system, including eligibility, reimbursement incentives, case mix impact, and the “carve out” of managed care.
- **OIG:** The US Department of Health and Human Services Office of the Inspector General 2008 work plan includes activities addressing hospice services and reimbursement: a review of Medicare hospice care for nursing home residents to determine services and appropriate payments, and a review of duplicate drug claims for hospice beneficiaries receiving benefits under Medicare Part D.
- **CMS-funded QIO special project:** Through a special project, the Carolinas Center for Medical Excellence, a CMS-contracted Quality Improvement Organization, is developing instruments, measures and procedures to help hospices and palliative care programs assess and improve the quality of care.
- **AHRQ:** Under its, the Agency for Healthcare Research and Quality is developing scientific information for other agencies and organizations on which to base clinical guidelines, performance measures, and other quality improvement tools. Hospice will be included.

It must be a priority for hospices to have, understand, and share accurate, complete data about their services. This means building systems to capture, report, and analyze patient information in anticipation of government requirements, because the right data has the potential to influence those requirements.

## CARE MANAGEMENT AND PERFORMANCE MEASUREMENT RESOURCES

National and state hospice associations, several vendors and selected hospice corporations have strengthened the education of both CMS and providers and developed tools to move hospices toward an increasingly data-rich approach to managing patient care and operations. The National Quality Forum (NQF) *National Framework and Preferred Practices for Palliative and Hospice Care* and the National Hospice and Palliative Care Organization (NHPCO) Quality Partners® initiative provide a broad vision for hospice quality and important direction for further quality and outcome measure development. The National Association for Home Care & Hospice (NAHC) QAPI Collaborative Project tested and developed quality of care measures to help hospices and provide standardization to allow for comparisons within or across hospice providers.

Vendor-driven data programs, such as the OCS Hospice PeerForum, Deyta LLC's Factual Foresight, and Hospice Pharmacia's Patient Reported Outcome Measures (PROM) project, have helped hospices to capture and report data about patient care for ongoing performance improvement. Many information system vendors have been improving hospice-specific programming, by embracing the evolving direction of industry quality efforts and applying a wide range of technological advances, supporting varying approaches to the management of patient care. Several proven patient assessment tools are being implemented in hospice, facilitating data-driven care management and the development of patient-level databases.

However, with the multitude of efforts, achieving a consistent data set for ongoing analysis is extremely challenging. Waiting for CMS to mandate specific data elements, however, is a risk. To accelerate the movement toward consistency, a group of hospice information vendors has committed to utilize a shared set of hospice data elements and support provider education for consistent interpretation of reporting requirements, through the Hospice Leaders Project (HLP). Managed by OCS, Inc., the HLP currently includes 15 vendors, representing a significant majority of hospices who have implemented electronic systems. The HLP Master Data List draws upon the OCS Hospice data base, an evolving, comprehensive data set including standard measures from multiple hospice sources and relevant measures across the continuum of care.

### Hospice Leaders Project Members

- ▶ OCS, Inc., *project manager*
- ▶ CareCentric, Inc.
- ▶ Cerner BeyondNow
- ▶ Delta Health Technologies, LLC
- ▶ Deyta, LLC
- ▶ HealthWyse
- ▶ Homecare Homebase
- ▶ McKesson Provider Technologies
- ▶ Mills and Murphy Software Systems
- ▶ Misys Healthcare Systems
- ▶ mumms Software
- ▶ Patient Care Technologies
- ▶ Procura
- ▶ Prodata
- ▶ Suncoast Solutions

### RECENT RESEARCH

The results of two studies published in the last few months of 2007 are being widely referenced in discussions considering hospice reimbursement levels and approaches.

Duke University researchers concluded that hospice saved Medicare an average of \$2,300 per beneficiary. They found that hospice use reduced costs for most days during the last three months of life. Further, if hospice were utilized for a longer period of time, Medicare costs would be reduced for 7 of 10 hospice recipients. "This is a rare situation whereby something that improves quality of life also appears to reduce costs," said Don Taylor, assistant professor of public policy at Duke's Sanford Institute of Public Policy and primary author of the study.

