



Hospice Face-to-Face Recertification

Embracing the Benefits and Challenges

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The Medicare hospice benefit provides quality end-of-life care for those with a prognosis of 6 months or less to live and their families. The utilization of the benefit has increased since its implementation in 1982. Eligibility requirements and conditions of participation guide the admission and recertification of patients enrolled in hospice care. The face-to-face (FTF) requirement for hospice recertification is a major revision of the conditions of participation as of 2011. The FTF recertification process was established to deter unsubstantiated benefits for those who do not qualify for hospice care and prevent Medicare fraud. Ultimately, this process is designed to enhance the quality and delivery of hospice care to those who need it most. Hospices, practitioners, patients, and caregivers are collaborating to comply with these requirements. Nurses play an important role in the ongoing assessment and reassessment of patient status. Nurse practitioners are essential providers who can assess and document the findings relevant to the FTF recertification process. This article describes the benefits and challenges of the FTF requirement and the role nursing plays in this relatively new provision. Regulation recommendations are presented for ease of compliance.

the third period of the hospice benefit. These encounters are thorough reassessments of patients' eligibility for continuing hospice services. Hospice physicians or nurse practitioners (NPs) reassess the patient status on scheduled basis to meet the requirements for recertification.²

Hospice leaders created and delegated resources, processes, and training to comply with these new regulations. Although compliance with these regulations has added a new layer of assessment and documentation, the goal of FTF recertification is to improve the quality of care for those who need the services and to refer others no longer in need to appropriate resources. The requirement encourages the entire nursing profession to exercise a greater role in hospice care, advocating for patients who qualify for services. Hospice nurses play an important role in complying with the regulations by assessing and reporting clinical decline to documenting need for continuing hospice services and educating patients and families about the importance of FTF encounters. The regulation specifically identifies NPs as key providers, yielding an opportunity to work within their full scope of practice.³

HISTORICAL BACKGROUND

Nursing has a long history of caring for the sick and the dying. The approach to care is redirected when a cure is improbable. This care addresses rather than neglects the specific needs of the dying.⁴ Dame Cicely Saunders, a nurse, social worker, and physician, is credited with beginning this method of care. As founder of St Christopher's Hospice in London, she emphasized pain control and relationships to prepare for death. Dr Saunders' 1963 lecture at Yale transformed Florence Wald, who went on to promote hospice care in the United States. In 1974, Wald opened Connecticut Hospice, the first hospice in the United States,⁴ and Wald began providing hospice as home care, then added an inpatient facility.⁴ This hospice care included an interdisciplinary approach with a collaborative shift. Nurses directed patient care while collaborating with physicians.

The foundation of the hospice philosophy is patient and family centered, directing care based on the patient's preferences.⁵ Hospice services provide palliative care, offering pain and symptom relief from serious and advanced illness along with psychosocial and spiritual support for patients

KEY WORDS

eligibility, face-to-face encounters, hospice, nurse practitioners, recertification

The US hospice community has seen many changes in the Medicare Hospice regulations since the 1982 implementation of the hospice benefit.¹ In 2011, a major change in the process of recertification was introduced with the Affordable Care Act. The Centers for Medicare & Medicaid Services (CMS) require face-to-face (FTF) encounters¹ between every hospice patient approaching

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and families. The influences of Saunders and Wald, nursing pioneers of hospice, remain evident today.

