
HOSPICE NEWS NETWORK

Recent News on End-of-Life Care

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ARTICLE REPORTS ON MEDICARE'S HOSPICE COMPARE & SHOWS PAIN ASSESSMENT NEEDS TO IMPROVE

Medicare's Hospice Compare went live in August, linking National Quality Forum-endorsed Hospice Item Set quality measures data for nearly 3,900 hospices. The site is open to the public, so patients, family members, caregivers, and competitors have access to a broad range of information. "Quality: Hospice Compare Launch Shows Lagging Scores for Pain Assessment," featured in *Eli's Hospice Insider* breaks down the key findings from the Hospice Compare launch and points to issues providers should watch closely.

While six of the seven measures show national average scores in the mid- to high-90s, the pain assessment measure is considerably lower. The "percentage of patient stays during which the patient screened positive for pain and received a comprehensive assessment of pain within 1 day of the screening," has the lowest national average (76.3%).

What accounts for this lower rating in pain assessment scores? "One of the key issues would be not having the assessment completed in the time frame specified," says Theresa Forster of the National Association for Home Care & Hospice. "Hospices only have one day from having a patient screen positive for pain to complete the assessment and have it count."

Looking at the high scores across the country, the usefulness of the metrics raises questions. CMS's fact sheet itself warns that the generally high scores across all providers could be misleading. "Even when measure scores may average over 90 percent, there is often a wide range of provider performance representing room for improvement," the agency says. To combat this, CMS is planning a five-star rating system, much like it does for home health agencies and other providers. Despite these limitations, Forster calls the launch "an important step forward in the evolution of the Hospice Quality Reporting Program (HQRP)," and one that "sets the hospice program firmly on the road toward greater transparency — on-par with other Medicare providers."

Data glitches in Hospice Compare have also spawned less than glowing press. In Fargo, North Dakota, one hospice's "First report card is ugly" reported a headline on a Detroit Lakes news website. The not-for-profit hospice was asked to explain its dramatically low 16.6% rate of patients getting a timely and thorough pain assessment. The hospice responded that the issue was a self-reporting issue: "I am 100 percent certain our staff prioritizes pain management."

The article proposes strategies for making the most out of the new site, particularly monitoring the reporting of data and contact information. "If you failed to catch errors such

as a wrong address or phone number in your Hospice Compare preview report,” the writer warns hospice providers, “you’re not going to see a quick fix for it.” Updates on the website are not automated and can take six months to be corrected. CMS also urges hospices to review their quarterly Hospice Compare Preview Report in ASPEN and the information displayed on the Hospice Compare website itself for accuracy. “If there’s a problem, report the correction to your state’s ASPEN coordinator — not CMS directly.” (*Eli’s Hospice Insider*, 9/18, www.supercoder.com/coding-newsletters/my-hospice-insider-alert/quality-hospice-compare-launch-shows-lagging-scores-for-pain-assessment-155451-article)

AMERICAN COLLEGE OF PHYSICIANS REAFFIRMS 2001 POSITION REJECTING PAS

While physician-assisted suicide (PAS) has seen increased public interest, the practice still faces legal and ethical questions. As patients and their families explore end-of-life care options, the question is sure to be at the center of ongoing debate. **The American College of Physicians (ACP), a proponent of patient-centered care, has said that ethical arguments against the legalization of physician-assisted suicide remain more compelling than those in favor of it.**

“Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper,” elaborates upon ACP’s view. The paper appeared in *Annals of Internal Medicine*. ACP opposes legalization of PAS. The group argues that PAS is “problematic given the nature of the patient–physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession’s role in society.”

The statement reaffirms claims that APC made in 2001. “Since then, there’s been a lot of interest in the subject, and several more states have legalized physician-assisted suicide,” says ACP President Jack Ende, MD, “We also felt there wasn’t enough attention given to patients with terminal illness to be sure they were receiving the best possible care, with hospice care and palliative care.”