Researchers at Harvard Medical School reported findings based on national data that point to significant differences in care across hospice settings and a growing need to analyze their implications. The data does not address whether agency costs differ between institutional and home settings. Further research is recommended to determine how the growing use of hospice outside the home may affect quality assessment, appropriateness of hospice utilization, and models of reimbursement.

Others are analyzing and describing hospice care and services. Some research may provide important answers – clear, supportive proof of what hospices "know". The same studies will also add to the list of open questions and areas of potential concern. Hospices should seek published research, to complement their own internal data in supporting decision-making and communications, as well as to anticipate the potential impact on constituents' understanding of hospice.

### ACTIVE EFFORTS TO BUILD THE "PROOF" OF HOSPICE VALUE

National organizations advocating the growth of hospice and palliative care, including NHPCO, NAHC, the American Hospice Foundation (AHF), and the Center to Advance Palliative Care (CAPC), are aggressively working to generate accurate, complete data to support decision-making that has an impact on the quality of and access to hospice and palliative care services. Efforts include developing and promoting the use of measurement tools and standard data; educating agencies in effective data-driven management of care and operations; building comparative databases and generating analysis to support advocacy efforts and consumer decision-making; and encouraging policies and legislation to make the right data available to regulators and policy-makers. State organizations actively support the national efforts, and selected states have local efforts to build hospice data proficiency and contribute analysis demonstrating hospice utilization and performance.

Independent initiatives target specific opportunities for the proof of hospice value to have an impact. For example, Reclaiming the End of Life was a New Hampshire-based project, led by Ira Byock, MD, that used the national spotlight on the New Hampshire presidential primaries to encourage substantial discussion, grounded in data, of the needs of seriously ill or frail individuals and their loved ones.

### PROOF AS A PRIORITY

What is the single most important message for hospices in 2008? “Accountability, accountability, accountability,” says Don Schumacher, President and CEO of the National Hospice and Palliative Care Organization (NHPCO). “It’s not enough to do the right things. Hospice providers need to document and demonstrate that they are doing the right things.” Proof means consistently doing the right things ... and being able to provide evidence that justifies legislation and reimbursement that is favorable to hospice providers, as well as those they serve.

#### Prove What?

- ▶ Prove that you provide extraordinary, high-quality care.
- ▶ Prove that your organization is a superior place to work.
- ▶ Prove that your internal priorities are appropriate, so that you can focus your resources.
- ▶ Prove that you utilize donations for meaningful, high value programs and services.
- ▶ Prove the level of services your hospice provides – beyond the “services” to be captured as visits in upcoming Medicare claims reporting requirements, specified in CR 5567.
- ▶ Prove, through appropriate documentation, that your social workers and chaplains provide high-value, effective services, central to the hospice plan of care.
- ▶ Prove that you meet patient and family goals, utilize effective interventions, and ensure patient safety, as required by the QAPI CoP.
- ▶ Prove that patients referred to hospice sooner experience higher quality outcomes ... and prove for which subsets of patients there is greatest opportunity to improve.
- ▶ Prove that the hospice program contributes to the health system mission and results, through effective, high-quality care and services that help other departments and divisions perform better.
- ▶ Prove that you can help partners in the continuum, especially home health agencies and nursing facilities, improve their quality of care and satisfaction, through appropriate, timely referrals to hospice.
- ▶ Prove to presidential candidates and their staffs that end of life care must be an explicit part of their healthcare reform recommendations.

## COMPLIANCE AND REIMBURSEMENT

At the most basic level, of course, Medicare-certified providers must adhere to the law, prove compliance with Conditions of Participation (CoPs) and, often, accreditation standards; and they must follow specified billing procedures, proving eligibility for reimbursement. Historically, that has meant documentation – documentation of policies, procedures, financial transactions, and employment information, as well as documentation of the length of service and level of care provided to patients.