Government Regulations of Hospice Care

In 1982, the US Congress created a Medicare hospice benefit⁵ to improve access to quality end-of-life care. Hospice Conditions of Participation were created and published in 1983.¹ This benefit was made permanent in 1986 with the implementation of eligibility criteria. In 1993, hospice became a nationally guaranteed benefit under the health care reform proposal.⁶ In order to qualify for the benefit, 2 physicians, typically the hospice medical director and the patient's physician, certify that the patient has a terminal illness with prognosis of 6 months or less, if the illness follows its usual trajectory.¹

The Medicare hospice benefit ensures quality end-of-life care for patients with a terminal illness life expectancy of 6 months or less. An interdisciplinary team (IDT) delivers care that addresses the physical, psychological, social, and spiritual needs of patients and provides support to the families, including the bereavement period following the patient's death. Team members must include nurses, a physician medical director, social workers, and volunteers. Spiritual care is offered as well as other services as needed, such as art and music therapy and occupational therapy. In addition to providing comprehensive care from the IDT, the benefit includes coverage for medications and all equipment needed for patient comfort and care. Hospice services in the plan of care support the management of the terminal illness and related conditions.¹ Care is most typically provided wherever the patient calls "home." The majority of patients' level of care is routine home care, followed by general inpatient, continuous, and respite (Figure 1) care.⁵ Hospice agencies change the level of care, depending on patient and family needs.

Prior to 2011, the Medicare benefit regulations required that patients were evaluated to determine their eligibility to elect the hospice benefit at the initial 90-day period. Continued eligibility was evaluated at the subsequent

90-day period, followed by the subsequent 30-day period. Ultimately, a patient was then granted a subsequent extension period of unlimited duration during the patient's lifetime. Under these regulations, patients with terminal diseases that are difficult to prognosticate, such as dementia and other lingering yet serious chronic diseases, could remain in hospice care for over a year and beyond. This unlimited extension contributed to the development of hospice Medicare fraud.⁷ Some hospices found patients with less intensive care and longer lengths of stay financially attractive. Between 2000 and 2007, the Medicare hospice payment system contained incentives for long hospice stays, and the number of for-profit Medicare-participating hospices increased.⁷

As health care in the United States continued to undergo reform with the Affordable Care Act, Congress enacted a provision to ensure appropriate use of the hospice benefit and eliminate fraud. The Medicare hospice regulation was updated in 2011 to ensure that patients with long-term serious illnesses continue to meet eligibility requirements. The CMS now requires FTF assessments for hospice eligibility or recertification. According to the regulation, a physician or NP, hired by the hospice agency, must assess the patient after the first two 90-day periods or before the third recertification period. Subsequently, the FTF visits are every 60 days until death or discharge rather than an unlimited extension period after the third election period of 30 days. To be in compliance with the regulation, the FTF visits must be completed no more than 30 days prior to the recertification date.² Face-to-face encounters are not billable services; they are bundled into the hospice benefit.

Financial Impact of Hospice Care

By electing the hospice benefit under Medicare Part A, patients choose aggressive comfort care rather than aggressive disease-management therapies. The needless suffering of repeated hospitalizations, difficult treatment regimens, and admissions to the intensive care unit are avoided, and most importantly, patients' goals of care are honored. An added bonus to this quality care is the ability to eliminate the financial burden of costly, futile care in the final months of life. Adverse economic deficits for patients and families addressing terminal illness were identified in the landmark SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment) in 1995.⁸ Since SUPPORT, numerous studies and reports have demonstrated the financial burden of serious illness for patients and families and also for the health care system.⁹⁻¹³

In addition to decreasing the financial burden of futile care at the end of life on families, when patients elect the hospice services there are financial advantages to the comprehensive care given to patients and families. The Medicare hospice benefit remains the primary source of payment

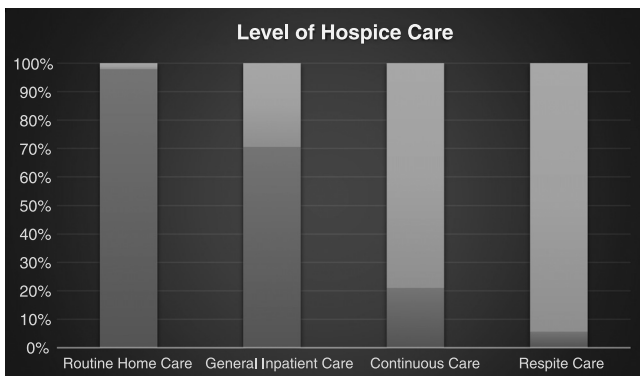


FIGURE 1. Utilization of hospice levels of care.



to the hospice agency for hospice care.⁵ There are no additional charges to the patient and family for this comprehensive care, saving patients and families from financial burden at end of life.