At the core of the debate rests the idea of patient autonomy, which APC acknowledges, but not without limitations. The public’s lack of awareness of “palliative care” may be a sizable and often overlooked component, according to ACP. In its statement, the group points to a study showing that 90% of US adults don’t know what the term means, but after hearing its definition that same 90% would want it for themselves or a family member in the case of a severe illness.

ACP supports their position with the idea that physicians should be in the position to heal, and uphold the “inherently unequal” physician-patient relationship, and build trust between physicians and the public. **“We believe physicians need to be healers, and part of the role of the physician as a healer does not include assisting the patient with suicide,” says Dr. Ende. “We are very strong proponents of patient autonomy and also recognize that patient autonomy has limits.”** (*ACP*, 9/19, <http://annals.org/aim/article/2654458/ethics-legalization-physician-assisted-suicide-american-college-physicians-position-paper>;

HOSPICE CARE OFTEN BEGINS TOO LATE

Hospice stays are often very short, with half of patients admitted within the last two weeks of life. The benefits of hospice, however, are not fully utilized in such a late transition. Why are patients with debilitating symptoms foregoing hospice care or transitioning care within the last two weeks of their lives?

“Distressing Symptoms, Disability, and Hospice Services at the End of Life: Prospective Cohort Study” was published in the *Journal of the American Geriatrics Society*. Yale researchers examine the relationship between restricting symptoms or disabilities and admission to hospice at the end of life. The research found that many patients experienced new symptoms that impeded their daily lives during the last six months of life. **The onset of any debilitating symptom correlated with a 66% spike in the decision to seek hospice care. Still, in that final year, just 43% took advantage of hospice care, according to the study. When they did, the average time in hospice care was only about 13 days.**

“The main message is that the duration of hospice is very short,” says lead study author Dr. Thomas Gill. This is true even when the team has “documented high rates of distressing symptoms well before the start of hospice.” As a service, hospice can treat symptoms that range from pain and nausea to anxiety, says Dr. Gill. But given this evidence found in this study, he suggests, “Health care providers might need to consider discussing referrals to hospice sooner.”

In the media, a range of publications including *Consumer Reports*, have taken the study as a chance to expand the conversation about end-of-life care. “These conversations can be difficult for patients, their families, and their doctors,” says an article in *Consumer Reports*, “which is why people often put them off until the last moment, sometimes sacrificing quality time at the end of life for dubious interventions or unnecessary hospitalization.” NHPCO added to public understanding of hospices in a *U.S. News & World Report*, noting that while stand-alone hospice centers exist, visiting caregivers most often provide care in patients’ homes.

The study’s findings are an insight into the public’s use of hospice and the gaps in awareness and timing when directing patients to appropriate care. The study’s authors conclude that while hospices “appear to be suitably targeted to older persons with the greatest needs at the end of life,” the short duration of patient utilization requires new strategies that better address the burden of distressing symptoms and disabilities. (*US News*, 9/12, <https://health.usnews.com/health-care/articles/2017-09-12/many-may-get-hospice-care-too-late>; *Home Health News*, 9/12, <https://homehealthcarenews.com/2017/09/yale-hospice-patients-are-admitted-too-late>; *Yale News*, 9/12, <https://news.yale.edu/2017/09/12/hospice-care-short-and-may-start-later-needed>; *Consumer Reports*, 9/13, www.consumerreports.org/hospice-care/when-to-consider-hospice-care; *Online Library*, 9/12, <http://onlinelibrary.wiley.com/doi/10.1111/jgs.15041/full>)

