MEMORANDUM

TO: The US Senate Committee on Health, Education, Labor and Pensions (HELP)

FROM: Margaret Dore, Esq., MBA
Choice is an Illusion, a nonprofit corporation opposed to assisted suicide, euthanasia and hospice/palliative care abuse

RE: Vote “No” on Bill S. 693, the “Palliative Care and Hospice Education and Training Act” (H.R. 1676)*

DATE: Updated, October 19, 2018

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I. INTRODUCTION

I am an elder law attorney and president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. Formed in 2010, Choice is an Illusion fights against assisted suicide and euthanasia throughout the U.S. and in other countries. We also fight against hospice and palliative care abuse.

S. 693 amends the Public Health Service Act to require financial support for “Palliative Care and Hospice Education Centers.” This will be a new program, which will include hands on patient care.

Existing palliative care programs, such as the Medicare hospice benefit, are plagued by fraud, poor quality care and a gross waste of taxpayer money. S. 693 must be rejected unless

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1 I am an elder law and appellate attorney licensed to practice law in Washington State since 1986. I am also a former Law Clerk to the Washington State Supreme Court and the Washington State Court of Appeals. My CV is attached hereto at A-1 to A-4. See also www.margaretdore.org

2 www.choiceillusion.org

3 A copy of the bill is attached hereto at pages A-5 to A-19.

4 See bill, at pages A-8 and A-9 (describing patient care including “clinical training” and “service rotations”).

5 See: Office of Inspector General (OIG) media release dated July 30, 2018, attached hereto at A-20; and Joanne M. Chiedi, Principal Deputy Inspector General, “Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio (excerpts attached hereto at A-21 to A-36). The portfolio can be viewed in its entirety at this link: https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf
the problems with existing palliative care programs are resolved; Congress must not throw good money after bad. The bill must also be rejected for the other reasons set forth below.

II. DEFINITIONS

"Assisted suicide" occurs when a person provides the means or information for another person to commit suicide, for example, by providing a rope or lethal drug. If the assisting person is a physician, a more precise term is "physician-assisted suicide."7

"Euthanasia" is the direct administration of a lethal agent to cause another person’s death.8 Euthanasia is also known as "mercy killing."9

"Hospice/palliative care abuse" occurs when non-dying people are administered lethal doses of medication under the guise of relieving pain and suffering. This practice is sometimes termed "stealth euthanasia" or just "euthanasia."

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7 See e.g., The American Medical Association (AMA) Code of Medical Ethics, Opinion 5.7 (defining physician-assisted suicide). Attached hereto at A-37.

8 Id., Opinion 5.8, "Euthanasia," attached at A-37, lower half of page.

III. OTHER TERMINOLOGY

Assisted suicide and euthanasia are sometimes described as "aid in dying," "death with dignity" and "medical aid in dying." Proponents use these terms interchangeably to mean assisted suicide and euthanasia.

IV. FACTUAL AND LEGAL CONTEXT

A. The Bill

On March 22, 2017, the bill was introduced in the Senate as S. 693 and in the House as H.R. 1676. The House version was amended and then passed on July 23, 2018. On July 24, 2018, the House version was received in the Senate, read twice and referred to this committee.

B. The OIG Portfolio

On July 30, 2018, the Office of the Inspector General (OIG) issued a portfolio highly critical of hospice. The portfolio states:

OIG investigations of fraud cases have uncovered hospices enrolling patients without the beneficiary's knowledge or under false pretenses, enrolling beneficiaries who are not terminally ill, billing for services not provided, paying kickbacks, and falsifying documentation. 12

10 See examples, attached at A-39 to A-41.
11 See footnote 5, supra
12 Id., attached hereto at A-25.
The portfolio also explains why enrolling patients in hospice who are not terminally ill can put patients at risk, due to their no longer being eligible for curative care. The portfolio states:

Medicare hospice does not pay for curative treatment for a beneficiary’s terminal illness....

[A] beneficiary who is inappropriately enrolled in hospice care might be unwittingly forgoing needed treatment. In one example, a hospice falsely told a beneficiary that she could remain on a liver transplant list even if she elected hospice. When the beneficiary elected hospice, she was removed from the ... list. (Footnote omitted).13

C. The OIG Recommendations

The OIG portfolio recommends 15 specific actions related to 7 areas for improvement to protect Medicare hospice beneficiaries and the integrity of the Medicare program.14 The recommendations include the following:

[T]he Centers for Medicare & Medicaid Services (CMS) ... should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries and their families and caregivers make informed choices about hospice care. (Emphasis added).15

13 Id., attached hereto at A-30.
14 Id., attached hereto at A-23.
15 Id.
D. A $60 Million Fraud

On February 28, 2017, the US Attorneys Office for the Northern District of Texas issued a press release announcing a grand jury indictment of 16 individuals, including Bradley J. Harris, a co-owner of Novus Health Services and Option Health Services (collectively “Novus”). According to the release, hospice beneficiaries suffered serious bodily injury and death in order to produce maximum profit for Novus. The release states:

Harris would direct that patients be placed on continuous care [which had a higher billing rate]....

When a beneficiary was on continuous care, ... nurses would administer high doses of Schedule II controlled medications ..., whether the beneficiary needed the medication or not....

One reason for this aggressive medicating practice was that Harris wanted to ensure that the beneficiaries' medical records contained documentation that would justify billing Medicare at the higher continuous care billing rate. There were instances when these excessive dosages resulted in serious bodily injury or death to the beneficiaries. (Emphasis added).

As of June 15, 2018, at least three Novus employees had plead guilty.
E. The Human Cost

The human cost of palliative care and hospice abuse can also be found in the articles, letters and posts of still hurting individuals whose friends and/or family were allegedly killed in hospice. (Attached hereto at A-48 to A-71).

V. THE BILL MUST BE REJECTED

A. Congress Must Not Throw Good Money After Bad

Prior to enacting the hospice program recommended by the proposed bill, the Committee must assure itself that existing hospice and palliative care programs have been rendered safe and financially sound. Otherwise, with the passage of a new hospice and palliative care program, there will only be more of the same: fraud, poor care and actual killing. The proposed bill must be rejected.

B. The Bill Works Against the Right of Individuals to Make Their Own Choices

The bill repeatedly describes hospice and palliative care as a benefit for patients and their families.¹⁹

Patients and families can have divergent interests. The patient may want to get well and move on to the next stage of his or her life. The patient’s children may want inheritances. It is also well known that perpetrators are often family members who

¹⁹ See bill, attached hereto at A-6, A-8 & A-17.
can feel themselves “entitled” to family member assets.\textsuperscript{20}

This is a fundamental problem with the bill, that it is designed to serve two masters, i.e., the patient and the family. The bill thereby takes away from the right of the individual to make his or her own choices. The bill must not be enacted unless and until it is rendered exclusively patient centered.

C. The Bill Applies to Persons with a “Serious Or Life Threatening Illness,” the Definition of Which Is Not to Be Decided until after the Bill Is Enacted in Consultation with Unnamed “Appropriate Professional Societies” and Other Parties. The Bill Has Other Undefined Terms So That Its Meaning Is Unclear and Therefore Not Ready for Passage

The bill uses the phrase, “serious or life-threatening illness,” twelve times, but does not define it.\textsuperscript{21} The bill also provides for the definition to be determined by the Director in consultation with other parties after the bill is enacted.\textsuperscript{22} The


\textsuperscript{21} See bill, attached hereto at A-5 to A-19.

\textsuperscript{22} The bill states:

The Director shall consult with appropriate professional societies, hospice and palliative care stakeholders, and relevant patient advocate organizations with respect to palliative care, psychosocial care, and complex chronic illness with respect to the following: ...

“(3) A definition of the term ‘serious or life-threatening illness’ for purposes of this section.”
bill also has terms such as "life-limiting prognosis" and "life-limiting illness," which are not defined.\textsuperscript{23} With this situation, there is uncertainty as to exactly whom the bill will apply and/or what it means.

Given that the bill topic involves life and death, the bill must not be enacted without having these terms defined and/or otherwise clarified with certainty. Once again, the bill is not ready for passage.

**D. If Enacted, the Bill Will Undermine OIG's Recommendation That the Centers for Medicare & Medicaid Disseminate Information on Hospices, Including Complaint Investigations**

As described above, OIG's recommendations for improvement of the Medicare hospice benefit include that the Centers for Medicare & Medicaid Services (CMS) should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries make informed choices about hospice care.\textsuperscript{24}

The bill instead provides for a mandatory national education and awareness campaign to inform patients, families and health care professionals about the benefits of palliative care.\textsuperscript{25}

\begin{itemize}
\item S. 693 excerpt, attached hereto at A-18.
\item Attached hereto at A-6.
\item Attached hereto at A-23.
\item The bill, attached hereto at A-16.
\end{itemize}

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The bill also requires publication of this information on the Internet websites of relevant Federal agencies and Departments, including the Centers for Medicare & Medicaid Services (CMS). \(^2\)

More to the point, if the bill is enacted, requiring relevant federal websites to "promote the benefits of palliative care," will those same sites be allowed to also describe problems with palliative care, and/or will those sites be silenced?

Moreover and regardless, will the required mandatory reporting of palliative care as a "benefit," no matter what the facts, be fair to the public or will it be a fraud on the public and a violation of the public's right to know?

For all of these reasons, the proposed mandatory national education and awareness campaign to promote the benefits of palliative care must be rejected.

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\(^2\) The bill states:

**REQUIRED PUBLICATION.**—The information and materials required to be disseminated under paragraph (1) and any information disseminated under paragraph (2) shall be posted on the Internet websites of relevant Federal agencies and Departments, including the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Administration on Aging, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs.

The proposed bill, S. 693, attached hereto at A-18.
E. The Bill Does Not Require Hospice Patients to Be "Terminally Ill," Which Will Potentially Create Confusion in the Law and/or Undermine Medicare Fraud Litigation

In order to elect hospice under Medicare, current law requires that an individual be certified as "terminally ill." This means:

[T]he individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.27

The bill does not use the phrase, "terminal illness."28 The bill also states:

Hospice is palliative care for patients in the last year of life.... Hospice is a covered benefit under the Medicare program.29

With this language, the bill can be read as expanding the Medicare hospice benefit to non-terminal people, who, if they sign up for hospice, will be disqualified from receiving curative care. Medicare fraud litigation based on the requirement of a terminal illness may no longer apply and/or may be unclear.

VI. CONCLUSION

Existing palliative and hospice care programs, such as the Medicare hospice benefit, are plagued by fraud, poor quality care, abuse, arguably murder, and a gross waste of taxpayer

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See bill in its entirety, attached hereto at A-5 to A-19.

28

The bill, attached hereto at A-6.

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money.

Adding another program when existing programs are far from under control makes no sense and will only cause more of the same. It's time to stop the waste, bleeding and heartache. I urge you to vote "No" on S. 693.

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CURRICULUM VITAE

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Law Offices of Margaret K. Dore, P.S., Seattle, Washington USA.
Attorney/President. Work has included litigation, civil appeals, probate, guardianship and bankruptcy. Also participate in legislation and court cases involving assisted suicide and euthanasia in the US, Canada, Australia, South Africa and other jurisdictions. (October 1994 to present).

Lanz & Danielson, Seattle, Washington USA.

Self-Employed Attorney, Seattle, Washington USA.
Worked for other attorneys and private clients. Work emphasized appeals and litigation generally. (September 1989 to December 1990).

The United States Department of Justice, Office of the United States Trustee, Seattle, Washington USA.

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.

The Washington State Court of Appeals, Tacoma, Washington USA.
ADMITTED TO PRACTICE:

- Supreme Court of the United States, 2000-present.
- United States Court of Appeals for the Ninth Circuit, 1988-present.
- United States District Court, Western District of Washington 1988-present.

PROFESSIONAL MEMBERSHIPS:

- American Bar Association, 2001 to present.
- American Bar Association, Elder Law Committee of the Family Law Section, Chair 2007.
- Choice is an Illusion, President, 2010 to present.
- Fellows of the American Bar Foundation, Life Fellow, 2007 to present.
- King County Bar Association, 1989 to present.
- King County Bar Elder Law Section, Chair, 1995-96.

PUBLICATIONS:

Assisted Suicide and Euthanasia

Margaret Dore, “California’s New Assisted Suicide Law: Whose Choice Will it Be?,” JURIST - Professional Commentary, October 24, 2015;

Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), The Voice of Experience, ABA Senior Lawyers Division Newsletter, Winter 2014;


State Senator Jim Shockley & Margaret Dore, "No, Physician-Assisted Suicide is not Legal in Montana: It's a recipe for elder abuse and more." The Montana Lawyer, November 2011;


Margaret Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit not by Name)," Marquette Elder's Advisor, Vol. 11, No. 2, Spring 2010;
Margaret K. Dore, "Death with Dignity: What Do We Tell Our Clients?,”
Washington State Bar Association, *Bar News*, July 2009; and

Margaret K. Dore, "Death with Dignity: What Do We Advise Our Clients?,”

**Guardianship, Elder Abuse and Family Law**

Margaret K. Dore, Ten Reasons People Get Railroaded into Guardianship, 21

Margaret K. Dore, The Time is Now: Guardians Should be Licensed and
Regulated Under the Executive Branch, Not the Courts, Washington State Bar

Margaret K. Dore, A Call for Executive Oversight of Guardians, King County Bar

Margaret K. Dore, The Case Against Court Certification of Guardians: The Case
for Licensing and Regulation, National Academy of Elder Law Attorneys, *NAELA
News*, Vol. 18, No. 1, February/March 2006;

Margaret K. Dore, The Stamm Case and Guardians ad Litem, King County Bar
Law Section Newsletter*, Winter 2004-2005, p. 3;

Margaret K. Dore, The "Friendly Parent" Concept: A Flawed Factor for Child
Custody, 6 *Loyola Journal of Public Interest Law* 41 (2004);

News*, August 2001;

Margaret K. Dore and J. Mark Weiss, “Lawrence and Nunn Reject the 'Friendly
Parent' Concept”, *Domestic Violence Report*, Vol. 6, No. 6, August/September
2001;

2001;

Margaret K. Dore, “Parenting Evaluators and GALs: Practical Realities,” King
County Bar Association, *Bar Bulletin*, December 1999; and

AWARDS/RECOGNITIONS:

- Butch Blum Award of Excellence in the Legal Arena, for 2005, in association with Law & Politics Magazine (One of nine nominees, only solo practitioner).