One of the advantages of hospice care for patients and families is the reduction of expenses for medical costs. Medications and durable medical equipment the patients need are covered by the benefit. Supportive services including social work and chaplaincy are available. Nursing is provided wherever the patient calls home. The team continues to provide bereavement support to the families during the year after the patient dies, and beyond if necessary. Patients and families benefit from receiving quality care while also decreasing financial burden. However, these services must be reserved for those who have 6 months or less to live, if their disease takes its anticipated trajectory, hence the need for a recertification process and the elimination of an unlimited period of services for those who qualify.

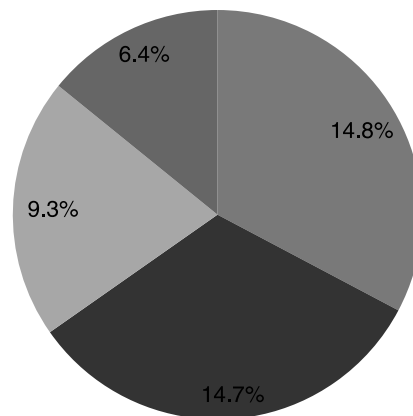
Changes in Hospice Utilization

The number of patients accessing hospices in the 1980s was approximately 25 000.¹⁴ In 2010, patient growth reached 1 380 680 and in 2014, an estimated 1 656 353.⁵ Recent statistics demonstrate that nearly half of the patients who died in the United States received hospice services.⁵ In 2014, 85.5% of hospice patients were covered by Medicare.⁵ Although the numbers of patients accessing hospice care have improved, the median length of stay (LOS) remains low (17.4 days)⁵, identifying the continued need to improve timely admission to hospice care for those who are near end of life.

The types of patient diagnoses have changed over time. This significant change has contributed to the need for ongoing recertification. In the early days of hospice care, most of the patients enrolled in hospice received a diagnosis of terminal cancer. Treatments were limited, and it was relatively easy to predict when patients were near the end of life. Now, only 36% of the hospice patients have a primary diagnosis of cancer.⁵

The top 4 noncancer diagnoses are dementia, heart disease, lung disease, and stroke or coma, as identified in Figure 2.⁵ It is important to note that these diagnoses can be more challenging to prognosticate than most stage IV cancers. Noncancer diagnoses, such as Alzheimer disease, usually have a slow progressive disease trajectory that can last for years. This chronicity combined with acute exacerbations of illness, as seen with patients with heart failure and chronic obstructive pulmonary disease (COPD) experience, makes it difficult to predict a prognosis of 6 months or less. The increase in noncancer diagnoses has been a contributing factor for the need for a recertification process.

Despite the increasing numbers accessing hospice and the diversity of diagnoses, many patients are enrolled in



■ Dementia ■ Heart Disease ■ Lung Disease ■ Stroke or Coma

FIGURE 2. Top four non-cancer diagnoses.

hospice close to their death. Currently, half of all hospice patients in the United States die within 3 weeks of enrollment, and 35.5% of them die within 7 days.⁵ However, the remaining half of all hospice patients have varying LOS and require reassessment for eligibility. In 2014, the average LOS was 71.3 days, or just over 2 months.⁵ The average LOS is higher than the median LOS because the 10.3% of patients who survive beyond the life expectancy of 6 months contribute to computing the average.⁵ This minority of patients are the ones who need recertification visits to determine continued eligibility as it is not uncommon for some patients with serious chronic illnesses to stabilize or even improve with hospice care.¹⁴