For the first time since the inception of the Medicare Hospice benefit over twenty years ago, new CoPs are on the horizon. The proposed CoPs, to be final by May 2008, “raise the stakes”, with regard to documentation, formalizing quality assessment and performance improvement (QAPI) and requiring data to drive all aspects of agency and patient care management. Further, the hospice reimbursement model, with rates calculated based on information from a Medicare demonstration project completed in the early 1980s, is under scrutiny; and hospices are now preparing for the second phase of additional Medicare claims data submission as a result of CMS Change Request CR 5567, as noted above.

## OPERATING MANAGEMENT

Successful hospice leaders manage their organizations to provide the highest quality care, with the most effective processes and efficient use of resources. The best managers use data throughout the organization to inform their decisions. Care plans are based on patient assessment data, with evidence-based interventions, where possible. Staff is assigned and visits are scheduled based upon patient volume and mix, taking into consideration patient diagnosis, severity, caregiver support, location of care, and more. Hiring, promotion, professional development and termination decisions are based upon well-documented information about individual and team performance. Budgets, productivity, outcome and customer satisfaction targets are set based upon internal and comparative data; and ongoing performance is monitored and managed relative to those targets.

Performance improvement projects are determined based on a 360° organizational quality assessment; and success is quantified based upon improvement relative to the initial quality assessment. (This is the embodiment of the QAPI.) Well-managed organizations have “proof” that their decisions are the right ones – proof that supports “buy-in” among those who must implement or are affected by the decisions, and proof to address questions about those decisions “down the road”.

**STRATEGIC DIRECTION**

Beyond managing an effective “status quo” organization (where patient volume is stable, referral sources and care partner relationships are solid, and outcome and satisfaction measures are good), hospice leaders may set and achieve strategic goals for the ongoing evolution of the hospice program. There are many potential strategic directions: How can you best grow your census? Is it a good time to build or lease space for your own inpatient facility? What information system is right for you, giving you access to needed patient-level data? How should you integrate palliative care services? Can you build community partnerships to improve access and care for selected cultural sub-populations?

Determining right strategy begins with data. The Strategic Planning Matrix, below, illustrates a data-driven approach to strategic goal setting. Achieving the goals requires the development and implementation of action plans, with responsibilities assigned, and performance monitoring against the quantified annual goals.