PUBLISHED DECISIONS:

- In re Guardianship of Stamm, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);
- Lawrence v. Lawrence, 105 Wn. App. 683, 20 P.3d 972 (2001) (3-0 opinion re: the “friendly parent” concept, that its use in a child custody determination would be an abuse of discretion);
- Jain v. State Farm, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and
- In Re Alpine Group, Inc., 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

EDUCATION:


University of Washington Foster School of Business, Seattle, Washington USA. Masters of Business Administration, 1983; Concentration: Finance.

University of Washington Foster School of Business, Seattle, Washington USA. Bachelor of Arts, Business Administration, 1979; Concentration: Accounting. Honors: Graduated Cum Laude; Phi Beta Kappa.

S. 693

To amend the Public Health Service Act to increase the number of permanent faculty in palliative care at accredited allopathic and osteopathic medical schools, nursing schools, social work schools, and other programs, including physician assistant education programs, to promote education and research in palliative care and hospice, and to support the development of faculty careers in academic palliative medicine.

IN THE SENATE OF THE UNITED STATES

MARCH 22, 2017

Ms. BALDWIN (for herself and Mrs. CAPITO) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to increase the number of permanent faculty in palliative care at accredited allopathic and osteopathic medical schools, nursing schools, social work schools, and other programs, including physician assistant education programs, to promote education and research in palliative care and hospice, and to support the development of faculty careers in academic palliative medicine.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Palliative Care and Hospice Education and Training Act".
SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Palliative care is interdisciplinary, patient- and family-centered health care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness, whatever the diagnosis. The goal of palliative care is to relieve suffering and improve quality of life for both patients and their families. Palliative care is provided by a team of doctors, nurses, social workers, physician assistants, chaplains, and other specialists who work with a patient’s other health care providers to provide an extra layer of support, including assistance with difficult medical decisionmaking and coordination of care among specialists. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment. Palliative care is not dependent on a life-limiting prognosis and may actually help an individual recover from illness by relieving symptoms, such as pain, anxiety, or loss of appetite, while undergoing sometimes difficult medical treatments or procedures, such as surgery or chemotherapy.

(2) Hospice is palliative care for patients in their last year of life. Considered the model for quality compassionate care for individuals 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. In most cases, care is provided in the patient’s home but may also be provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. In 2014, an estimated 1,600,000 to 1,700,000 patients received services from hospice, including non-Medicare beneficiaries. Nearly 48 percent of all Medicare decedents in 2014 received care from a hospice program. Hospice is a covered benefit under the Medicare program. There were 4,025 Medicare-certified hospices serving more than 1,300,000 Medicare beneficiaries in 2014.

(3) Despite a high intensity of medical treatment, many seriously ill patients experience troubling symptoms, unmet psychological and personal care needs, and high caregiver burden. Numerous studies have shown that adding palliative care can improve pain and symptom control, quality of life, and family satisfaction with care.

(4) Health care providers need better education about pain management and palliative care. Students graduating from medical, nursing and other health professional schools today have very little, if any, training in the core precepts of pain and symptom management, advance care planning, communication skills, and care coordination for patients with serious or life-threatening illness. Even for specialists, training is lacking. For example, the Accreditation Council of Graduate Medical Education mandates that residents in internal medicine have 40 hours of palliative care training, but the vast majority of residents fall well short of this requirement.
for Graduate Medical Education requires oncology fellowship programs to integrate competence in palliative care into their curriculum and the American Society of Clinical Oncology has recommended the integration of palliative care services into standard oncology practice at the time a person is diagnosed with metastatic or advanced cancer. Yet a 2015 national survey found that hematology/oncology fellows were “inadequately prepared” to provide palliative care to their patients. Less than half had a rotation in palliative care and 25 percent of fellows reported no explicit teaching on key skills such as assessing prognosis, conducting a family meeting to discuss treatment options, and referral to palliative care.

(5) The American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education provided formal subspecialty status for hospice and palliative medicine in 2006, and the Centers for Medicare & Medicaid Services recognized hospice and palliative medicine as a medical subspecialty in October of 2008.

(6) As of February 2017, there were a total of 127 hospice and palliative medicine training programs accredited by the Accreditation Council for Graduate Medical Education. For the 2016–2017 academic year, these programs were training 327 physicians in hospice and palliative medicine. Some programs include an additional track in pediatrics, geriatrics, research, or public health. Fewer than a dozen of these ACGME-accredited training programs focus solely on pediatric palliative medicine though data show an increasing prevalence of children with complex chronic conditions who could benefit from such specialized care.

(7) There is a large gap between the number of healthcare professionals with palliative care training and the number required to meet the needs of the growing population of individuals with serious or life-threatening illness. In 2015, 75 percent of United States hospitals with 50 or more beds had a palliative care program though not all these programs have in place the interdisciplinary team necessary to provide comprehensive, high-quality palliative care. Hospital data reported to the National Palliative Care Registry show that in 2015 only 44 percent of programs met national staffing standards set by the Joint Commission, even when including unfunded positions. Among the 56 percent of programs without complete interdisciplinary teams, 30 percent have no physician, 10 percent have no advanced practice registered nurse or RN, 54 percent have no social worker, and 70 percent have no chaplain. Looking at just physician specialists, 2017 projections by the George Washington University Health Workforce Institute show that current training capacity for hospice and palliative medicine is not sufficient to provide hospital-based care and keep pace with growth in the population of adults over 65 years old. The shortages are exacerbated when considering the current rapid expansion of community-based palliative care, such as in outpatient and home-
based settings. A separate survey of physicians in the field found that, if the rate of those entering and leaving hospice and palliative medicine maintains, there will be no more than 1 percent absolute growth in this physician workforce in 20 years, during which time the number of persons eligible for palliative care will grow by over 20 percent. The study’s authors project this will result in a ratio of one palliative medicine physician for every 26,000 seriously ill patients by 2030.

(8) According to the National Academy of Medicine, there is a “need for better understanding of the role of palliative care among both the public and professionals across the continuum of care so that hospice and palliative care can achieve their full potential for patients and their families”.

SEC. 3. PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING.

(a) In General.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by inserting after section 759 the following:

“SEC. 759A. PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING.

“(a) Palliative Care And Hospice Education Centers.—

“(1) In General.—The Secretary shall award grants or contracts under this section to entities described in paragraph (1), (3), or (4) of section 799B, and section 801(2), for the establishment or operation of Palliative Care and Hospice Education Centers that meet the requirements of paragraph (2).

“(2) Requirements.—A Palliative Care and Hospice Education Center meets the requirements of this paragraph if such Center—

“(A) improves the training of health professionals in palliative care, including residencies, traineeships, or fellowships;

“(B) develops and disseminates curricula relating to the palliative treatment of the complex health problems of individuals with serious or life-threatening illnesses;

“(C) supports the training and retraining of faculty to provide instruction in palliative care;

“(D) supports continuing education of health professionals who provide palliative care to patients with serious or life-threatening illness;

“(E) provides students (including residents, trainees, and fellows) with clinical training in palliative care in long-term care facilities, home
care, hospices, chronic and acute disease hospitals, and ambulatory care centers;

"(F) establishes traineeships for individuals who are preparing for advanced education nursing degrees, social work degrees, or advanced degrees in physician assistant studies, with a focus in palliative care in long-term care facilities, home care, hospices, chronic and acute disease hospitals, and ambulatory care centers; and

"(G) does not duplicate the activities of existing education centers funded under this section or under section 753 or 865.

"(3) EXPANSION OF EXISTING CENTERS.—Nothing in this section shall be construed to—

"(A) prevent the Secretary from providing grants to expand existing education centers, including geriatric education centers established under section 753 or 865, to provide for education and training focused specifically on palliative care, including for non-geriatric populations; or

"(B) limit the number of education centers that may be funded in a community.

"(b) PALLIATIVE MEDICINE PHYSICIAN TRAINING.—

"(1) IN GENERAL.—The Secretary may make grants to, and enter into contracts with, schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs, for the purpose of providing support for projects that fund the training of physicians (including residents, trainees, and fellows) who plan to teach palliative medicine.

"(2) REQUIREMENTS.—Each project for which a grant or contract is made under this subsection shall—

"(A) be staffed by full-time teaching physicians who have experience or training in palliative medicine;

"(B) be based in a hospice and palliative medicine fellowship program accredited by the Accreditation Council for Graduate Medical Education;

"(C) provide training in palliative medicine through a variety of service rotations, such as consultation services, acute care services, extended care facilities, ambulatory care and comprehensive evaluation units, hospice, home health, and community care programs;
“(D) develop specific performance-based measures to evaluate the competency of trainees; and

“(E) provide training in palliative medicine through one or both of the training options described in subparagraphs (A) and (B) of paragraph (3).

“(3) TRAINING OPTIONS.—The training options referred to in subparagraph (E) of paragraph (2) are as follows:

“(A) 1-year retraining programs in hospice and palliative medicine for physicians who are faculty at schools of medicine and osteopathic medicine, or others determined appropriate by the Secretary.

“(B) 1- or 2-year training programs that are designed to provide training in hospice and palliative medicine for physicians who have completed graduate medical education programs in any medical specialty leading to board eligibility in hospice and palliative medicine pursuant to the American Board of Medical Specialties.

“(4) DEFINITIONS.—For purposes of this subsection the term ‘graduate medical education’ means a program sponsored by a school of medicine, a school of osteopathic medicine, a hospital, or a public or private institution that

“(A) offers postgraduate medical training in the specialties and subspecialties of medicine; and

“(B) has been accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association through its Committee on Postdoctoral Training.

“(c) PALLIATIVE MEDICINE AND HOSPICE ACADEMIC CAREER AWARDS.

“(1) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program to provide awards, to be known as the ‘Palliative Medicine and Hospice Academic Career Awards’, to eligible individuals to promote the career development of such individuals as academic hospice and palliative care physicians.

“(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an award under paragraph (1), an individual shall—

“(A) be board certified or board eligible in hospice and palliative medicine; and
“(B) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine or osteopathic medicine.

“(3) LIMITATIONS.—No award under paragraph (1) may be made to an eligible individual unless the individual—

“(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

“(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

“(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend a majority of the total funded time of such individual on teaching and developing skills in interdisciplinary education in palliative care.

“(4) MAINTENANCE OF EFFORT.—An eligible individual who receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

“(5) AMOUNT AND TERM.—

“(A) AMOUNT.—The amount of an award under this subsection shall be equal to the award amount provided for under section 753(c)(5)(A) for the fiscal year involved.

“(B) TERM.—The term of an award made under this subsection shall not exceed 5 years.

“(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments for awards under this subsection to institutions, including schools of medicine and osteopathic medicine.

“(6) SERVICE REQUIREMENT.—An individual who receives an award under this subsection shall provide training in palliative care and hospice, including the training of interdisciplinary teams of health care professionals.
The provision of such training shall constitute a majority of the total funded obligations of such individual under the award.

“(d) **PALLIATIVE CARE WORKFORCE DEVELOPMENT.** —

“(1) **IN GENERAL.** — The Secretary shall award grants or contracts under this subsection to entities that operate a Palliative Care and Hospice Education Center pursuant to subsection (a)(1).

“(2) **APPLICATION.** — To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) **USE OF FUNDS.** — Amounts awarded under a grant or contract under paragraph (1) shall be used to carry out the fellowship program described in paragraph (4).

“(4) **FELLOWSHIP PROGRAM.** —

“(A) **IN GENERAL.** — Pursuant to paragraph (3), a Palliative Care and Hospice Education Center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a ‘fellowship’) that focus on palliative care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, physician assistant education, chaplaincy, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in palliative care, to upgrade their knowledge and clinical skills for the care of individuals with serious or life-threatening illness and to enhance their interdisciplinary and interprofessional teaching skills.

“(B) **LOCATION.** — A fellowship under this paragraph shall be offered either at the Palliative Care and Hospice Education Center that is sponsoring the course, in collaboration with other Palliative Care and Hospice Education Centers, or at medical schools, schools of nursing, schools of pharmacy, schools of social work, schools of chaplaincy or pastoral care education, graduate programs in psychology, physician assistant education programs, or other health professions schools approved by the Secretary with which the Centers are affiliated.

“(C) **CONTINUING EDUCATION CREDIT.** — Participation in a fellowship under this paragraph shall be accepted with respect to...
complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall subsequently provide a minimum of 18 hours of voluntary instruction in palliative care content (that has been approved by a palliative care and hospice education center) to students or trainees in health-related educational, home, hospice, or long-term care settings.

“(5) TARGETS.—A Palliative Care and Hospice Education Center that receives an award under this subsection shall meet targets approved by the Secretary for providing palliative care training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

“(6) AMOUNT OF AWARD.—Each award under this subsection shall be in the amount of $150,000. Not more than 24 Palliative Care and Hospice Education Centers may receive an award under this subsection.

“(7) MAINTENANCE OF EFFORT.—A Palliative Care and Hospice Education Center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the Center under the award will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by such Center.

“(e) PALLIATIVE CARE AND HOSPICE CAREER INCENTIVE AWARDS.—

“(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of palliative care.

“(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an award under paragraph (1), an individual shall—

“(A) be an advanced practice nurse, a social worker, physician assistant, pharmacist, chaplain, or student of psychology who is pursuing a doctorate, masters, or other advanced degree with a focus in palliative care or related fields in an accredited health professions school; and

“(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) CONDITIONS OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice palliative care in health-
related educational, home, hospice, or long-term care settings for a minimum of 5 years under guidelines established by the Secretary.

“(4) PAYMENT TO INSTITUTION.—The Secretary shall make payments for awards under this subsection to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, chaplaincy or pastoral care education, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school or program (such as a physician assistant education program) that is approved by the Secretary.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $44,100,000 for each of the fiscal years 2018 through 2022.”

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective beginning on the date that is 90 days after the date of enactment of this Act.

SEC. 4. HOSPICE AND PALLIATIVE NURSING.

(a) PREFERENCE FOR GRANTS OR AWARDS FOR NURSING WORKFORCE DEVELOPMENT PROJECTS.—Section 805 of the Public Health Service Act (42 U.S.C. 296d) is amended—

(1) by striking “or help” and inserting “help”; and

(2) by inserting the following before the period at the end: “, or for education and training in hospice and palliative nursing”.