HOSPICE & PALLIATIVE CARE NOTES

*A study, titled “Utilization of hospice services in a population of patients with Huntington’s Disease,” appears in the September issue of the *Journal of Pain and Symptom Management*. The researchers found “that Huntington’s patients enter hospice at a younger age than patients with other chronic conditions,” and they have longer stays in hospice as well. The researchers explore the difficulties in caregiving for these persons, and examine other aspects of the disease. The hospice median length of stay for these patients is 42 days, and fewer of these patients die in their own homes. The researchers, from University of Pennsylvania, say, “Hospice workers and administrators could benefit from more education about the disease to improve care.” (*Journal of Pain and Symptom Management*, September 2017, [http://www.jpmsjournal.com/article/S0885-3924\(17\)30468-2/fulltext](http://www.jpmsjournal.com/article/S0885-3924(17)30468-2/fulltext); *Huntington’s Disease News*, 9/21, <https://huntingtonsdiseaseneews.com/2017/09/21/huntingtons-patients-would-benefit-from-more-hospice-involvement-researchers-argue/>)

* **The Office of Inspector General released “Duplicate Drug Claims for Hospice Beneficiaries,” reminding everyone that hospice providers must “render all services necessary for the palliation and management of a beneficiary’s terminal illness and related conditions, including prescription drugs.”** It notes a Medicare Part A per diem for hospice patients, and that part of this payment should cover drugs related to terminal illness. This means “Medicare Part D drug plans should not pay for prescription drugs related to a hospice beneficiary’s terminal illness because the drugs are already included in the Part A hospice benefit.” **This statement comes after “OIG work (A-06-10-00059) found that Medicare may have paid twice for prescription drugs for hospice beneficiaries, once under the Part A per diem rate and again under Part D.”** (*OIG*, 8/2017, <https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000240.asp>)

* **In the aftermath of Scripps Health “getting out of the hospice business,” an *Inewssource* article retrospectively examines the multi-year history of San Diego Hospice.** The report reviews the crippling issues faced earlier by San Diego Hospices, the process of the Scripps purchase of the hospice, and the process of Scripps’ “hiring [San Diego Hospice] employees, taking in its patients and winning a bidding war to buy the Hillcrest facility” before it eventually faced “federal auditors [beginning] to ask whether the people it cared for were actually dying.” The hospice is now closing, saying the ongoing financial losses are not sustainable. (*Inewssource*, 9/15, <http://inewssource.org/2017/09/15/san-diego-hospice-end-journey>)

* **Nebraska Hospice & Palliative Care Association released its 2017 End-of-Life Survey findings.** While a strong majority in the state, 84%, say they’re comfortable talking about death and most know what an advanced directive is, only about one third of Nebraskans have completed the document. The survey also shows that while 95% of all survey respondents had heard of hospice, only about 63% had heard of palliative care. News articles and the complete report are available online at the links below. (*Journal Star*, 9/20, http://journalstar.com/lifestyles/health-med-fit/nebraskans-are-comfortable-talking-about-death-but-don-t-sign/article_dce7590a-b95f-5942-879b-366b1bdf16e7.html; NHPCA, 7/2017, http://c.ymcdn.com/sites/www.nehospice.org/resource/resmgr/2017_Resources/NHPCA_2017_End-of-Life_Surve.pdf;

http://c.ymcdn.com/sites/www.nehospice.org/resource/resmgr/2017_Resources/EOL_Survey_Online_Pager_-_Consu.pdf)

* **The percentage of acute hospitals that have common investor ties to the post acute or hospice sectors increased dramatically in the past decade.** The findings are discussed in a study published in *Health Affairs*. The rise of overlap changed from 24.6% in 2005 to 48.9% in 2015. The authors say, “These changes have important implications for antitrust, payment, and regulatory policies.” (*Health Affairs*, 9/2017, <http://content.healthaffairs.org/content/36/9/1547.abstract>)