Strategic Planning Matrix		
The Strategic Questions	Data Required	Quantified Annual Goals
<p><i>Can we increase access by targeting specific patient populations?</i></p> <ul style="list-style-type: none"> <li>▶ What populations are underserved?                             <ul style="list-style-type: none"> <li>- by race, religion, or cultural community?</li> <li>- by diagnosis?</li> <li>- by age?</li> <li>- by location?</li> </ul> </li> <li>▶ How much growth is possible?</li> </ul>	<ul style="list-style-type: none"> <li>▶ Current patient mix by subset</li> <li>▶ Community demographics (number of people in targeted categories)</li> <li>▶ Competitor patient mix and marketing strategies</li> <li>▶ Potential marketing and educational resources to apply</li> </ul>	<ul style="list-style-type: none"> <li>▶ Care for 30% of deaths at two selected nursing facilities</li> <li>▶ Serve 10 pediatric patients</li> </ul>
<p><i>Can we grow census by targeting referral sources?</i></p> <ul style="list-style-type: none"> <li>▶ Which referral relationships could be cultivated or strengthened?</li> <li>▶ How would focused efforts affect patient length of stay and diagnosis mix?</li> </ul>	<ul style="list-style-type: none"> <li>▶ Current patient volume by referral source</li> <li>▶ Diagnosis mix by referral source</li> <li>▶ Length of service by referral source</li> <li>▶ Competitor relationships and marketing strategies</li> </ul>	<ul style="list-style-type: none"> <li>▶ Increase number of admissions referred from local cardiac center by 25%</li> <li>▶ Increase cancer ALOS by 5 days</li> <li>▶ Decrease cancer LOS &lt; 7 days by 10%</li> </ul>
<p><i>How should we change our model of care to optimize use of home health aides?</i></p> <ul style="list-style-type: none"> <li>▶ Will increasing HHA visits increase overall quality of care?                             <ul style="list-style-type: none"> <li>- Which specific outcomes or aspects of satisfaction will be affected?</li> </ul> </li> <li>▶ Can we reduce visits from other disciplines if we increase HHA visits?</li> <li>▶ Is there a sufficient HHA population in the market to grow HHA staffing levels?</li> </ul>	<ul style="list-style-type: none"> <li>▶ Current number of patient visits by discipline by patient                             <ul style="list-style-type: none"> <li>- overall</li> <li>- by diagnosis</li> <li>- by location</li> </ul> </li> <li>▶ Selected outcomes by patient</li> <li>▶ Cost per visit by discipline; cost to hire and train new HHA</li> <li>▶ HHA visit length</li> <li>▶ HHA, RN, LPN % of time by task</li> <li>▶ HHA market data (certificates earned, competitor HHA staffing levels, local unemployment)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Increase average HHA visits per patient week by 25%</li> <li>▶ Increase HHA productivity (weekly visits per FTE) by 25%</li> <li>▶ Decrease average length of HHA visit by 15 minutes</li> <li>▶ Decrease incidence of patient falls by 10%</li> <li>▶ Increase caregiver confidence scores by 15%</li> <li>▶ Maintain total staff cost per patient day</li> </ul>

### ADVOCACY

A proven hospice organization has an impact far beyond its service area – and even beyond the reach of educational sessions its staff may present or the relationships and reputation of its executives. A proven hospice contributes to the body of good data about hospice care. The collective evidence of hospice care and services is a growing, but still very incomplete, database. Existing evidence generates the perception – but also the reality – of hospice as a component of the healthcare system and our social fabric.

Hospices should directly support advocacy on their behalf, by contributing data for national efforts to evaluate and demonstrate the value of the care they provide. Further, hospices should build data-driven communications to promote their value and increase patient access locally.

### CONCLUSION

There is a new urgency for hospice leaders to be *truly* accountable for their strategic decisions and managerial effectiveness – to have the necessary data to prove that they are “doing the right things” now and working toward targeted performance improvements. They must know that they are taking the best possible care of each patient and, at the same time, optimizing resources and strengthening their organizations. And they must share data externally.

With thorough evidence of what hospices do and how effectively they do it, the potential value to the broader healthcare system will be demonstrated; and the right decisions may be made. Reimbursement will allow for the appropriate spectrum of services to be provided; and eligibility for those services will be expanded. Through the sharing of meaningful – if not yet mandated – data, hospices may demonstrate their value and support the ongoing expansion, improvement and fair reimbursement of hospice and palliative care services. ***Prove it, or lose it.***

# REFERENCES AND RESOURCES

## **Quality Assessment and Performance Improvement CoP**

### **The proposed Medicare Conditions of Participation**

*Federal Register/Vol. 70, No. 102/ May 27,*

*2005/Proposed Rules*

[www.cms.hhs.gov/quarterlyproviderupdates/Downloads/CMS3844P.pdf](http://www.cms.hhs.gov/quarterlyproviderupdates/Downloads/CMS3844P.pdf)

## **CR5567 – CMS Expansion of Claims Data Reporting**

### **CR5567 Instructions for Regional Home Health**

**Intermediaries (RHHs), revised 11/02**

*Change Request to the Medicare Claims Processing*

*publication, initially transmitted July 20, 2007*

[www.cms.hhs.gov/transmittals/downloads/R1372CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1372CP.pdf)