(b) ADVANCED EDUCATION NURSING GRANTS.—Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking “and” at the end;

(B) by redesignating paragraph (2) as paragraph (3); and

(C) by inserting after paragraph (1), the following new paragraph:

“(2) palliative care and hospice career incentive awards under section 759A(e); and”; and

(2) in subsection (g)(2), by inserting “or for education and training in hospice and palliative nursing” after “section 332”.

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(c) **Nurse Education, Practice, and Quality Grants.**—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in subsection (a)—

(A) by striking “or” at the end of paragraph (1);

(B) by striking the period at the end of paragraph (2) and inserting “; or”;

(C) by adding at the end the following new paragraph:

“(3) education and training in hospice and palliative nursing.”; and

(2) in subsection (b)(3), by inserting “hospice and palliative nursing,” after “coordinated care,”.

(d) **Nurse Retention Grants.**—Section 831A of the Public Health Service Act (42 U.S.C. 296p–1) is amended—

(1) in subsection (c)(2), by inserting “, and to applicants with programs that include initiatives to train nurses in hospice and palliative nursing” before the period; and

(2) in subsection (d), by inserting “, and to train nurses in hospice and palliative nursing” before the period.

(e) **Additional Palliative Care and Hospice Education and Training Programs.**—Part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by adding at the end the following:

“**SEC. 832. PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING.**

“(a) **Program Authorized.**—The Secretary shall award grants to eligible entities to develop and implement, in coordination with programs under section 759A, programs and initiatives to train and educate individuals in providing palliative care in health-related educational, hospice, home, or long-term care settings.

“(b) **Use Of Funds.**—An eligible entity that receives a grant under subsection (a) shall use funds under such grant to—

“(1) provide training to individuals who will provide palliative care in health-related educational, home, hospice, or long-term care settings;

“(2) develop and disseminate curricula relating to palliative care in health-related educational, home, hospice, or long-term care settings;
“(3) train faculty members in palliative care in health-related educational, home, hospice, or long-term care settings; or

“(4) provide continuing education to individuals who provide palliative care in health-related educational, home, hospice, or long-term care settings.

“(c) Application.—An eligible entity desiring a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

“(d) Eligible Entity.—For purposes of this section, the term ‘eligible entity’ shall include a school of nursing, a health care facility, a program leading to certification as a certified nurse assistant, a partnership of such a school and facility, or a partnership of such a program and facility.

“(e) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2018 through 2022.”.

SEC. 5. NATIONAL PALLIATIVE CARE EDUCATION AND AWARENESS CAMPAIGN.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following new section:

“SEC. 904. NATIONAL PALLIATIVE CARE EDUCATION AND AWARENESS CAMPAIGN.

“(a) In General.—Under the authority under section 902(a) to disseminate information on health care and on systems for the delivery of such care, the Director shall provide for the planning and implementation of a national education and awareness campaign to inform patients, families, and health professionals about the benefits of palliative care throughout the continuum of care for patients with serious or life-threatening illness.

“(b) Information Disseminated.—

“(1) Mandatory Information.—The campaign under subsection (a) shall include dissemination of the following:

“(A) Palliative Care.—Information, resources, and communication materials about palliative care as an essential part of the continuum of quality care for patients and families facing serious or life-threatening illness (including cancer; heart, kidney, liver, lung, and infectious diseases; as well as neurodegenerative disease such as dementia, Parkinson’s disease, or amyotrophic lateral sclerosis).
“(B) PALLIATIVE CARE SERVICES.—Specific information regarding the services provided to patients by professionals trained in hospice and palliative care, including pain and symptom management, support for shared decisionmaking, care coordination, psychosocial care, and spiritual care, explaining that such services may be provided starting at the point of diagnosis and alongside curative treatment and are intended to—

“(i) provide patient-centered and family-centered support throughout the continuum of care for serious and life-threatening illness;

“(ii) anticipate, prevent, and treat physical, emotional, social, and spiritual suffering;

“(iii) optimize quality of life; and

“(iv) facilitate and support the goals and values of patients and families.

“(C) PALLIATIVE CARE PROFESSIONALS.—Specific materials that explain the role of professionals trained in hospice and palliative care in providing team-based care (including pain and symptom management, support for shared decisionmaking, care coordination, psychosocial care, and spiritual care) for patients and families throughout the continuum of care for serious or life-threatening illness.

“(D) RESEARCH.—Evidence-based research demonstrating the benefits of patient access to palliative care throughout the continuum of care for serious or life-threatening illness.

“(E) POPULATION-SPECIFIC MATERIALS.—Materials shall be developed that target specific populations, including patients with serious or life-threatening illness who are among medically underserved populations (as defined in section 330(b)(3)) and families of such patients or health professionals serving medically underserved populations. Such populations shall include pediatric patients, young adult and adolescent patients, racial and ethnic minority populations, and other priority populations specified by the Director.

“(2) OTHER INFORMATION.—In addition to the information described in paragraph (1), such campaign may include dissemination of such other information as the Director determines to be relevant.

“(3) INFORMATION FORMAT.—The information and materials required to be disseminated under paragraph (1) and any information disseminated under
paragraph (2) shall be presented in a variety of formats (such as posted online, in print, and through public service announcements).

"(4) REQUIRED PUBLICATION.—The information and materials required to be disseminated under paragraph (1) and any information disseminated under paragraph (2) shall be posted on the Internet websites of relevant Federal agencies and Departments, including the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Administration on Aging, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs.

"(c) CONSULTATION.—The Director shall consult with appropriate professional societies, hospice and palliative care stakeholders, and relevant patient advocate organizations with respect to palliative care, psychosocial care, and complex chronic illness with respect to the following:

"(1) The planning and implementation of the national palliative care education and awareness campaign under this section.

"(2) The development of information to be disseminated under this section.

"(3) A definition of the term ‘serious or life-threatening illness’ for purposes of this section.”.

SEC. 6. CLARIFICATION.

None of the funds made available under this Act (or an amendment made by this Act) may be used to provide, promote, or provide training with regard to any item or service for which Federal funding is unavailable under section 3 of Public Law 105–12 (42 U.S.C. 14402).

SEC. 7. ENHANCING NIH RESEARCH IN PALLIATIVE CARE.

(a) In General.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following new section:

"SEC. 409K. ENHANCING RESEARCH IN PALLIATIVE CARE.

“(a) In General.—The Secretary, acting through the Director of the National Institutes of Health, shall develop and implement a strategy to be applied across the institutes and centers of the National Institutes of Health to expand national research programs in palliative care.

“(b) Research Programs.—The Director of the National Institutes of Health shall expand and intensify research programs in palliative care to address the quality...
of care and quality of life for the rapidly growing population of patients in the United States with serious or life-threatening illnesses, including cancer; heart, kidney, liver, lung, and infectious diseases; as well as neurodegenerative disease such as dementia, Parkinson’s disease, or amyotrophic lateral sclerosis.”.

(b) EXPANDING TRANS-NIH RESEARCH REPORTING TO INCLUDE PALLIATIVE CARE RESEARCH.—Section 402A(c)(2)(B) of the Public Health Service Act (42 U.S.C. 282a(c)(2)(B)) is amended by inserting “and, beginning January 1, 2018, for conducting or supporting research with respect to palliative care” after “or national centers”.

https://www.congress.gov/115/bills/s693/BILLS-115s693is.xml
MORE INFORMATION, ACCOUNTABILITY NEEDED TO ADDRESS POOR QUALITY HOSPICE CARE, LACK OF SERVICES AND HOSPICE FRAUD

(Washington D.C., Tuesday, July 30, 2018) - Hospice use has grown steadily over recent years, with Medicare paying $16.7 billion for 1.4 million beneficiaries in hospice care in 2016. A decade before, in 2006, those numbers were $9.2 billion for fewer than 1 million beneficiaries.

Terminally ill patients who choose hospice expect to receive support and services that make end of life as comfortable as possible. However, some of these individuals are faced with improper care and fraudulent billing.

In a new hospice portfolio released by the Inspector General for the U.S. Department of Health and Human Services (OIG), the agency found that hospices do not always provide needed services to patients and sometimes provide poor quality care. OIG also found that patients and their families and caregivers do not receive crucial information to make informed decisions about their care. And taxpayers are bankrolling much of this poor care and fraud through the Medicare hospice benefit.

Nancy Harrison, Deputy Regional Inspector General overseeing the portfolio, explains problems in the hospice industry and what can be done to improve the hospice program.

SOUNDBITE #1: NO ONE WANTS THEIR LOVED ONES TO SUFFER NEEDLESSLY IN THEIR FINAL DAYS. WE NEED TO IMPROVE HOSPICE CARE FOR OUR MOTHERS, OUR FATHERS, OUR FRIENDS, OURSELVES. OUR AGENCY'S COMMON SENSE RECOMMENDATIONS WOULD IMPROVE HOSPICE CARE FOR ALL OF US. (:18)

SOUNDBITE #2 IT IS SO IMPORTANT TO HAVE RELIABLE INFORMATION AND GOOD RESOURCES WHEN YOU'RE FACING A TERMINAL ILLNESS AND CONSIDERING HOSPICE CARE. AS IT STANDS NOW, YOU HAVE THE LEAST INFORMATION WHEN YOU ARE THINKING ABOUT END OF LIFE CARE. OUR RECOMMENDATIONS WOULD IMPROVE THE RESOURCES AVAILABLE TO HELP PATIENTS AND THEIR FAMILIES MAKE THE BEST DECISIONS POSSIBLE. (:24)

To read the hospice portfolio, visit oig.hhs.gov.

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U.S. Department of Health and Human Services
Office of Inspector General

Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio

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Principal Deputy Inspector General
Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity

What OIG Found

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary’s life. Use of hospice care has grown steadily over the past decade, with Medicare paying $16.7 billion for this care in 2016. It is an increasingly important benefit for the Medicare population; 1.4 million beneficiaries received hospice care in 2016.

However, OIG has identified vulnerabilities in the program. OIG found that hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care. In some cases, hospices were not able to manage effectively symptoms or medications, leaving beneficiaries in unnecessary pain for many days.

OIG also found that beneficiaries and their families and caregivers do not receive crucial information to make informed decisions about their care. Further, hospices’ inappropriate billing costs Medicare hundreds of millions of dollars. This includes billing for an expensive level of care when the beneficiary does not need it. Also, a number of fraud schemes in hospice care negatively affect beneficiaries and the program. Some fraud schemes involve enrolling beneficiaries who are not eligible for hospice care, while other schemes involve billing for services never provided.

Lastly, the current payment system creates incentives for hospices to minimize their services and seek beneficiaries who have uncomplicated needs. Within each level of care, a hospice is paid for every day a beneficiary is in care, regardless of the quantity or quality of services provided on that day. While CMS has made some changes to payments, the underlying structure of the payment system remains unchanged.
What OIG Recommends and How the Agency Responded

We recommend that the Centers for Medicare & Medicaid Services (CMS) implement 15 specific actions that relate to 7 areas for improvement. CMS should strengthen the survey process—its primary tool to promote compliance—to better ensure that hospices provide beneficiaries with needed services and quality care. CMS should also seek statutory authority to establish additional remedies for hospices with poor performance. Also, CMS should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries and their families and caregivers make informed choices about hospice care. CMS should educate beneficiaries and their families and caregivers about the hospice benefit, working with its partners to make available consumer-friendly information. CMS should promote physician involvement and accountability to ensure that beneficiaries get appropriate care.

To reduce inappropriate billing, CMS should strengthen oversight of hospices. This includes analyzing claims data to identify hospices that engage in practices that raise concerns. Lastly, CMS should take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.

In our draft report to CMS, we recommended 16 specific actions. CMS concurred with six recommendations, did not concur with nine, and neither concurred nor nonconcurred with one. We considered CMS's comments carefully, and we clarified and combined two of our recommendations. See Appendix A for a list of OIG's 15 recommendations. We remain committed to our recommendations and will continue to work with CMS to promote their implementation.
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BACKGROUND

The Office of Inspector General (OIG) Portfolio presents recommendations to improve program vulnerabilities detected in prior audits, evaluations, and investigations. The Portfolio synthesizes OIG's body of work in a program area and identifies trends in payment, compliance, oversight, or fraud vulnerabilities requiring priority attention and action to protect the integrity of Department of Health and Human Services (HHS) programs and the beneficiaries they serve. This portfolio focuses on the Medicare hospice benefit.

Hospice is an increasingly important benefit for the Medicare population. It can provide great comfort to beneficiaries and their families and other caregivers at the end of a beneficiary's life. The number of hospice beneficiaries has grown every year for the past decade. In 2016, Medicare spent about $16.7 billion for hospice care for 1.4 million beneficiaries, up from $9.2 billion for fewer than 1 million beneficiaries in 2006. With this growth, OIG has identified significant vulnerabilities. OIG evaluations and audits have raised concerns about hospice billing, Federal oversight, and quality of care provided to beneficiaries. OIG investigations of fraud cases have uncovered hospices enrolling patients without the beneficiary's knowledge or under false pretenses, enrolling beneficiaries who are not terminally ill, billing for services not provided, paying kickbacks, and falsifying documentation.

This portfolio describes the growth in hospice utilization and reimbursement, and it summarizes key vulnerabilities that OIG has identified and continues to monitor. The portfolio also includes recommendations to CMS to address these vulnerabilities.

OIG's body of work covering hospice care since 2005 serves as the basis for this portfolio. This work includes in-depth looks at specific levels of care and settings. It focuses on covered hospice services such as nursing, physician, medical social, and hospice aide services. It does not focus on volunteer services. See Appendix B for a list of OIG hospice reports. The portfolio also includes descriptions of OIG investigative efforts involving hospices, which resulted in 25 criminal actions, 66 civil actions, and $143.9 million investigative receivables from fiscal year (FY) 2013 to FY 2017.
OIG recognizes that many hospices meet Medicare requirements and provide high-quality care. This portfolio focuses on vulnerabilities and possible solutions to improve the program for all hospice beneficiaries. Future OIG work will focus on quality of care in hospices, hospice billing, and compliance.

By leveraging advanced analytic techniques to detect potential vulnerabilities and fraud trends, OIG is better able to target resources at those hospices in need of oversight, leaving others free to provide care and services without unnecessary disruption.

OIG work referenced throughout this document was conducted in accordance with the professional standards applicable to audits, evaluations, and investigations.

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**The Four Levels of Hospice Care**

Medicare pays for four levels of hospice care. Medicare-certified hospices are required to provide each of these levels when needed.

Hospices can provide services directly or under arrangement.