FTF PROCESS

All patients who are still receiving hospice care 180 days after admission to hospice are involved in the FTF recertification process. During the FTF encounter, the hospice physician or NP completes an examination and documentation of clinical findings. The findings may or may not support a life expectancy of 6 months or less. These findings are documented as an attestation in the record in narrative with an accompanying signature and the date. This is a separate and distinct section of, or an addendum to, the recertification form and must be clearly titled.¹ If the NP completes the FTF, then the NP must share the findings with the certifying hospice physician who then makes the determination if recertification is in accordance with CMS.¹ The NP cannot certify or recertify terminal illness. As previously mentioned, the FTF encounter is not a billable service; it is considered as part of the hospice bundle of services. However, the NP acting as the attending physician may bill separately after the encounter if medical changes (ie, medication adjustments) are made during that visit.² If medical changes are identified during an encounter, the patients, families, and hospice agencies can benefit from



the practitioners' interventions, symptom management, and education.¹⁵ The FTF encounters must occur no more than 30 days before the third benefit period recertification and each subsequent recertification.² Timeframe and recertification requirements and exceptions should be carefully monitored according to CMS regulations. Medicare hospice coverage is distributed in compliance with these statutes.

CASE STUDY: HOSPICE ELIGIBILITY AND THE FTF PROCESS

B.G. is a stable, long-term hospice patient. He is a 91-year-old black man and admitted to hospice more than a year. His primary diagnosis is end-stage COPD with comorbidities of colon cancer, hypertension, urinary incontinence, and gastric esophageal reflux disease. B.G. and his wife have lived in their modest, suburban home for nearly 50 years.

The NP, employed by hospice, went to B.G.'s home to complete the fifth FTF visit for recertification. Prior to the visit, the NP reviewed his hospice chart, including nursing notes since the prior FTF visit. The chart included a pulmonary function test result from 2 years ago: FEV₁ (forced expiratory volume in 1 second) of 45%; no further testing had been done. The charting demonstrated that B.G. had not had a COPD exacerbation and had stable blood pressure readings and stable weight. There was no documented complaint of pain, anxiety, constipation, or changes in shortness of breath. The NP reviewed the purpose of this visit with B.G. and his wife. They were informed that the visit was to assess eligibility for current hospice benefit recertification. They both verbalized understanding and agreement.

B.G. was slumped in the dining room chair wearing nasal cannula with oxygen tank set at 2 L, breathing comfortably. His wife was preparing a meal and reported that B.G.'s appetite had improved during their recent trip to visit the grandchildren. The wife denied any acute concerns and confirmed B.G.'s adherence to his medication regimen including use of his walker. B.G.'s review of systems was remarkable for baseline shortness of breath and dyspnea level of 3 on a 0- to 10-point scale. He denied cough, wheezing, chest pain, edema, urinary changes, constipation, falls, confusion, anxiety, and skin conditions. The NP reviewed B.G.'s medications and obtained vital signs: 94% oxygen saturations on oxygen 2 L via nasal cannula and 89% on room air, temperature of 98.5 F, pulse 88 beats/min and regular, blood pressure 132/74 mm Hg, and respiratory rate of 24 breaths/min. He was alert and oriented to time, place, and person.

The NP observed B.G.'s thin, frail, and weakened posture. Physical examination revealed lungs with diminished breath sounds in bases bilaterally, no wheezing, rales, or rhonchi; heart rate rhythm regular, S₁, S₂ with no S₃ or S₄

appreciated; 2+ bilateral radial pulse, diminished pedal pulses, no peripheral edema; and abdomen soft, nontender, with bowel sounds present in all 4 quadrants. Musculoskeletal examination demonstrated limited strength (4/5) in all 4 extremities with limited range of motion. The dermatologic and neurologic examinations were grossly unremarkable. The NP's assessment included a Palliative Performance Scale score of 50% and a Karnofsky Performance Status Scale score of 60%.