### **CMS Website, Hospice Center**

*Current information about Medicare CoPs, billing requirements, and other CMS initiatives*

[www.cms.hhs.gov/center/hospice.asp](http://www.cms.hhs.gov/center/hospice.asp)

### **NHPCO Members Only Webpage for CR5567**

*Complete set of resources for interpretation, education, and tools to address the new billing requirements*

[www.nhpc.org/login.cfm?nextpage=/i4a/pages/index.cfm?pageid=5320](http://www.nhpc.org/login.cfm?nextpage=/i4a/pages/index.cfm?pageid=5320)

## **Hospice Quality and Performance Measurement Resources**

### **Framework and Preferred Practices for Palliative and Hospice Care**

*Report on National Quality Forum framework to evaluate hospice and palliative care, including 38 preferred practices*

[www.qualityforum.org/publications/reports/palliative.asp](http://www.qualityforum.org/publications/reports/palliative.asp)

### **NHPCO Quality Partners initiative**

*Vision and resources for hospice quality improvement, organized by 10 Components of Quality*

[www.nhpc.org/quality](http://www.nhpc.org/quality), 703-837-1500

### **Hospice Leaders Project (HLP) Hospice Master Data List**

*Hospice patient-level data elements and definitions being implemented by members of the HLP vendor collaborative*

[HLP@ocsys.com](mailto:HLP@ocsys.com), 888-325-3396

### **Comprehensive Hospice Performance Measure Listing**

*Consolidated listing of broadly-implemented hospice performance measures (financial, operational, staffing, patient volume and mix, customer satisfaction, outcomes, quality, bereavement, clinical and management practices) from multiple sources*

[info@ocsys.com](mailto:info@ocsys.com), 888-325-3396

### **The QAPI Requirement: Resources for Hospice Programs**

*Manual on what hospices need to know and do about*

*QAPI, with CD of customizable planning, documentation*

*and education materials, by Merriman, Tecca, and Wilson.*

[www.weatherbeeresources.com](http://www.weatherbeeresources.com)

### **CMS Visit Reporting Guide**

*Updated summary of requirements, interpretation challenges, and advocacy efforts, with priorities for preparation and action*

For copies, contact [HLP@ocsys.com](mailto:HLP@ocsys.com), or call 888-325-3396

### **NHPCO Performance Measurement Initiatives**

*Tools, protocols, comparative data*

[www.nhpc.org/research](http://www.nhpc.org/research), 703-837-1500

### **Epidemiology of Dying and End of Life Experience**

*(EDELE) Searchable online database with access to websites and web pages with useful data about*

*decedents, dying and end-of-life experience*

[www.edeledata.org](http://www.edeledata.org)

### **AHRQ Evaluation of End-of-Life Outcomes and Research Priorities**

*Evidence report/technology assessment,*

*commissioned by the National Institute of Nursing*

*Research (NINR), with the Agency for Healthcare*

*Research and Quality (AHRQ), December 2004*

[www.ahrq.gov/clinic/epcsums/eolsum.htm](http://www.ahrq.gov/clinic/epcsums/eolsum.htm)

### **"Patient Level Data Analysis in Hospice"**

*State of the art and science and recommendations for action. (Tecca)*

*Caring*, November 2007, pages 16-23.

# REFERENCES AND RESOURCES

## **Patient Assessment Tools**

### **Missoula-VITAS Quality of Life Index**

Assessment and outcome measure for palliative care  
[www.dyingwell.org/MVQOLI.htm](http://www.dyingwell.org/MVQOLI.htm)

### **Palliative Performance Scale**

A tool for evaluating patients requiring palliative care  
[www.victoriahospice.org/ed\\_tools.html](http://www.victoriahospice.org/ed_tools.html)

### **Edmonton Symptom Assessment System (ESAS)**

Patient data capture tool and process provide a clinical profile of symptom severity over time  
[www.palliative.org/PC/ClinicalInfo/AssessmentTools/esas.pdf](http://www.palliative.org/PC/ClinicalInfo/AssessmentTools/esas.pdf)