- **Routine home care** is the most commonly used. It is for any day a hospice beneficiary is at home and not receiving continuous home care, which is a more intensive level of care. Routine home care can be provided in the home or other places of residence, such as an assisted living facility or nursing facility. In FY 2017, hospices were paid $190.55 per day for days 1-60 of a beneficiary’s routine home care and $149.82 per day after day 60. Before 2016, the daily rate paid to hospices did not change based on the beneficiary’s time in care.

- **General inpatient care** is for pain control or symptom management that cannot be managed in other settings, such as the beneficiary’s home. General inpatient care is intended to be short term and may be provided in a hospice inpatient unit, a hospital, or a skilled nursing facility (SNF). In FY 2017, hospices were paid $734.94 per day for general inpatient care.

- **Continuous home care** is allowed only during brief periods of crisis and only as necessary to maintain the individual at home. In FY 2017, hospices were paid $964.63 per day for continuous home care. This is based on an hourly rate of $40.19 per hour.

- **Inpatient respite care** is short-term inpatient care provided to the beneficiary when necessary to relieve the caregiver. In FY 2017, hospices were paid $170.97 per day for inpatient respite care.
**FINDINGS: TRENDS IN MEDICARE HOSPICE**

**Hospice Use Has Grown Steadily Over the Past Decade**

Medicare paid $16.7 billion for hospice care in 2016, an increase of 81 percent since 2006. Over this period of time, the number of Medicare hospice beneficiaries increased each year. About 1.4 million beneficiaries received hospice care in 2016, an increase of 53 percent since 2006. See Exhibit 1. Increases in hospice care were greater than increases in Medicare spending and enrollment in general. From 2006 to 2016, total Medicare spending grew 66 percent, while the total number of Medicare beneficiaries grew 32 percent.

**Exhibit 1: Hospice payments, providers, and beneficiaries have grown.**

![Graph showing hospice care payments, numbers of hospices, and beneficiaries]


OIG has found that patient characteristics, Medicare payments, and services provided differ among care settings and between for-profit and nonprofit hospices.

More than one-half of hospice beneficiaries—55 percent—received care in the home, and 25 percent received care in a nursing facility or SNF in 2016. Thirteen percent of hospice beneficiaries received care while residing in an assisted living facility (ALF). Compared to other settings, ALFs has had the greatest growth in hospice beneficiaries; from 2010 to 2016, the number of beneficiaries receiving care in ALFs grew 64 percent.

The number of hospices serving Medicare beneficiaries has increased every year since 2006. In 2016, a total of 4,374 hospices provided care to Medicare beneficiaries. For-profit hospices accounted for 64 percent of the total. These hospices received more than one-half of the dollars (55 percent), and served just under half (49 percent) of the beneficiaries. Of all hospices, 34 percent were small (fewer than 90 beneficiaries per year), 37 percent were medium sized (90 to 320 beneficiaries per year), and 29 percent were large (over 320 beneficiaries per year).
FINDINGS: ENSURING BENEFICIARIES RECEIVE APPROPRIATE HOSPICE

Hospices Do Not Always Provide Adequate Services to Beneficiaries and Sometimes Provide Poor Quality Care

Key services are sometimes lacking

When beneficiaries elect hospice care, they are choosing to receive care that will not cure their terminal illness, but should provide comfort and relief from pain. All services related to their terminal illness become the hospice’s responsibility. Yet hospices do not always provide the care beneficiaries need to control pain and manage symptoms.

Notably, hospices provided fewer services than outlined in the plans of care for 31 percent of claims for hospice beneficiaries residing in nursing facilities. In addition, hospices did not provide adequate nursing, physician, or medical social services in 9 percent of general inpatient care stays in 2012. These services are particularly important to beneficiaries in general inpatient care because they have uncontrolled symptoms requiring pain control or symptom management that cannot be provided in other settings. In some cases, hospices were not able to effectively manage symptoms or medications, leaving beneficiaries in pain for many days.

Examples of Hospices Providing Poor Quality Care

- A hospice billed Medicare for serving a 101-year-old beneficiary with dementia. He had uncontrolled pain throughout his 16 days in general inpatient care. The hospice did not change his pain medication until the last day and did not provide him the special mattress he needed for more than a week.

- A hospice billed for 17 days of general inpatient care for a 70-year-old beneficiary, but never visited him. Instead, the hospice called his family to inquire how he was doing.

- An 89-year-old beneficiary's respiratory symptoms were uncontrolled for 14 days during a general inpatient care stay in which the hospice rarely changed his medication dosage. The beneficiary continued to experience respiratory distress and anxiety.
Hospices often do a poor job care planning

Proper care planning helps ensure that beneficiaries receive the care and attention they need and that services are coordinated effectively. Yet hospices often fall short in care planning.

Hospices are required to establish an individualized written plan of care for each beneficiary they serve and to provide services that meet the plan.\textsuperscript{11} The plan of care must be developed by an interdisciplinary group that includes a physician, a registered nurse, a social worker, and a pastoral or other counselor. This helps ensure that the hospice team meets all of the beneficiary’s needs. The plan of care must also contain a detailed statement of the scope and frequency of needed services.\textsuperscript{12}

Hospices often fail to meet these requirements. Specifically, hospices did not meet plan of care requirements in 85 percent of general inpatient care stays in 2012.\textsuperscript{13} An OIG study several years earlier, which focused on all levels of hospice care provided in nursing facilities, found that hospices failed to meet requirements for plan of care for 63 percent of claims.\textsuperscript{14} Hospices often did not involve all members of the interdisciplinary group in establishing the plans or failed to include a detailed statement of the scope and frequency of needed services in the plans of care.\textsuperscript{15}

In each year from 2006 to 2016, hundreds of hospices provided only the most basic level of care—routine home care—to all the beneficiaries they served throughout the year. In 2016, a total of 665 hospices provided only routine home care. This is an increase of nearly 55 percent from 2011, when 429 hospices did so.\textsuperscript{16}

Medicare pays for three other levels of hospice care in addition to routine home care.\textsuperscript{17} Hospices must provide, directly or under arrangements, these levels when needed.\textsuperscript{18} When hospices provide just routine home care, it calls into question beneficiaries’ access to needed services. It is critical that intense services, such as general inpatient care and continuous home care, be available to control the beneficiary’s pain and other symptoms when needed. Respite inpatient care, which offers relief to caregivers, should also be available given the essential role that caregivers and family members play in caring for their loved ones at the end of life.
Most beneficiaries do not see a hospice physician

In each year from 2006 to 2016, about three-quarters of hospice beneficiaries did not have a visit with a hospice physician. Medicare does not require physician visits, and hospices can separately bill for them if provided. Most beneficiaries do not receive visits.

This includes beneficiaries with complex needs receiving general inpatient care in hospice inpatient units. Again, physician visits are not a requirement of general inpatient care. However, it is important to note that beneficiaries are placed in this high level of care when the hospice determines that their pain or other symptoms are uncontrolled and cannot be managed at home.

Common fraud schemes involve inappropriately enrolling beneficiaries

OIG has uncovered a number of fraud schemes in hospice care that negatively affect beneficiaries and their families and caregivers. Some fraud schemes involve paying recruiters to target beneficiaries who are not eligible for hospice care, while other schemes involve physicians falsely certifying beneficiaries. For example, a hospice physician inappropriately certified a beneficiary as terminally ill who just days before was determined by a hospital to be in "good shape."

Beneficiaries are put at risk when they are enrolled in hospice care inappropriately, as Medicare hospice does not pay for curative treatment for a beneficiary's terminal illness. Therefore, a beneficiary who is inappropriately enrolled in hospice care might be unwittingly forgoing needed treatment. In one example, a hospice falsely told a beneficiary that she could remain on a liver transplant list even if she elected hospice care. When the beneficiary elected hospice care, she was removed from the transplant list. After the beneficiary learned of this, she stopped hospice care so she could be reinstated on the transplant list. As this example demonstrates, it is critical that beneficiaries know when they are in hospice care and what that means for their treatment options.
Examples of Fraud Schemes Affecting Beneficiaries

- An owner of a Mississippi hospice used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were not even aware that they were enrolled in hospice care. The owner submitted fraudulent charges and received more than $1 million from Medicare. The owner was later excluded from the Medicare program.

- A Minnesota-based hospice chain agreed to pay $18 million to resolve allegations that it inappropriately billed Medicare for care provided to beneficiaries who were not eligible for hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.

- Two certifying physicians from one California hospice were found guilty of health care fraud for falsely certifying beneficiaries as terminally ill. Both physicians were excluded from the Medicare program. The false certifications were part of a larger fraud scheme organized by the hospice owner. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, creating fraudulent diagnoses, certifying beneficiaries as terminally ill when they were not, and altering medical records. The owner pleaded guilty to health care fraud and was sentenced to 8 years in Federal prison.

Beneficiaries and Their Families and Caregivers Do Not Receive Crucial Information To Make Informed Decisions About Hospice Care

CMS provides beneficiaries little information about hospice quality

CMS does not provide comprehensive information to the public that is essential for making informed decisions about hospice care. CMS launched a compare website about hospices in August 2017 called Hospice Compare. Hospice Compare was created much later than compare websites for hospitals, nursing facilities, and home health agencies. Compare websites for each of these providers were created over a decade ago.

Hospice Compare does not include critical information about the quality of care provided by individual hospices and offers no information about complaints filed against individual hospices. This information is essential in helping beneficiaries and their families choose the hospice that would best fit their needs and provide good care.

CMS is required to develop quality measures for hospices. These measures must go through a process in which they are endorsed by a consensus-based entity, such as the National Quality Forum. Hospices review the data for these measures before they are made available to the public.
Currently, Hospice Compare includes some quality measures self-reported by the hospice, such as whether the patient was checked for pain, and some quality measures from a survey of family caregivers, such as their willingness to recommend the hospice. These measures do not capture a patient's full experience with hospice care.

Hospice Compare does not include any information about the number, type, and severity of problems found during surveys and complaint investigations. This information would benefit beneficiaries and their families and caregivers by alerting them to hospices found to have done a poor job caring for patients. Although this information is required to be made public, CMS does not include it on Hospice Compare. Instead, some States publish this information on their websites.

Gaining access to hospice survey and complaint information is difficult and time consuming, rendering it largely unhelpful. In contrast, CMS publishes survey and complaint information about nursing homes on the nursing home compare website.

Beneficiaries and their families and caregivers do not always get the information they need when they elect hospice care because hospices often provide incomplete or inaccurate information on election statements. The hospice election statement is an important source of information about the benefit, and hospices are required to provide it. It is written by the hospice and must be signed by a beneficiary or representative before the start of care. The statement should be complete and accurate so that beneficiaries and their caregivers understand what they are entitled to receive and what they must give up with the election of hospice care.

In 35 percent of general inpatient care stays, however, hospices' election statements lacked required information or had other vulnerabilities. Most commonly, these statements neglected to specify that the beneficiary was electing the Medicare hospice benefit as opposed to Medicaid hospice or some other insurance. It is important for beneficiaries to know which benefit they are receiving, especially because eligibility criteria and election periods in some State Medicaid programs differ from those of Medicare, and private health insurance may cover hospice care differently than Medicare.
Some election statements did not mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated which Medicare benefits were waived. Other election statements did not state—as required—that hospice care is palliative rather than curative. CMS recently developed model text that hospices can use when they write their election statements. It is crucial that beneficiaries and their families and caregivers understand that when beneficiaries begin hospice care they are turning over all care for their terminal illness to the hospice.
Inappropriate Billing by Hospices Costs Medicare Hundreds of Millions of Dollars

Hospices frequently bill Medicare for a higher level of care than the beneficiary needs. Reviews of individual hospices have found improper payments ranging from $447,000 to $1.2 million for services not meeting Medicare requirements. In these cases, the hospices billed for inappropriate levels of care, lacked required certifications of terminal illness, or did not have sufficient clinical documentation.

Hospices have also inappropriately billed for expensive levels of care that were not needed. Specifically, in 2012 hospices billed one-third of general inpatient care stays inappropriately, costing Medicare $268 million. General inpatient care is the second most expensive level of hospice care and should only be billed when the beneficiary has uncontrolled pain or symptoms that cannot be managed at home.

Hospices often billed for general inpatient care when the beneficiary needed only routine home care. As a result, these hospices were paid $672 per day instead of $151 per day. At other times, the hospice inappropriately billed for general inpatient care when the beneficiary’s caregiver was not available and inpatient respite care was needed. Again, the hospices received more than they should have. By billing inappropriately, the hospices received $672 per day for general inpatient care instead of $156 per day for inpatient respite care, the level of care specifically designed to relieve caregivers.

Hospices were more likely to bill inappropriately for general inpatient care provided in SNFs than general inpatient care provided in other settings. Forty-eight percent of general inpatient care stays in SNFs were inappropriate compared to 30 percent in other settings. In addition, for-profit hospices were more likely than other hospices to bill inappropriately for this level of care. For-profit hospices billed 41 percent of their general inpatient care stays inappropriately. In comparison, other hospices, including nonprofit and government-owned hospices, billed 27 percent of their general inpatient care stays inappropriately.
Examples of Hospices Billing Inappropriately

- A for-profit hospice in Mississippi inappropriately billed Medicare for a general inpatient care stay lasting over 7 weeks for a beneficiary whose symptoms were under control. She needed assistance only with personal care, eating, and the administration of medication, yet the hospice was paid almost $30,000 for general inpatient care.34

- A for-profit hospice inappropriately billed for a beneficiary in Florida who entered general inpatient care for symptom management. Her symptoms were managed within 2 days, yet she remained in general inpatient care for 15 additional days. Medicare paid close to $12,000 for this stay.35

- A hospice in New York billed for 1 month of continuous home care for dates after the beneficiary's death. The hospice improperly received at least $1,266,517 for hospice services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.36

- A hospice in Puerto Rico billed for services after the beneficiary revoked the hospice election. The hospice received at least $453,558 in improper payments for services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.37

Medicare sometimes paid twice for the same service

Medicare sometimes paid for drugs through Part D for hospice beneficiaries when payment for these drugs should have been covered by the daily rate paid to the hospice. Hospices are required to provide the beneficiary’s drugs that are used primarily for the relief of pain and symptom control related to the terminal illness.38 If Part D pays for them, Medicare is in effect paying twice. Also, beneficiaries may face significant copays depending on the plan and the drug.