* **While Pennsylvania home hospice workers can’t dispose of patient medications, they may guide the family in doing so.** “We can assist them as they destroy the medications,” says Dr. Joan Harrold, chief medical officer for Hospice & Community Care in Lancaster. “We cannot take possession, but we can walk them through” the process. Harrold sees this responsibility as a “moral authority issue ... especially with medications that have had such (severe) public health implications.” (*Lancaster Online*, 9/23, http://lancasteronline.com/news/health/who-s-responsible-for-leftover-home-hospice-care-medications-in/article_847dcd9e-9af4-11e7-b5b2-a32ac15d4269.html)

* **Patients with advanced non-small cell lung cancer underutilize palliative care and hospice, according to a study presented at International Association for the Study of Lung Cancer Multidisciplinary Symposium in Thoracic Oncology.** “Among patients with stage IV disease,” the article relates, “those who received oncologic treatment were less likely to use palliative care or hospice services than patients who received no oncologist treatment.” (*Healio*, 9/16, <https://www.healio.com/hematology-oncology/lung-cancer/news/online/%7Bcab729cb-9962-472f-ab80-d54fc1c250d1%7D/palliative-care-hospice-resources-underutilized-for-advanced-non-small-cell-lung-cancer>)

* **The Center for Hospice Care in Connecticut has launched its “Sooner is Better” campaign.** Sean Mitchell, Director of Development for Southeast Connecticut’s Center for Hospice Care, spoke with WTNH on the air about the campaign’s five-point pitch for why “Sooner is Better”: You live longer, feel better, regain control of your life, don’t have to stay, and share the care with family members. (*WTNH*, 9/17, <http://wtnh.com/2017/09/17/center-for-hospice-care-launches-sooner-is-better-campaign>)

* **The US government claims that UAW and FCA executives in Detroit laundered money through a fake hospice center.** The investigation is ongoing, but so far four individuals have been charged. (*Detroit Free Press*, 9/19, <http://www.freep.com/story/news/2017/09/19/feds-uaw-and-fca-execs-laundered-money-through-fake-hospice-center/682358001>)

* **CMS reports that some hospice providers incorrectly received footnote “e.”** “Results are based on a shorter time period than required” on the Hospice Provider Preview Report for the reporting period Quarter 1- 2016 to Quarter 4- 2016, which CMS distributed via CASPER on August 29, 2017. If your hospice received this footnote in error, your data will be shown correctly on Hospice Compare, without this footnote, when this data is publicly reported in November 2017. Additionally, this issue will be corrected for the next quarterly Hospice Provider Preview Report, which is due to be released on December 1, 2017. More details are online. (*CMS*, 9/13, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient>

Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html)

* **“Electing Full Code in Hospice: Patient Characteristics and Live Discharge Rates”** published in the *Journal of Palliative Medicine* found that patients “electing full code status on admission to hospice are at high risk of live hospice discharge after short enrollments, particularly nonwhite enrollees.” The study looked at over 25,000 decedents enrolled in two Michigan hospices from 2009 – 2014. (*LiebertPub*, 9/5, <http://online.liebertpub.com/doi/abs/10.1089/jpm.2017.0276>)

* **“We’re going broke.” That’s the assessment of many patients when facing palliative care costs.** Through the example of Max, a 48 year-old stage IV lung cancer patient, a *Medscape* article explores methods of reducing cost and stress across all serious illnesses. “Even for patients with healthcare coverage through Medicare or other health insurance plans, the personal costs are enormous, resulting in financial distress and even bankruptcy for a significant number of patients.” (*Medscape*, 9/19, <http://www.medscape.com/viewarticle/885624>)

END-OF-LIFE NOTES

* **Chatbots are on the rise, and they’ve reached end-of-life care.** Timothy Bickmore, a professor at Northeastern University in Boston, and his team have developed a chatbot to “offer spiritual and emotional guidance” regarding end-of-life care decisions. For now, the bot “isn’t fully autonomous” and “sticks to a fairly rigid script,” but further development is underway. The Conversation Project praised the step into the technology as a “non-judgmental” way to approach these discussions. (*The Blaze*, 9/20, www.theblaze.com/news/2017/09/20/scientists-develop-chatbot-to-advise-patients-about-end-of-life-care)