### **NAHC QAPI Collaborative Clinical Quality Measures**

Process and outcome measures developed and tested by a provider collaborative, based on the Edmonton Symptom Assessment System  
Contact [jen@NAHC.org](mailto:jen@NAHC.org)

## **Selected Hospice Data News and Research**

### **NHPCO Facts and Figures on Dying**

Key demographics and outcomes of hospice patients, caregivers, and providers, based upon 2006 NHPCO National Data Set, supplemented with additional sources.

[www.nhpc.org/files/public/Statistics\\_Research/NHPCO\\_facts-and-figures\\_Nov2007.pdf](http://www.nhpc.org/files/public/Statistics_Research/NHPCO_facts-and-figures_Nov2007.pdf)

### **Reclaiming the End of Life – Citizen Voices**

A report on aging, living with serious illness, and family care-giving, based on findings of Citizen Forums held March-July, 2007 throughout NH in anticipation of the presidential race.

[www.ReclaimTheEnd.org](http://www.ReclaimTheEnd.org)

### **Hospice Services Payment Briefing**

Primer on Medicare reimbursement policy by the Medicare Payment Advisory Commission (MedPAC); revised October 2007

[medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_07\\_hospice.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_07_hospice.pdf)

### **MedPAC Report on Access to Hospice Care**

11/8/08 review of data on hospice utilization and payments (with focus on payment cap), issues in access to care, incentives for long lengths of stay and additional policy considerations

[www.medpac.gov/transcripts/1107\\_hospice\\_access JM\\_pres.pdf](http://www.medpac.gov/transcripts/1107_hospice_access JM_pres.pdf)

### **Palliative Care Quality Measurement Project (PEACE)**

CMS-funded project by the Carolinas Center for Medical Excellence, to develop tools and procedures to help assess quality of care and improve performance; report due by February, 2008; to be reviewed by CMS and NQF prior to public dissemination

[www2.thecarolinascenter.org/ccme/ccme.aspx?tabid=209&itemid=254&mid=95](http://www2.thecarolinascenter.org/ccme/ccme.aspx?tabid=209&itemid=254&mid=95)

### **Pain and Palliative Care Assessment and Research Tools**

Links to tools, available free, from the International Association of Hospice and Palliative Care (IAHPC)

[www.hospicecare.com/resources/pain-research.htm](http://www.hospicecare.com/resources/pain-research.htm)

### **OIG Fiscal Year 2008 Work Plan**

US Department of Health and Human Services Office of the Inspector General (OIG) work plan, including activities addressing hospice services and reimbursement

[www.oig.hhs.gov/publications/docs/workplan/2008/Work\\_Plan\\_FY\\_2008.pdf](http://www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf)

### **“Differences in Hospice Care between Home and Institutional Settings”**

Harvard Medical School study comparing hospice care delivered at home with that in institutional settings, showing significant differences and recommending further research for policy-making  
*Journal of Palliative Care* Volume 10, Number 5, 2007  
[www.liebertonline.com/doi/abs/10.1089/jpm.2007.0071](http://www.liebertonline.com/doi/abs/10.1089/jpm.2007.0071)

### **“In Hospice Care, Longer Lives Mean Money Lost”**

11/22/07 *New York Times* article on impact of Medicare Hospice Cap on some hospices  
[www.nytimes.com/2007/11/27/us/27hospice.html?pagewanted=1](http://www.nytimes.com/2007/11/27/us/27hospice.html?pagewanted=1)

 **CONTACT US**

Address: 1818 E Mercer Street  
Seattle, WA 98112

Email: [info@ocsys.com](mailto:info@ocsys.com)

Website: [www.ocsys.com](http://www.ocsys.com)

Tel: 888.325.3396

Fax: 206.720.6018