OIG found that Part D and beneficiaries paid more than $30 million in 2009 for drugs in certain categories that potentially should have been covered under the daily rate paid to hospices. These categories include analgesic, antinausea, laxative, or antianxiety drugs, which are commonly used in hospice care.39

In 2012, OIG found that Part D inappropriately paid for more than 100 drugs for beneficiaries in sampled general inpatient care stays.40 These 110 drugs were used primarily for the relief of pain and symptom control related to the hospice beneficiary's terminal illness and should have been provided by the hospice. Some of them were analgesic, antinausea, laxative, or antianxiety drugs while others were not.41

In addition to drugs, Medicare also paid twice for some physician services for hospice beneficiaries. OIG identified nearly $566,000 in questionable claims for physician services provided to hospice beneficiaries in 2009.42 In
each of these cases, a service was billed under both the Part A hospice benefit and Part B even though it was from the same physician, on the same day, for the same beneficiary and terminal illness, leading OIG to suspect that the beneficiary did not receive two distinct services, but rather one service billed twice.\(^43\)

**Hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care**

For hospice services to be covered by Medicare, a physician must certify a beneficiary as terminally ill every election period.\(^44\) This certification is based on the physician’s clinical judgment.\(^45\) The physician is required to compose a narrative and include an attestation in each certification of terminal illness. These requirements help to ensure that physicians are involved in determining that hospice care is appropriate for the beneficiary.

However, some hospice physicians are not meeting requirements when certifying beneficiaries. In 14 percent of general inpatient care stays in 2012, the certifying physician did not meet at least one requirement.\(^46\) Specifically, the physicians did not explain their clinical findings or attest that their findings were based on their examination of the beneficiary or review of the medical records.

**Hospice fraud schemes are growing and include kickbacks and false billing**

OIG has increasingly uncovered fraud schemes that put the program at risk of improper payments. These schemes include paying kickbacks for patient referrals, billing for medically unnecessary services, upcoding, and billing for services not provided. In one case, a physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill, but were seeking opioids. OIG has taken action against a number of hospices involved in fraud schemes.

**OIG Investigative Receivables for Hospice**

In FY 2013, OIG investigative receivables were $15.5 million and grew to $55.8 million in FY 2017. In total, investigative receivables from FY 2013 to FY 2017 amounted to $143.9 million.
Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

*AMA Principles of Medical Ethics: I, VII*

### 5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

*AMA Principles of Medical Ethics: I, IV*

### 5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life.
Mercy killing - definition of mercy killing by The Free Dictionary

https://www.thefreedictionary.com/mercy+killing

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merciful killing
Also found in: Thesaurus, Medical, Legal, Acronyms, Encyclopedia, Wikipedia.

merciful killing
n.
Euthanasia.
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merciful killing
n.
(Medicine) another term for euthanasia

euthanasia (yu əˈnəsə, -əˌzi) n.
Also called mercy killing. the act of putting to death painlessly or allowing to die, as by withholding medical measures from a person or animal suffering from an incurable, esp. a painful, disease or condition.
[1640–50; < New Latin < Greek euthanasia easy death]

Thesaurus
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Noun 1. mercy killing - the act of killing someone painlessly (especially someone suffering from an incurable illness)

hash euthanasia

https://www.thefreedictionary.com/mercy+killing
Model Aid-in-Dying Act

Creator:
Brandt, Craig A.

Bibliographic Citation:

Permanent Link:
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http://hdl.handle.net/10822/738671

Date:
1989-10

Subject:
Active Euthanasia; Adults; Advance Directives; Allowing to Die; Autonomy; Beneficence; Biomedical Technologies; Chronically Ill; Competence; Conscience; Counseling; Consent; Euthanasia; Government; Government Regulation; Health; Health Facilities; Informed Consent; Legal Aspects; Legal Liability; Legislation; Liability; Minors; Patient Advocacy; Records; Regulation; Right to Die; State Government; Suffering; Terminally Ill; Third Party Consent; Treatment Refusal; Withholding Treatment;

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'Aid-in-Dying' and the Taking of Human Life
Campbell, Courtney S. (1992-09)

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Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?

Creator:
CelóCruz, Maria T.

Bibliographic Citation:

Abstract:
Recent news stories, medical journal articles, and two state voter referenda have publicized physicians' providing their patients with aid-in-dying. This Note distinguishes two components of aid-in-dying: physician-assisted suicide and physician-committed voluntary active euthanasia. The Note traces these components' distinct historical and legal treatments and critically examines arguments for and against both types of action. This Note concludes that aid-in-dying measures should limit legalization initiatives to physician-assisted suicide and should not embrace physician-committed voluntary active euthanasia.

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Date:
1992

Subject:
Active Euthanasia; Assisted Suicide; Autonomy; Criminal Law; Drugs; Economics; Euthanasia; Historical Aspects; Killing; Law; Legal Aspects; Legal Rights; Life; Liability; Patients; Physician's Role; Physicians; Public Policy; Rights; Suicide; Terminally Ill; Value of Life; Voluntary Euthanasia;

Collections:
BioethicsLine: 1972-1999

Metadata:
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What is death with dignity?

FAQs - Physician-Hastened Death - Death With Dignity
https://www.deathwithdignity.org/faqs/

FAQs - Physician-Hastened Death - Death With Dignity
https://www.deathwithdignity.org/terminology/ 

Opponents' Language: Physician-assisted suicide, or PAS, is an inaccurate, inappropriate, and biased phrase opponents often use to scare people about death with dignity laws. Reporters and editors often use the term "assisted suicide" to describe a terminally ill patient's choice to hasten the dying process.

Death with Dignity Acts - States That Allow Assisted Death - Death
https://www.deathwithdignity.org/learn/death-with-dignity-acts/ 

Death with dignity laws, also known as physician-assisted dying or aid-in-dying laws, stem from the basic idea that it is the terminally ill people, not government...

Ten Facts About Medical Aid in Dying | MD Magazine

Aug 28, 2018 - His essay is in response to the submitted column "Twelve Myths About Physician Assisted Suicide and Medical Aid In Dying," published on July...

I'm dying, and I'd like D.C.'s Death with Dignity Act to help - The...

Apr 6, 2018 - I would like the option of medical aid in dying, which is authorized under D.C.'s Death with Dignity Act and that took effect in February 2017 for those terminally ill patients who meet strict requirements. The law has been upheld, and the D.C.

Ten Years of "Death with Dignity" - The New Atlantis
https://www.thenewatlantis.com/publications/ten-years-of-death-with-dignity

The Oregon Death With Dignity Act (ODA), which permits physicians to write ... what is variously called "physician-assisted suicide," "physician aid in dying," or ...

[prof] CONVERSATION GUIDE – DEATH WITH DIGNITY

Aid in Dying. Other. GEC DISCUSSION: Those members who are proponents of the initiative argue that the phrase "Death with Dignity". (DWD) is the fairest and ...

Two Misleading Myths Regarding "Medical Aid in Dying" | Psychiatric ...
www.psychiatrictimes.com/two-misleading-myths-regarding-medical-aid-dying
Sixteen Individuals Charged in $60 Million Medicare Fraud Scheme

North Texas Defendants Owned and Operated Novus Health Services

DALLAS – An indictment returned by a federal grand jury in Dallas last week, and unsealed today, charges 16 individuals with offenses related to their participation in a health care fraud scheme, announced John Parker, U.S. Attorney for the Northern District of Texas.

The defendants charged are:

Bradley J. Harris, 35, of Frisco, Texas
Amy L. Harris, 42, of Frisco, Texas
Melanie L. Murphey, 35, of Fort Worth, Texas
Patricia B. Armstrong, 33, of Coppell, Texas
Mark E. Gibbs, 46, of Lindsay, Texas
Laila N. Hirjee, 50, of Plano, Texas
Syed M. Aziz, 51, of Frisco, Texas
Reziuddin Siddique, 63, of Allen, Texas
Charles R. Leach, 64, of Arlington, Texas
Jessica J. Love, 37, of Gainesville, Texas
Ali Rizvi, 49, of Carrollton, Texas
Tammie L. Little, 55, of Brashear, Texas
Mary Jaclyn Pannell, 29, of Krum, Texas
Taryn E. Stuart, 32, of Sanger, Texas
Slade C. Brown, 47, of Plano, Texas
Samuel D. Anderson, 35, of Carrollton, Texas

Each indicted defendant is charged with one count of conspiracy to commit health care fraud. Twelve of the defendants are also charged with at least one other count related to the conspiracy.
"That tens of millions of dollars were stolen through fraud is shocking enough," said U.S. Attorney Parker. "That these defendants used human life at its most vulnerable stage as the grist for this scheme displays a shocking level of depravity that this community simply cannot tolerate."

The indictment alleges that from July 2012 to September 2016, Novus billed Medicare and Medicaid more than sixty million dollars for fraudulent hospice services, of which more than thirty-five million dollars was paid to Novus. Specifically, defendants submitted false claims for hospice services, submitted false claims for continuous care hospice services, recruited ineligible hospice beneficiaries by providing kickbacks to referring physicians and healthcare facilities, and falsified and destroyed documents to conceal these activities from Medicare.

Novus Health Services and Optim Health Services, Inc. were operated and co-owned by Harris, who was a certified public accountant without any medical licenses. Harris operated the two companies essentially as one. Licensed physicians who were paid Novus medical directors provided little to no oversight of Novus's hospice patients. Care was directed primarily by Novus nurses and by Harris. Defendants who were not physicians would determine whether a beneficiary would be certified for, recertified for, or discharged from hospice; whether they would be placed on continuous care; and how and to what extent they would be medicated with drugs such as morphine and hydromorphone. These decisions on medical care were often driven by financial interest rather than patient need. The defendants would decide whether to place, keep, or discharge a beneficiary from hospice depending on how that decision would affect Novus's ability to bill Medicare.

Physicians were recruited who would refer hospice patients in exchange for medical director salaries. Assisted living facilities, in exchange for patient referrals, were provided remuneration including Certified Nursing Assistants paid for by Novus to staff the facilities.

Novus medical directors would sign certificates of terminal illness indicating that they had determined that a beneficiary was eligible for hospice services regardless of whether this was true or not; prepare recertifications of terminal illness for beneficiaries already on hospice, which falsely indicated that the beneficiaries continued to be hospice eligible; and routinely give medical directors' login information to others to log into Novus's electronic medical records database to create and sign physician orders for services that had not been performed or had not been performed by the medical directors.

Harris would direct that beneficiaries be placed on continuous care, whether the beneficiaries needed this service or not. This decision would often be made without any consultation with a physician. Continuous care physician's orders were falsified and uploaded into Novus's electronic medical records database. When a beneficiary was on continuous care, the Novus nurses would administer high doses of Schedule II controlled medications such as morphine or hydromorphone, whether the beneficiary needed the medication or not. The defendants and others obtained these Schedule II medications with "C2" prescription forms (used for the prescription of controlled substances) which had been unlawfully pre-signed by medical directors. One reason for this aggressive medicating practice was that Harris wanted to ensure that the beneficiaries' medical records contained documentation that would justify billing Medicare at the higher continuous care billing rate. There were instances when these excessive dosages resulted in serious bodily injury or death to the beneficiaries.

An indictment is merely an allegation and defendants are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law. If convicted, however, each count of conspiracy to commit health care fraud and substantive health care fraud count carries a maximum statutory penalty of 10 years in federal prison and a $250,000 fine.

The case is being investigated by the Federal Bureau of Investigation, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), and the Texas Attorney General's Medicaid Fraud Unit.
Control Unit (MFCU).

Assistant U.S. Attorney Russell Fusco is prosecuting the case.

###

Attachment(s):
Download novus_indictment_1.pdf

Topic(s):
Health Care Fraud

Component(s):
USAO - Texas, Northern

Updated February 28, 2017
Frisco Hospice Executive Admits Role in Overdosing Patients to Maximize Profits

Melanie Murphey of Novus Health Services pleaded guilty to health-care fraud charges
By Scott Gordon
Published at 6:53 PM CDT on May 17, 2018 | Updated at 3:46 PM CDT on May 18, 2018

A former executive of a North Texas hospice on Thursday admitted her role in an alleged $60 million scheme that included overdosing patients to "hasten their deaths," according to a court document.

Melanie Murphey, operations director for Novus Health Services in Frisco, pleaded guilty to federal health-care fraud charges. She faces up to ten years in prison.

She is expected to testify against 15 others involved in the alleged conspiracy, including Novus' owner Bradley Harris and his wife Amy.

In court documents detailing her crime, Murphey said she was the "go-between" between Bradley Harris and five nurses and five doctors who are also charged in the alleged conspiracy. The others have pleaded not guilty.

Murphey acknowledged she falsified paperwork to admit patients who weren't even eligible for hospice services and took directions from Harris designed to maximize profits.
A former manager of a North Texas hospice has pleaded guilty to health care fraud, admitting her role in a $60 million scheme that involved drugging patients to "hasten their deaths," according to court documents, Thursday, June 14, 2018.

Jessica Love was the registered nurse case manager and regional director for Novus Health Services from 2012 until 2014. She faces up to ten years in prison and a $250,000 fine.

Love is now expected to testify against Novus’ owner, Bradley Harris, and 13 others, including four nurses and five doctors who also were charged in the FBI investigation. Agents searched Novus’ Frisco offices in September 2015.

Love said Harris, an accountant with no medical training, gave orders about which drugs patients should receive, how much, and when they should die.

Love detailed her role in a court document known as a factual resume. She accused Harris of personally directing patient care.

"These directions included Bradley Harris instructing nurses to intentionally over-prescribe anti-anxiety drugs and morphine with intent to hasten their deaths," according to court documents. The scheme involved a North Texas hospice that allegedly drugged patients to hasten their deaths.
Physician pleads guilty in $60M fraud scheme allegedly linked to patient deaths

Written by Ayla Ellison (Twitter | Google+) | September 14, 2018 | Print | Email

A physician at Novus, a shuttered hospice provider in Frisco, Texas, has pleaded guilty to a conspiracy charge for his role in a $60 million fraud scheme that federal prosecutors say involved fatally overdosing patients for profit, according to The Dallas Morning News.

Charles Raymond Leach, MD, pleaded guilty Sept. 11 to one count of conspiracy to commit healthcare fraud. He joined Novus in 2014 and became medical director before the company shut down in late 2015. He is one of 16 defendants charged in the healthcare fraud scheme in February 2017.