* **A study published in JAMA followed patients with advanced cancer receiving palliative care.** They found that adding lorazepam to haloperidol resulted in greater reduction in agitation. The randomized clinical trial studied 90 patients with a mean age of 62. (*JAMA*, 9/19, <http://jamanetwork.com/journals/jama/article-abstract/2654385>)

* **Atul Gawande, a surgeon and author of *Being Mortal: Medicine and What Matters in the End*, spoke with Robin Young on *Here & Now* on treatment of the elderly and how dying can be improved.** This issue became personal for Gawande after his father was diagnosed with incurable brain cancer. (*WPSU*, 9/15, <http://radio.wpsu.org/post/atul-gawande-how-improve-end-life-care>)

* **While four out of five wish to die at home, only about one in five person will, according to Angelo Volandes, author of *The Conversation: A Revolutionary Plan for End-of-Life Care*.** “Doctors are writing the end of your life,” Volandes said in a recent talk. “You need to take that back ... you need to know how you can write your own end of life.” Volandes encourages patients to slow down, consider options, and think hard about hospital admissions. He says there are “infections there and a lot of the procedures we do are painful. Hospitals were designed for

healthy people.” (*Sentinel Source*, 9/20, www.sentinel-source.com/news/local/author-know-how-to-write-your-own-end-of-life/article_04e7a7ec-6599-58ad-bcbd-7f3733119cd5.html)

ADVANCED CARE PLANNING NOTES

* **The “Medicare Choices Empowerment and Protection Act,” reintroduced in July by Sens. Bill Cassidy (R-LA), John Barrasso (R-WY) and Michael Bennet (D-CO), would have CMS pay Medicare beneficiaries \$75 for writing and registering digital advance directives.** An article discusses a notable gap in incentives and technology. For instance, while CMS reimburses clinicians for advanced care planning, “the agency has yet to encourage patients to set up these plans.” The current advice from CMS is a notably “low-tech, hands-off approach,” the author notes, as patients are advised to print off documents and carry a note in their wallet. (*Modern Healthcare*, 9/13, www.modernhealthcare.com/article/20170913/NEWS/170919959/healthcare-groups-lawmakers-push-medicare-to-promote-advance)

* **The Rochester Academy of Medicine is holding a four-part education series in the hopes that more families will begin discussions about end-of-life care.** “Each session has its own topic: improving care and honoring the individual’s preferences; nursing home and hospice care; spiritual life; and palliative care. Each discussion is led by local experts.” (*Democrat & Chronicle*, 9/12, <http://www.democratandchronicle.com/story/news/2017/09/12/final-wishes-palliative-care-hospice-end-of-life/641022001>)

* **Understanding the “ecosystem of family caregiving,” is at the heart of CareMaps, according to the project’s founder, Rajiv Mehta.** CareMaps is a tool by *Atlas of Caregiving*, “an ambitious project that hopes to gather comprehensive data about family caregivers.” The tool is being piloted in San Francisco and staff are working to gather comprehensive data about family caregivers. *Atlas of Caregiving* says, “Family caregiving is an isolated and under-appreciated endeavor that is not well understood. As such, current systems intended to support family caregivers cannot scale to help meet their needs, and in turn, affect those who are requiring care.” More information on the CareMaps is online at the third link below. (*KHN*, 9/21, <http://khn.org/news/caregivers-draw-support-by-mapping-their-relationships>; *Atlas of Caregiving*, <https://atlasofcaregiving.com/about/>; <https://atlasofcaregiving.com/drawing-using-caremap/>)