As part of his plea agreement, Dr. Leach, who surrendered his medical license in January, said he falsified documents and pre-signed blank prescription forms in bulk as part of the scheme. The pre-signed prescription forms were filled in by other people and used to obtain controlled substances, including morphine and hydromorphone. Novus nurses then allegedly used high doses of those drugs to hasten patients' deaths, according to The Dallas Morning News, which cited court documents.

After the hearing Sept. 11, Mick Mickelsen, Dr. Leach's attorney, said his client signed the blank prescriptions "out of convenience." He said his client had no knowledge the drugs were being used to accelerate patients' deaths, according to the report.

"He was horrified to find out," Mr. Mickelsen said. "He's responsible, though, for making that possible by breaking the rules when it comes to how those scripts were issued."

According to court documents, Novus' owner and CEO, Bradley Harris, and others allegedly enrolled as many people as possible in hospice care, even patients who were not eligible for the services. Once the patients were enrolled, they were given around-the-clock care, which Medicare reimbursed at a higher rate than routine care. If hospice patients were in continuous care for too long, Novus workers allegedly overmedicated them so they would die.

According to plea documents, Dr. Leach knew Mr. Harris often directed medical services, even though he had no medical license.

Dr. Leach is the fourth defendant to plead guilty in the case. Twelve other people under indictment in the case are tentatively set for trial in January.

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As more hospices enroll patients who aren’t dying, questions about lethal doses arise

The hospice industry is booming, but concerns are rising about treatments for patients who aren't near death.

By Peter Whoriskey
August 21, 2014

This is the fourth story of an ongoing Washington Post series on the hospice industry in America called the “Business of Dying.”

MAIDEN, N.C. — Clinard “Bud” Coffey, 77, a retired corrections officer, did the crossword in The Charlotte Observer after breakfast every morning, pursued his hobby of drawing cartoons, talked seven or eight times a day to his son Jeff and, just two weeks before his death, told a pal that he still felt “like a teenager.”

He did, however, have some chronic back pain, and in late March he was enrolled in hospice care “essentially for pain management,” his doctor said. Over a two week period, he received rising doses of morphine and other powerful drugs, grew sleepy and disoriented, and stopped breathing, dying peacefully at home, according to his family and medical records they provided.

His death certificate, which was signed by the hospice doctor, listed the cause as “renal cell carcinoma” or kidney cancer. But that doctor had never examined Coffey, his family said, and medical records from just a few weeks earlier do not mention it.

“My dad wasn’t dying of cancer,” said his son, Jeff Coffey. “Once he was on hospice, their answer for everything was more drugs. Everything we know about his death is consistent with an overdose.”

An attorney for the hospice company, Curo Health, said it could not comment on the case without authorization from Coffey’s family. When Jeff Coffey authorized the company to comment, however, the attorney said that the company would not comment because the Coffey family had hired an attorney in preparation for a lawsuit.

The hospice industry in the United States is booming and for good reason, many experts say. Hospice care can offer terminally ill patients a far better way to live out their dying days, and many vouch for its value.
But the boom has been accompanied by what appears to be a surge in hospices enrolling patients who aren’t close to death, and at least in some cases, this practice can expose the patients to the more powerful pain-killers that are routinely used by hospice providers. Hospices see higher revenues by recruiting new patients and profit more when they are not near death.

There are no statistics on how often such abuses may be occurring. But complaints from around the country illustrate the potential dangers of enrolling patients in hospice even though they are not near death, the families involved say.

— In South Carolina, famed college football coach Jim Carlen, who was suffering from Alzheimer’s but could walk with a walker and speak, died days after entering a hospice as an in-patient because, according to family attorney Eric Bland, Carlen’s diabetes and blood pressure medicine were withdrawn and replaced with lethal doses of morphine and klonopin, an anxiety medicine. An attorney for the hospice said they would dispute the allegations.

“We are proud of the care we provide to our patients, including Coach Carlen,” said Sam Outten, Greenville-based attorney representing Tidewater Hospice.

— In Tennessee, Shalynn Womack has testified to the state legislature about her mother, who had been receiving hospice care under a diagnosis of “failure to thrive.” She entered an inpatient hospice for what was supposed to be a brief stay — a “respite” — but died after being given what her daughter called a “toxic cocktail” of morphine and other drugs.

— In Maryland, Beverly Gargiulo, 62, of Pylesville, was admitted to the hospital for ulcers, was mistakenly advised to get hospice care, and then was given excessive doses of pain-killers and died, according to a family lawsuit. A jury last year awarded the Gargiulo family more than $900,000.

The hospital “provided Ms. Gargiulo with compassionate and clinically appropriate care,” a statement from University of Maryland Upper Chesapeake Health said. “We are confident that the case will be overturned on appeal.”

Several other cases document patients who emerged from hospice alive, sometimes with addictions to the pain-killer morphine, which is frequently used in hospice care.

But the harm in enrolling patients in hospice even though they aren’t dying is also financial. Multiple lawsuits have sought to recover more than $1 billion in federal money from hospices that have billed for patients who were admitted but not near death, attorneys said. Medicare rules require that doctors certify that hospice patients are likely to die within six months.

J. Donald Schumacher, president and chief executive of the National Hospice and Palliative Care Organization, said family satisfaction surveys rate most hospice care very highly, “reflecting the high
standard of quality care the vast majority of hospices across the nation provide.”

“Hospice is consistently rated as one of the best health care services available to patients near the end of life,” he said.

***

As the hospice industry has grown, hospices are more frequently enrolling patients who aren’t near death.

To track how often this happens, Medicare, which pays for the vast majority of hospice care in the United States, counts how many patients leave hospice care alive.

At least some of these patients simply get better, unexpectedly. But the proportion of so-called “hospice survivors” has been increasing, and experts believe some hospices are purposely enrolling and keeping patients who are not actually dying.

For each patient like Coffey, who stayed at home, the hospice can bill the government about $155 a day, regardless of whether anyone from the hospice visits.

At hundreds of U.S. hospices, more than one in three patients were released alive, according to a new study funded by Medicare.

In 2010, for example, more than 63,000 patients left hospice alive, did not re-enter hospice and were still alive six months later, according to the study.

Betty Mathews, 76, a retiree from a Las Vegas casino, was diagnosed last year with colon cancer, received chemotherapy treatments and then was enrolled in a hospice in August 2013. The hospice sent a nurse every Friday, Mathews said.

“I kept telling them to give me a blood test to see if I still had cancer,” Mathews said “They gave me pain-killers but I never took anything. My hair was growing, I was gaining weight. But they wouldn’t give me the test. The hospice people kept coming every Friday. I thought I was going to die.”

Last month, nearly a year after enrolling in hospice, the agency finally did a blood test. It indicated that she did not have cancer, she said.

Had she known she was healthy, “I would have got up out of this bed and started living. I’ve got a new great grand-daughter — and I haven’t even seen her.”

***
In the fragmented U.S. health-care system, where patients are sometimes shuffled from doctor to doctor and place to place, the details of a patient’s condition can get lost in translation.

Bud Coffey’s diagnosis appears to have changed when he was enrolled into hospice.

The Coffey family provided The Post with records of Coffey’s last visit to his primary care doctor, the notes of the hospice nurses, a list of his medications, hand-written tallies of what drugs family members administered to him and a copy of the doctor’s order referring him to hospice.

For years, he’d been living under the shadow of knowing that he had an aortic aneurysm, a bulge in his body’s critical artery that seemed poised at some point to rupture and cause sudden death. Medical references put the annual risk of an aortic aneurysm like Coffey’s rupturing at 30 to 50 percent.

“It would be fatal almost instantly,” Coffey wrote to a friend in March. But he said he felt healthy, and his interest in life — and the Carolina Panthers — was avid. Videos of Bud Coffey taken just weeks before his death show him out for a drive with his son, slow and frail, but walking with a cane and talking.

On March 17, just a few days before he was enrolled in hospice, Coffey’s primary care doctor listed three diagnoses: an “unspecified disorder” of the kidney, the aortic aneurysm and chronic back pain. The report also noted numerous kidney stones.

The list of diagnoses did not mention cancer. The diagnosis of an unspecified kidney ailment arose after a scan showed a two-centimeter spot on his kidney. Even if it had proven to be cancer, a spot that small is generally considered to reflect an early stage of the disease, doctors said. In rare cases, it could have spread.

On March 20, Coffey’s primary care doctor referred him for hospice care, “essentially for pain management,” because he was taking Percocets and still felt some pain, according to records.

“Hopefully they can manage his pain better,” the notes on his medical record say.

The doctor referred the family to Community Home Care and Hospice, which in May 2012 had been acquired by Curo Health, a company formed through acquisitions by a private equity firm.

When a few days later Coffey was formally enrolled at the hospice, however, his diagnosis appears to have changed. The hospice’s insurance verification form lists the diagnosis as “kidney cancer,” according to a copy of the document. For the hospice to be reimbursed by Medicare, the diagnosis must involve a terminal condition that is likely to lead to death within six months.

Then, throughout the rest of his two weeks under hospice care, workers for the hospice referred to “the cancer,” his family said.
After Bud Coffey refused to eat a hot dog from one of his favorite restaurants, and the next day rejected another of his favorites, “the hospice nurse relayed the doctors message that the cancer was spreading to his stomach,” Jeff Coffey said. “When his neck hurt, they said it had spread to his bones.

“Looking back I can’t believe I didn’t see how ridiculous it was,” Jeff Coffey said.

Bud Coffey was not in extreme pain, according to the medical records. The nursing notes say he ranked his pain as a three on a scale of 10 on some days, and some days as a four.

The response to any discomfort, the family said, was to use more drugs. After rising doses of morphine and other drugs, Bud Coffey appears to have become confused.

Three days before he died, the hospice nurse recorded that Coffey “has not been eating well...has been talking to people who aren’t there...did not recognize a family member today.”

The family, worried, requested that the hospice send a nurse who could stay with him. The request was denied, the family said.

On his last day, the family said they were, under the hospice’s direction, giving Bud Coffey 40 milligrams of liquid morphine every three hours, a substantial increase over his previous dosage, according to notes taken by the family. They had also stopped giving him his breathing medication, the family said.

He died peacefully.

“Patient died at home with family at his side,” the hospice notes say. “Wife reported he was calm when he stopped breathing.”

The next day, the hospice doctor signed the death certificate, listing the cause of death as renal cell carcinoma, or kidney cancer.

The family said the doctor never examined Coffey during his time on hospice, and that based on the manner of his death and other information, the cause of death was not cancer, and not the aneurysm which would likely have caused a sudden death, but the effects of a drug overdose. That much morphine could have been fatal, independent doctors told The Washington Post, but the lethal threshold varies from person to person.

The family was stunned by his sudden decline, Jeff Coffey said. His father may have been, too.

On March 24, he wrote an e-mail to a childhood friend.
As more hospices enroll patients who aren't dying, questions about lethal doses arise - The Washington Post

“I know that usually hospice is called in only when death is imminent, but hospice was called in this time to monitor my medications, vital signs, etc,” he wrote. “I still feel like a teenager and if I didn't know what was happening inside me [the aneurysm] I’d feel like I was a perfect example of good health.”

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Terminal neglect? How some hospices treat dying patients

Is that hospice safe? Infrequent inspections mean it may be impossible to know

Rising rates of hospice discharge in U.S. raise questions about quality of care

Peter Whoriskey

Peter Whoriskey is a staff writer for The Washington Post whose investigative work focuses on American business and the economy. Previously, he worked at the Miami Herald, where he contributed to the paper’s coverage of Hurricane Andrew, which was awarded a Pulitzer Prize for public service. Follow

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Kathleen Spry outside the home of her late mother, Evelyn Maples, in Mims, Fla. Maples' family believes Vitas hospice care hastened Maples' death.

How Dying Became A Multibillion-Dollar Industry

By Ben Hallman
Development and data reporting by Shane Shifflett.
Additional reporting by Chris Kirkham.
Design by Hilary Fung.

JUNE 19, 2014

Evelyn Maples' last day as a hospice patient wasn't anything like her family imagined when the nurse from Vitas Healthcare first pitched the service two months before.
On the morning of Dec. 31, 2011, Maples’ daughter, Kathleen Spry, found her mom unconscious and gasping for breath, with her eyes rolled back in her head. Maples was at a Vitas inpatient facility on Merritt Island, 30 miles from the home the two women shared on Florida’s east coast. No one from Vitas had called to warn the family that the woman everyone called “granny” was in sharp decline, Spry said. No one from Vitas had sought treatment for the blood infection that had made her severely ill, despite the family’s standing request that she receive life-saving care in the event of a crisis.

KEY FINDINGS

The U.S. hospice industry has quadrupled in size since 2000. Nearly half of all Medicare patients who die now do so as a hospice patient — twice as many as in 2000, government data shows.

Since 2006, the U.S. government has accuses nearly every major for-profit hospice company of billing fraud.

Hospices bill by the day, and stays at for-profits are substantially longer than at nonprofits (105 days versus 69 days).

In 2009, for-profit hospices charged Medicare 29 percent more per patient than nonprofits, according to the inspector general for the health service.

The average hospice stay has increased dramatically since 2000, regardless of diagnosis, a HuffPost analysis of Medicare data found. This has led to a surge in expenditures: $15 billion in federal dollars in 2013.

Despite widespread allegations of fraud and abuse, regulators have consistently rated hospice as a lower priority for inspection than traditional health facilities like hospitals.
The average U.S. hospice has not undergone a full certification inspection in more than 3.5 years, a HuffPost analysis of Medicare data found. HuffPost found 759 hospices that haven't been inspected in more than 6 years. Nursing home inspections, by contrast, are required by federal law at least every 15 months.

Over a recent three-year span, 55 percent of all U.S. hospices were cited for a violation, many care-related, HuffPost found. HuffPost found 20 providers that were cited for more than 70 violations each during that time.

Frantic and near tears, Spry called her son, David Dunn, who demanded an ambulance. Maples was taken to a nearby hospital, where she recovered from the infection. But her fragile health was permanently compromised, her family claims. She died a month later.

Hospices exist to provide comfort to people who doctors determine are at the end of their lives, with six months or less to live. The paramount objective, according to the National Hospice and Palliative Care Organization, a trade association, is to make patients comfortable, with a focus "on enhancing the quality of remaining life(http://www.nhpco.org/ethical-and-position-statements/preamble-and-philosophy)."

But Maples' family claims she never belonged on hospice, and that she was recruited for the purpose of inflating the company's Medicare billings.

In a complaint letter to the Florida attorney general, Dunn alleges the company enrolled his grandmother "for the sake of billing the government for payment for their own financial gain." The company misled the family about the purpose of hospice – emphasizing benefits such as at-home nursing care and free medications, without explaining that hospices don't provide curative treatments, according to Dunn.
Once enrolled, Dunn alleges, Vitas gave Maples a powerful cocktail of drugs against the family's wishes, and repeatedly bumped her up to the most intrusive and expensive levels of care.

The final straw was the apparent confusion over Maples' "full code" status. It's a designation rarely seen in hospice, because it means the family wants the kind of life-saving treatment that hospices don't provide.

When Dunn tried to cancel the service, he was ignored, he says.

"Once she was on hospice, they did whatever the hell they wanted to do," Dunn said in an interview. "It's like she was a prisoner in their system."

According to Dunn, Vitas' actions hastened Maples' death.

Allegations like those leveled by Maples' family against Vitas have become increasingly common over the past decade as the hospice industry has undergone a titanic shift. What once was a collection of mostly small, religious-affiliated nonprofits is now a booming, $17 billion industry dominated by national chains.

These large companies have proved tremendously effective at expanding hospice's reach. More than 1 million people die each year while receiving hospice services in the U.S., according to the major hospice trade association.[1](http://data.huffingtonpost.com/documents/business/1174929-nhpco-2013-facts-figures). Nearly half of all Medicare patients who die now do so as a hospice patient — twice as many as in 2000, government data shows.[2](http://data.huffingtonpost.com/documents/business/1093512-medpac-2014-report#document/p3/a150591)

But mounting evidence indicates that many providers are imperiling the health of patients in a drive to boost revenues and enroll more people, an investigation by The Huffington Post found.

Every day, hospice marketers descend on doctor's offices, rehab centers and hospitals. These workers have been known to rifle through patient logs at nursing stations, scramble to sign up what some in the industry call "last gasp" patients — people with just hours left to live — and even
SUNDAY, MARCH 3, 2013

Doctor Effectively Euthanized Against his Will

For published version, click here.

My husband, Dr. James E. Mungas, was a respected physician and surgeon here in Great Falls. He developed amyotrophic lateral sclerosis, and I took care of him. His mind was clear and thought processes unimpaired. He was against assisted suicide and euthanasia.

I needed to travel out of town for a day and a half. We agreed he would stay at a local care facility in my absence. Once there, nurses began administering morphine. After the first dose, my husband knew that he had been overdosed and typed out a message to call respiratory therapy. None came that day. Over the next few days, he struggled to breathe and desperately struggled to remain conscious to communicate, but the nurses kept pushing the morphine button and advised our children to do the same. My children and I did not understand the extent morphine would repress the respiratory system until later. This was neither palliative care nor managing pain; this was hastening death. He was effectively euthanized against his will. He did not get his choice. It is traumatic, still, to realize his last communications were attempts to get help....

— Carol Mungas
Great Falls, Montana

Labels: euthanasia, Hospice Abuse, palliative care abuse

Links to this post

Create a Link
**Death by Dehydration and Starvation**

Click here to view original letter.

My mother, Sharon Moe, was diagnosed with colon cancer in February of this year. After her surgery, I was told that she may be able to live for 6 months to 2 years. My mother was against assisted suicide and euthanasia and wanted to live as long as possible. She was placed back in the care of the nursing facility where hospice started to care for her. She was placed on a continual feed through a feeding tube because she was unable to take in anything orally due to her medical condition.

From the beginning, hospice wanted to stop the continual feed. My mother was adamant that she wanted to live and told the hospice nurse that she wanted to stay on the continual feed. My mother was able to converse and sit upright within a day or so after being taken back to the nursing facility. Her health was improving and she was doing really well after surgery despite the fact that she was underweight from not being able to eat.

The hospice nurse was still wanting to remove the continual feeding, even though my mother was doing well. My mother was able to tolerate the food and was not aspirating from it. The nurse placed a pain patch on my mother even though she wasn’t in pain. They didn’t ask her if she was in pain—they just administered the pain patch because she had a ‘furrowed brow’. This pain patch caused my mother to hallucinate and be in a semi-comatose state. She was talkative and looking better before the patch was administered. After the patch had been in her system overnight, she started seeing things and was very scared.

My mother did not get the chance to live on longer as she had willed, but her death was hastened by dehydration and starvation after removing the continual feeding. My mother was not experiencing any pain and would tell someone if she had it.

Mike Moe, Great Falls Montana

**Links to this post**

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Newer Post Home Older Post
"Choice" Is An Illusion: My Mother "Fears For Her Clients"

I live in Washington State where assisted suicide is legal. I want to become a doctor.

My mother is a caregiver. Sometimes I help her with her clients.

I am here to tell you about how older people are at risk in Washington, from doctors and hospitals. I will also talk about how attitudes about older people have changed for the worse. This is especially true since our assisted suicide law was passed in 2008.

I grew up in an adult family home. An adult family home is a small elder care facility located in a residential home. The caregivers live in the home with the clients.

My parents and two of my brothers lived in the home. With the clients there, it was like having six grandparents at once. It was a very happy environment.

This was true for the clients too, no matter what their condition was or how long they had to live. My mom could make them happy even when they were dying. The clients' family members were supportive and seemed happy too and never suggested that one of the clients should die.

Today, in 2013, we no longer live in an adult family home. My mother is a caregiver for private clients. She also now fears for her clients, especially in the hospital. She is afraid that the hospital will begin "comfort care" (that's morphine) and her patient will suddenly die. This has already happened. She tries to never leave her patients alone in the hospital. Either she or a family member will be there.

Excerpt from Elizabeth Polena's Testimony to the Montana Senate Judiciary Committee (HB 505, 2013 Legislative Session)

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OTHERS DIFFERENT FOR HER

http://missoulian.com/news/opinion/mailbag/mother-s-death-provided-painful-personal-example-of-need-to/article_3c8a1e98-1a9c-11e4-bbe8-001a4bcf8887.html

The July 25 guest column by Sara Myers and Dustin Hankinson begins with a discussion of pain, "great pain," specifically. The paragraph goes on to use the phrase "great pain" to justify "death with dignity," meaning assisted suicide and euthanasia.

With their column, I couldn't help but think of my mother's last years and the decision of others that it was time for her to die. Pain was used as a justification for increases in her medication - to get the job done. This happened three times before she finally died in the hospital on Sept. 6, 2010. The coroner's report, case No. 100906, lists the cause of death as congestive heart failure with oxygen deprivation and "fentanyl therapy." The manner of death is listed as "accident."

Fentanyl is reported "to be 80 to 200 times as potent as morphine." It's also well known that fentanyl patch problems cause overdoses, injuries and deaths. See www.aboutlawsuits.com/fentanyl-patch-problems-continue-overdose-deaths-55136. A 100 mcg/hour fentanyl patch has a range within 24 hours of 1.9-3.8 ng/mL. Mom's death result was 2.7 ng/mL on/for about 48 hours.

A complaint was filed by me with the Montana Board of Medical Examiners, No. 2012-069-MED. The screening panel dismissed the complaint with prejudice, which means that the board may not consider the complaint in the future.

Since then, I have talked with other people who have had similar experiences involving the death of a family member via a medical overdose. Please see here: http://www.choiceillusionmontana.org/2013/04/dont-give-doctors-more-power-to-abuse.html

The column by Myers and Hankinson states, "I believe one should have control of one's life including its ending."

I agree with that statement. However, my mother did not have that control. Others dictated for her. Please rethink legalizing assisted suicide and euthanasia so that we do not give others even more power to kill.

Gail Bell, Bozeman
SATURDAY, SEPTEMBER 28, 2013

My Grandma’s Journey and Experience with Hospice: The Experience.

IF YOU WOULD LIKE TO JUST READ HER HOSPICE EXPERIENCE SKIP DOWN

From beginning to end my grandma was a fighter who was battling stage IV stomach cancer and was given 6 months to live back in January she outlived their time table, but the story doesn't end with a closed book.

I moved in with her in March this year and was with her every step of the way so my final decision came from what I thought was from the heart. We had a few good months where we would go out and she would go to gamble. She always kept a smile on her face up until the last few days we had with her.

Around mid June we had a ER visit which left her in the hospital for about 3 days. The final day we were there waiting around for the case manager to come talk to us about discharge. When she finally comes around she mentioned us taking hospice as an option. Now...I was quite accustomed to having RNs and doctors come to us about taking the hospice route, but I never thought we were at that point. So my answer was always no. This time it was different. They made me feel like the time was getting closer, which made no sense to me because my grandma seemed like she could run laps around this woman. She pushed to just set up an “interview” with a rep from hospice so they could explain what they provide. Since she was not a rep for hospice she couldn't answer my questions. I made the appointment and later on that day we had the interview. I asked my questions. First question, was my most important question and was the make or break for my decision to go with hospice. Will they provide TPN? (Total Parenteral Nutrition) what that basically is, is an alternative way to get your nutrients that you need into your body through PICC. My second question was, will they still do blood work? She answered yes to both of my questions. So in my mind it was a win. Why not? She gets what she needs and the pain medication when she needs it. Everything 100% covered. Oh, and home visits when needed from nurses and doctors. Fantastic, right? Wrong. They provided neither of the things I had made pretty clear were key points to what I wanted for my grandma...Long story short to this situation, my grandma's health started to decline within a day on the second day I called Hospice and revoked their services and rushed my grandma to the ER. Within 3 days or so she was back to her smiling self again.

Over the next two months things became real hectic. Mostly because our usual hospital was full so they took her to UMC (which is a teaching hospital.) At this time my grandma was completely capable of making her own decisions. So when they approached her with doing a stents procedure she thought "Wow finally a doctor that actually cares enough to do something." Since this entire time nothing had worked the 5 sessions of chemo had done no help and every doctor she had spoken to up until that day had said they couldn’t do anything for her. After the surgery she was in so much pain and I noticed her stomach was bloaty. I mentioned it to the nurse and she said she would keep an eye on it and give her some pain medication. The following day she had said they were discharging her. Which surprised me because all the pain she was in the day before and the bloating. I drive to the hospital and see that her stomach is twice as big and experiencing lots of pain. I fetch the nurse to ask her how and why they were discharging her. She had said the swelling would go down and that the pain would subside and the doctor agreed to send her home with a script for pain medication. Great. Day went by and the swelling did not go down. The pain increased.
Second week of September came along and we were being told by the current rehab my grandma was in that we had to find a permanent placement for my grandma since she wasn’t in need of rehabilitation any longer. They even said she could go home with us. Which I questioned because I’ve seen a lot things go wrong with the PEG while she was in rehab care. Not to mention that I wasn’t qualified to even know how the wall suction even worked. Finally a case manager from Senior Dimensions got involved and was able to get the doctor to back off temporarily, but we still needed to find a facility that would cater to my grandma’s medical needs. We talked out our options and my grandma’s final request was to try getting back home back to Hawaii. If she was gonna spend thousands of dollars on a medical nursing home here why not spend the money getting back to Hawaii. So I said that sounds like an awesome idea, let me see what I can do. I spent the next few days talking to doctors, pharmacists, and airlines. All to figure out what I needed to do to get my grandma where she wanted to be. All checked out to work in my favor except for her doctor at the rehab. She told me my grandma was unfit to fly, which made sense because of the PEG. Though she had been off of that for hours at a time before so in my eyes the only thing we had to manage was her pain. Which I know I would be able to get from her primary doctor, but this doctor would not release my grandma into my care because it was too dangerous. Which again I understood. I brain stormed again and thought of....Hospice. If all we needed was pain medication lets see if I can find a facility that would work with me. I called a few places none were interested in hearing my story. Until I came across a high ranked facility.

Odyssey Hospice- A Gentiva Company.
I reached out to them and they agreed to see myself and my grandma. A lovely RN from this company who I think of now as the poster child for Gentiva. Came and painted a beautiful picture for us after hearing our goals for my grandma and going to Hawaii. Now she did say that it would be a challenge, but boy did she go far. She spoke with the director of this company and got them to agree to keep my grandma on ProcalAmine. Which is a generic TPN not modified to cater to any specific individual's needs, but that was okay because this was temporary. They would still do the PEG suction and of course we all know this they would give all the pain medication she would need. My grandma agreed and everyone else that I spoke with all agreed if they would do what they could to get her back to Hawaii then lets go for it. Who knew things would slip so fast.

That night they came to transport her to their facility. She said her goodbyes to the nurses and CNAs that were with her everyday at the rehab. She was laughing and carrying on with conversations as she got into the medic transport and was taken over to Odyssey as we all followed. After we arrived we see that they had already put her in her room and were prepping her and asked my sister that had road with her to step out so that the doctor could talk to us all. 30 minutes later a doctor comes out and talks to us. Says we would talk about plans the following day. We go in and she already seemed kind of out of it. I asked the nurse if they had given her something and she said Ativan and Morphine that was part of protocol. I asked what ativan was since I’ve never heard of it til that night. She said its mostly for anxiety, nausea and insomnia. I didn’t fight it because my grandma suffered from nausea a lot. I kissed her goodbye and said I would be back in the morning. My sister stayed with her that night, and I came back first thing in the morning. Not even 12 hours later.

What happens now are the worst days of my life. I walk into the room to see my grandma "sleeping." So I let her rest and ask my sister how long has she been sleeping. She said its been off and on but the nurses kept coming in to give her something. I didn’t think that sounded right so I found one of the nurses that was overseeing my grandma and asked her how often they give her morphine and her answer was "whenever the patient seems to need it." I said okay and left it at that. I watched when they would give her the morphine and it would literally be every time they heard her make the slightest noise so I finally said enough is enough. I kept them from giving her the ativan that was part of "protocol." Every time my grandma would get restless we would go to her and do our best to get her to relax and she would most
of the time. Some times it would be so scary because we could see she was in pain and we couldn't do anything to help her. A nurse came in during one of these times and came to me and said, "we're here to keep our patients as comfortable as possible and you're keeping us from that and seeing her in this much pain makes me feel so bad for her." Those words ate me for the rest of the day. I felt I was the one torturing her.

I tried to talk with this nurse about how my grandma was fine not even a day ago. How it was possible for her to be able to go to the bathroom, laugh, and talk for hours and hours. Now not even a day later she can't even open her eyes to look at me? Her next words made me wanna punch her in the face along with every other person that had said this to me.."It's part of the process sweetie." I was so taken back by this response I had no words that would come out of my mouth. How could you say this to a family? Oh, because we're all the same. In their eyes every person that is in inpatient hospice care has the same story. So, "It's the process" is a generic I'm sorry you're going through this, but get over it you chose hospice.