PHYSICIAN ASSISTED SUICIDE NOTES

* **In Oregon’s Death With Dignity Act’s (DWDA) 20-year history, 0.2% of deaths come from DWDA prescriptions.** However, according to a report in *Annals of Internal Medicine*, “DWDA death rates showed relative increases of 14% each year from 1998 to 2013 and 36% annually from 2013 to 2015.” Why is the rate rising? “I can’t tell you why [the increase] is happening, whether it’s that more people are aware of it, changes in social norms or something else,” says lead author Katrina Hedberg, MD. (*Medscape*, 9/18,

<http://www.medscape.com/viewarticle/885868>; *ACP*, 9/19,
<http://annals.org/aim/article/2654460/oregon-s-death-dignity-act-20-years-experience-inform-debate>)

* **A personal essay, “I’m a doctor. Here’s what it’s like helping terminally ill patients end their lives” appeared in *Vox*.** Catherine Sonquist Forest discusses how she came to support medical aid in dying, the logistics of medications (and the fact that requested medication are often not used), and the doctor’s duty to listen to the needs of the patient. Forest is a Santa Cruz family medicine physician, medical director of Stanford Health Care at Los Altos, and an assistant clinical professor of medicine at Stanford School of Medicine. (*Vox*, 9/21, www.vox.com/first-person/2017/9/21/16335534/aid-in-dying-california-legal-end-of-life)

* **Healthcare professionals, including psychiatrists, are adapting to an increase in “pre-planned death” discussions, according to an article in *Journal of Psychiatric Practice*.** Dr. Joel Yager offers a discussion of pre-planned death, and discusses the decisions that should be afforded to mentally capable individuals. “Shouldn’t they be accorded the same dignities and care that physicians would want for themselves?” he asks. He urges professionals to “address the quality of human experiences surrounding death.” (*Medical Press*, 9/14, <https://medicalxpress.com/news/2017-09-shifting-attitudes-pre-planned-death-clinicians.html>)

OTHER NOTES

* **Healthcare has long been viewed as a secure career path. United Nations projects world populations of people over 60 doubling by 2050 (from 841 million to more than 2 billion).** An article identifies 10 specializations that are likely to be in high demand as these numbers grow. They include: bioinformatician, cryopreservation specialist, custom implant organ designer, end-of-life therapist, genetic counselor, health specialties professor, health care navigator, medical scribe, medical roboticist, and telesurgeon. **End-of-life therapists are defined in the article.** In addition to working with family members, these therapists will be “armed with backgrounds in fields like social work, palliative care, education and human psychology.” These professional therapists “will work with older people to prepare for their final life stage. Issues discussed may include how to ensure the eventual dying process is as smooth and painless as possible; how to best prepare yourself emotionally for this phase and the possible legal issues that may occur with advanced age.”

(*How Stuff Works*, 9/2017 health.howstuffworks.com/medicine/healthcare/10-future-jobs-in-health-care4.htm)

* **Oncologist Mark Lewis faces a Whipple operation for a tumor in his pancreas and reflects the impact of this on his family, and on the beauty in life.** “It’s so tempting to liken cancer to a ravenous animal, but it’s worse than that. It’s not even a parasite, trying to occupy one host and move on to the next one, forever restless and nomadic,” he says. Yet the piece ends with optimism. He speaks of his young son who has the same genetic issue that he has. “I have stood with him by the ocean. I have wondered how he will chart the course ahead ... I hope I have taught him to enjoy the beach in spite of the crab. Naughty as it may be, it does not cancel out life’s beauty.” (*KevinMd*, 9/10,

<http://www.kevinmd.com/blog/2017/09/cancer-doesnt-take-away-beauty-life.html>)

* ***Art of Dying, Volume II* has put its latest issue online.** It includes Jack Curry’s “Death and Dying in Digital Times,” Sarah Treanor’s “Still, Life,” Kathleen Dreier’s “All Souls Procession,” and Bill Palmer’s “I’ve Led 50 Death Cafes: Here are 50 Things I Learned.” The magazine is edited by John Wadsworth and designed by Ashley Grove Mars. (*Art of Dying*, <https://view.joomag.com/art-of-dying-volume-ii/0559854001505256063>)

* **A new ASCO guideline recommends that oncologists participate in communication skills training.** This “underscores that an important skill for each provider is to understand the patient as an individual and their families’ unique needs,” says Walter F. Baile, MD, co-chair of the ASCO panel that developed the guidelines. The multidisciplinary panel was composed of experts from oncology, psychiatry, nursing, hospice and palliative medicine, communication skills, health disparities, and advocacy. (*Healio*, 9/11, <http://www.healio.com/hematology-oncology/practice-management/news/in-the-journals/%7B2f835326-c99c-4cae-a6b6-7ce3a0685ef2%7D/asco-communication-skills-training-should-be-available-to-every-oncologist>)

* **The Center for Medicare and Medicaid Innovation (CMMI) at CMS issued a request for information (RFI) to stakeholders in the healthcare industry.** The RFI, according to a C-TAC update, is seeking “feedback in order to promote patient-centered care and pilot reforms that empower beneficiaries, provide price transparency, ensure quality care, reduce costs, and improve overall care outcomes.” C-TAC expressed encouragement, saying the request “indicates that regulators are prepared to incorporate innovative strategies in caring for America’s advanced illness population.” The full RFI is online at the second citation below, and comments will be taken until 11/2017. (*C-TAC Alert*, 9/22; *CMS*, https://innovation.cms.gov/Files/x/newdirection-rfi.pdf?utm_source=Member+Alert&utm_campaign=28461ca0ad-Member_Alert&utm_medium=email&utm_term=0_e1d9f6f769-28461ca0ad-150801781)

* **How do we acknowledge and share the hard work of caregivers?** Palliative Care Buffalo in Cheektowaga has created The Photographs of Meaning Program with photography and audio from parents and caregivers to tell their stories. The collection is online at <https://www.hospicebuffalo.com/healthcare-providers/research/pomp> (*The Buffalo News*, 9/19, <http://buffalonews.com/2017/09/19/caregivers-tell-stories>)

* **Marilyn Cramer, an 85-year-old former French horn player with the Johnstown Symphony, will attend the Pittsburgh Symphony Orchestra’s annual thanks to the Dream Foundation, an organization that helps fulfill the end-of-life dreams of terminally ill adults.** The touching story overlaps with a larger story about music therapy. “Music therapy can help with cognitive goals as well as social or physical goals,” says Jessica Mull, a music therapy board-certified therapist. “We have a natural connection to music, and we can use that connection to accomplish clinical goals.” (*Pittsburgh Post-Gazette*, 9/23, www.post-gazette.com/ae/music/2017/09/17/Pittsburgh-Symphony-Orchestra-Music-Therapy-Dream-Foundation-Cramer-Terminal/stories/201709140228)

* The idea of a “nudge” is not new to governments or businesses trying to push individuals into action, but the technique has been slow to catch on in health care. **Dr. Scott Halpern, a critical care physician at University of Pennsylvania studies such ‘nudges’ and “believes the**

technique can play a greater role in improving the patient experience” particularly “for those living with serious illnesses, and who often struggle to make sound decisions at times of great emotional and physical complexity.” Instead of a fully neutral tone when discussing potentially harmful resuscitation, for instance, Halpern “became comfortable saying, ‘In this situation your loved one’s heart may stop. If it did, we would not routinely do chest compressions, because they would be unlikely to work. Does this seem reasonable?’” (*STAT*, 9/14, <https://www.statnews.com/2017/09/14/end-of-life-doctors-nudges>)

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Hospice Analytics is the national sponsor of Hospice News Network for 2017. Hospice Analytics is an information-sharing research organization whose mission is to improve hospice utilization and access to quality end-of-life care. For additional information, please call Dr. Cordt Kassner, CEO, at 719-209- 1237 or see www.HospiceAnalytics.com.

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