The next day, my grandma developed a sort of gurgle. My mom looked up different cases of this and found that most call it "deaths rattle." Which comes when a person is close to passing. When the nurse came in to check up on her we asked her what could be causing the noise. The first thing out of her mouth was "Oh its definitely pain." So we agreed to have them give her the medications again. After they gave her the alivan and morphine the noise didn't stop. So we searched google and found that its because she was unable to swallow and was producing too much saliva. So it caused the gurgle. So why was this woman's first and only response "Oh its definitely pain?"

I couldn't sleep this night my mom, uncle, sister, and myself all stayed with her. The one thing I loved about this place was how they did cater to the families anything we needed they would get for us. So that night around 1am I got up and sat in the recliner next to her and held her hand for a bit and I fell asleep for about an hr. I woke up and just sat there and watched her not knowing my mom was awake she asked "how come grandmas not making that noise?" I looked at my grandma and said I didn't know, but she was still breathing. All of us were awake at that point watching her breathe. Each breath was getting slower. Was about 6 seconds between each breath. Her last breath was a gasp that I will never forget. It made me jump and yell "oh my god" I turned the light on to get ready to turn her over on her side because I thought she was throwing up. When I stopped in place because I notice she was not breathing. I waited...and waited for her to take a breath that never came.

I am thankful that myself and my family were there with her at this time, but with all my heart I know that this came too soon. This was not part of the deal we signed up for. We had no say in anything. We were not spoken to about their agenda and what they would be giving my grandma. It was a promise to get her back to Hawaii once they could see if she would be able to be off of the tube for the duration of the flight. My grandma died not even a week within Hospice inpatient care and endured what I strongly believe to be a medically induced coma. If this is what they mean by dying with dignity I must not understand what I myself find dignifying.

My biggest mistake in all of this was believing and putting my faith into doctors and nurses that have their own agenda's and took their word that they would do right by us. Maybe I am just angry or maybe I do not want to accept that this was the process. Though in my heart I truly think I am not wrong in this.

My advice to anyone who finds this message:
1. Ask your doctors questions. Do not be afraid to ask any question that comes to mind. As ridiculous as you may think it sounds, ask your question.
2. Be proactive with everything. Do not let the doctors our nurses persuade you to decide on something that does not feel right. Majority of the time its as clear as day just like with everything else that comes up in life. If not take the time to decide do not let them rush you.
3. Hospice might be the right route for some people, but they are not for everyone and if you truly believe that you are NOT at that point yet or that your loved one is not at that point yet. Please do not let anyone talk you into something you don't feel is right. You'll live with the regret for the rest of your life if you do.
4. They will talk down to you and they will make it seem like all hope is lost. You know your situation they know just the lining of your situation. No one with a medical title will help you decide what is right. They will answer as it benefits their own agenda and base your situation as a general situation. They cannot invest emotions or personal opinions in your life. In most cases your family is your biggest asset. Or your trusted one.

5. Hospice is exactly the same as it was years and years ago. They will tell you that they are nothing like they were before. That they are not about death. That they are about helping you and your loved one reach your goals and in the worst case scenario to help you or your loved one be comfortable and die with dignity. When in most cases if you do your research which I highly suggest you do before making ANY decision. In most cases your story will end just like my grandma’s. Our country does not have a legal way to commit suicide per say, but going through what I have within those short days with hospice I would beg to differ. Agendas between Medicare and Hospice facilities are kept so quiet that it makes it hard to question what’s really going on behind closed doors.

The one thing I would truly push is to make sure you please do not rush any decisions if at all possible take as much time as you need before you decide anything. I hope this helps you for I wish I would have found support sooner.

had to re-share this.

It’s been about 4 months since my grandma has passed and my feelings on this matter has not changed. I cannot stress how important it is for you to truly be ready for Hospice. I wish now I would have had a autopsy done before we had my grandma cremated, but having already an idea of how her last days were....I probably wouldn’t want to know. I regret everything. Every moment I let these people drug her up and feed my family and myself lies. I don’t think I’ll ever fully stop blaming myself for the way things ended. I know feeling this way doesn’t do me any good, but for now it’s something I have to live with.

If you found my page on your own check this blogspot out to compare stories or to just get a better understanding of what you or your loved one is getting into. (Instead of just hearing what hospice is all about from hospice reps/drs/rns.)


Posted by Cherelle Samuel at 6:20 PM

13 comments:

Anonymous October 2, 2013 at 2:26 PM

Cherelle, I’m a reporter at the Huffington Post. Do you have a few minutes to discuss this experience? ben.hallman@huffingtonpost.com

sent to me and my entire family... And now I am a joyful woman once again... here is his website:
Email: Osauyilovespell@gmail.com OR CALL +2347064294395 Mrs Miller Moore from England City. (http://osauyilovespelll.webs.com/)

Cyndi gives February 9, 2016 at 9:39 PM
I need help. My husband was told less then a year on January 13 he died a very awful death. I am still horrified. What did u do.

Mz. Many Names August 31, 2010 at 12:57 AM
Sorry for anyone who had to go through a hospice horror - we need to get the world out about how hospice kills - there is a such a thing as a hospice "Pro Life Pledge" and you can find it here in my own blog about hospice. I am linking your site to mine and hope you will do the same. All we can do is hopefully educate some people so they will have the info that we did not at the time we had to go through our own nightmare experiences with hospice. I will never get over it - the family is torn apart... it was my sister (the nurse and chief care giver for our parents on hospice at home) which "Killed Them Softly" much against certain family members wills... the rest who went along with it just simply didn't have a clue... but a few of us took it upon ourselves to RESEARCH hospice care and "back-door euthanasia" which, as you know, is more prevalent than most people think; http://involuntarybackdooreuthansia.blogspot.com/
Keep up the good work and sorry for your troubles.
Jeanette May 22, 2015 at 7:18 AM
You have given me an answer to what was up with the Hospice that my sister in law was so efficient at getting, along with my family's estate, she is a lawyer and was consulting with Louisiana Health Dept in order to get rid of both of my parents, and our nurse who knew what was going on. Where are our laws?

Baggies23 September 19, 2015 at 9:33 AM
I'm in Canada and I just went through this with my mother. It was as if they were chemically pulling the plug. She had 6 months and was dead within 2 weeks of hospice care. They removed insulin, blood thinners as they increased their doses of morphine and Ativan. Sadly my mother did suffer in the end. She did not peacefully fall asleep. The nurses refused to call the doctor. She was awake struggling for breath strange at me the whole time.

greensea December 28, 2015 at 6:20 PM
My husband had cardiac arrest in a hospital, and they didn't discover it until he had suffered brain damage. I feel it was their fault, since they did nothing to protect his heart, and they also didn't monitor him. After the cardiac arrest they tried to bully me into letting them pull the plug. They harassed me constantly. I refused to go along with them, and wanted them to work with him and give him a chance. Eventually he had a second CA, which might have been prevented had they implanted a defibrillator, and he died. All this really opened my eyes about the agenda for Medicare patients. Killing a defenseless human being is evil, even if it's being done by default.

ExposeThem511 July 20, 2016 at 12:56 PM
I just went through this horror and can not bear the pain of not knowing. My mother went into a coma and there was really no reason other than she was overmedicated with a morphine, ativan cocktail. I am so heartbroken I can't even describe. They must be exposed so Christians like me don't sacrifice their relationship with the Father and Son in heaven. I thought I was doing the right thing for my mother but they clearly
killed her. I am SICK over this and can't stop crying. Will I ever be forgiven for this wicked deception hospice portrayed and I fell prey?

Reply

Anonymous January 29, 2011 at 6:18 PM

Why would hospice want to hasten death if they are getting money from medicare while they are there? I am just curious as why. Anyone have thoughts on that for me?

Reply

morie February 7, 2013 at 6:52 PM

I think they're on the in and out they are like on an assembly line type of business

Anonymous February 8, 2014 at 9:15 AM

I think there are limits on amounts also that can be paid. My mom was in a Salem Oregon one, and when I was able to get to Oregon (I live in a different state) I was immediately pulled into the hospice owner's office about the $$. She died Jan 29, 2012 after only about 4 weeks there...about a month. I can't remember all the details now (and I normally have an excellent memory) because I was in such a fog and stressed because my 2 older siblings left everything for me to handle...I had to take care of everything and didn't know really what I was doing or dealing with...AND THEY took advantage of that...families are distraught and not much of objective people. I just know that a hospice person went to her apartment before they moved her to hospice and got her to sign all the papers...Nobody else had a say in it because, like the hospice people kept telling me, "your mother signed the papers while she was fully cognizant". I remember her telling me the lady was coming to her apartment (that was in first part of December, when she was still fine, I told her she could come and stay with me, I had a spare room in my small house because my son had moved out for college. She said she couldn't make the trip that far. I beg to differ. She would have been fine, she just needed to have all her stuff in the car and could have sat back and "left the driving to me"!!

She was diagnosed with lung cancer in early November. I visited her for over a week at Thanksgiving and we had a nice time. She had to wait for about 1 month before she got into the cancer clinic (I thought that was bad too). After she saw the doctor in early December, right after she signed those papers, she was given shit loads of morphine. Of course she was so doped up and disoriented that she then was moved to the hospice at end of Dec and died about a month later. She was a tough 'ol gal. If she hadn't been a smoker she would have lived a long life.

When I went down again in January to take care of her old apartment and all the financial and other matters she had them quit giving her so much morphine and seemed to be doing better. After I went back home they "upped" her dose and she quickly deteriorated. I was having trouble getting back down there due to my old car unable to make another trip, and was trying to get other family members to go so I could get a ride but she died. So, I feel guilty not being there too. Last time I talked to her I said I was working on getting down there. Anyways, the morphine got her and they still put Lung Cancer as cause of death.

Anonymous March 1, 2014 at 8:49 PM

My sweet beloved aunt Gil was speaking clearly and eating full meals the day before she went in. Within one day, she was unable to form words, in spite of her obvious immense effort. They said it was her cancer that caused her to sleep and not speak. Oddly, that slow growing cancer had been inside of her for nine years before that, and she spoke just fine.

I asked why they would not give her fluids to drink or an IV. I was told by the stepford nurse that," HOSPICE DOES NOT promote death or enhance life."

If you immediately dope up a patient and dehydrate them, any one, sick or not, will die soon.

My aunt was murdered. I also read that although hospice won't admit it, one of the first things that happen when someone dies under hospice care is they are taken off life support and fluids and are told they are "too far gone to do any good."

I guess hospice fears people being able to ask for food or water, or worse, to ask them to stop the overdose. It's tragic that most of us humans just roll over and allow these greedy companies to make decisions...
The problem was... could not quickly leave. I just don't think I like Hospice, she was only there 2 days. They gave her morphine 5 mg, which all she was hurting was from laying in bed for 2 weeks. She had no other pain... this I knew, she was able to speak before she became so sleepy at the hospital. They had started giving her 1 mg of morphine every 4 hours. They also gave mom antivan at hospice... they gave her 1 mg at first. They did that in the hospital for a pic line and she slept for 3 days. Another time they gave her .5 mg (1/2 mg) and she slept for almost 2 days. So with 1 mg coming in at hospice and I tried to tell them don't give her but a pinch of antivan and they didn't listen. They said the Dr will decide. Well that 1 mg knock my mom out and then the morphine on top of it... I was hoping to have several days with my mom. I have heard of other people going in there and finding out that they are only in there for avg amount of 2 days. It has been 4 weeks since my mom has been gone. I wished I had stumbled upon this sooner.

deb

Reply

Joanne Pezzullo August 31, 2012 at 8:38 AM
I just went through the same thing with Hospice and my brother. It was absolutely horrifying to watch him being doped up. He was asked if he was in pain and said no -- the nurse five minutes later told his wife I'm giving him morphine for his pain... then proceeded to show her how to keep him doped up so he had no energy to eat anything and to barely speak. On the second day, surrounded by his loved ones the Hospice nurse told his wife everyone needed to leave because he 'needed his rest' -- NEEDED HIS REST? The problem was we were keeping him alive for a few more hours, a few more days. The final straw was as he asked me for a sip of water I was told that when he awoke and asked for something, even a sip of water we were not to give it to him. It was obvious at that point they were killing him quickly but with his wife and three other sisters and two brothers who would not listen - I left and couldn't go back, could not watch him begging for water with his eyes and not able to give it to him. It has caused rifts in this family that
These stories are exactly like ones I know personally. One lady I know had a husband. He was a sweet man with Alzheimer's and not dying. Went to hospital for something and was supposed to be ok. Hospice was brought in. She chose to take the advice of in-home Hospice nurse tell her not to give her husband water even though he begged and cussed. She was tortured by his all night cries and he died. After her short relief from her husband by his passing, she became so depressed she is in a mental hospital getting shock treatments. I think guilt got to her.

Reply

I can understand you find these stories hard to believe, however so many people cannot all be wrong! You speak very harshly when you say the family deserves as much blame as the nurse. This is where I feel you show very little compassion. When entering a Hospice situation one would likely be a layperson and could not be expected to fully understand the scope of what is happening. Before my Mother went into the Hospice Care Facility for assessment, I did not know anything about "palliative care", the "dying process", etc. So please to not condescend or take for granted the accounts recorded here to be untrue or without merit. Remember, there is always bad wherever there is good. Evil lurks even where righteousness rests. Hospice care is discreet. They do not come out saying "By the way we are going to place your precious loved one in a drug induced coma, and then they will lay in their death bed for however long it takes, grooping for air, mouth dry with thirst, moaning with every breath they take, they won't be able to talk to you, they won't be able to hold your hand, they will just lie there dying while you watch!" NO! Hospice is discreet. "We will make her comfortable". All the while you are thinking pain management, not sedated drug induced death! It happens so quickly and without consent that at first you are not even aware of what they are doing. After a couple of days, you notice something is wrong. You question the Nurses who are not forthright with information. Finally you insist they tell you what medication they are giving your loved one. The Nurse says "Give it 24 hours and see if she stabilizes before you make a judgment." You wait but there is no change only a worsening of the coma-like condition. You ask the Doctor to withdraw sedative medication and he refuses, saying "You will only prolong her suffering." By now the team players (family) are divided. Some players are still ignorant to what Hospice is really doing, and some