After completing the assessment, the NP discussed the findings with B.G. and his wife. The NP informed them that the good news is that his condition is stable. Because his chronic lung disease has been stable since his last FTF assessment, he may not qualify for continued hospice care. The hospice physician will determine ongoing hospice eligibility based on B.G.'s current state of health. B.G. and his wife were assured that the hospice team will work with them on a transition plan of care if he no longer qualifies for hospice services. An attestation statement that the clinical findings were provided to the certifying physician for review was delivered to the hospice administrative office.

The assessment was based on the medical guidelines for determining a pulmonary disease-specific hospice referral or recertification. B.G. did not meet the requirements for advancing disease. Requirements include evidence of advanced and irreversible obstructive disease, indicated by disabling dyspnea at rest or minimal exertion, progression of the end-stage disease, and hypoxemia at rest.¹⁶ A FEV₁ of less than 30% would be needed to demonstrate a decline in function. Documentation of a COPD exacerbation identified by pulmonary infection and/or respiratory failure would have supported progression of end-stage disease. Other data that would have demonstrated progression of disease include changes in arterial blood gases or oxygen saturation rates (<88%) suggestive of hypoxemia at rest. Because B.G.'s assessment did not indicate progressive disease, he lacked supporting documentation for his hospice recertification. The hospice physician denied recertification, and the hospice team assisted in a transition of care for B.G.

The hospice team made sure the patient and family understood that the assessments indicated the disease has currently stabilized. The team then assessed for fears of abandonment and loss of trust and provided ongoing reassurance that both the patient and family will never be abandoned and that a plan for continuity of care would be put in place. The team assessed for potential financial and caregiver burdens that may be associated when the patient is no longer receiving hospice care. At this point in B.G.'s disease trajectory, he agreed to receive outpatient palliative care from the local hospital system. When evidence of B.G.'s disease progression occurred, he would be assessed for admission to hospice.



BENEFITS OF THE FTF REGULATIONS

Patients and Caregivers

The hospice team delivers quality care to meet physical, psychological, social, and spiritual needs of patients with terminal illnesses and their families. The team is responsible for assessing changes in patient status and documenting need for pain and symptom management and need for psychosocial and spiritual support. The hospice nurse contributes to this assessment at every visit and provides essential documentation for need for services. At the time of the FTF recertification visit, the NP relies on this documentation to assist in the assessment of the total picture of the patient and family at the time of recertification.

The FTF visits offer an opportunity to provide the patient and family additional education and support. The visit allows patients and/or family caregivers to discuss unrelieved symptoms, fears, and concerns. A detailed, updated history and physical examination offers additional education about diagnosis, disease trajectory, possible treatment options, and medication changes. During this visit, the NP lays the foundation for the probable transition of care and offers the emotional support needed.

Increased Use of Nurse Practitioners in the FTF Process

Many hospice agencies sought a solution to the FTF visit requirements by employing NPs for their skill as providers, flexibility, accessibility, and cost savings. Nurse practitioners with hospice and palliative care education and expertise are well prepared to manage both primary and palliative care needs for patients with serious illness.^{15,17} Nurse practitioners can address patient and/or caregiver's concerns, assess symptom management issues, and support shared decision making. The NP involved in FTF assessments collaborates with the interdisciplinary hospice team for optimal symptom management and appropriate care planning.

Identification of Need for Palliative Care for Those Not Hospice Eligible

As a result of the hospice recertification process, hospice and palliative care providers have gained insight into their population served. Regardless of the concerns expressed regarding the updated regulations, these regulations have highlighted the palliative care needs of our aging population with chronic illnesses. These visits identify the unmet need of symptom management.¹⁸ The vast majority of hospice patients discharged because their medical condition stabilizes are admitted to hospital or readmitted to hospice within 30 to 180 days.¹⁹ Hospice agencies and providers have reexamined chronic diseases, such as debility and dementia diagnosis, to strategically capture the need for hospice care.¹⁶ These diagnoses often fail to meet the

criteria and hospice eligibility.¹⁹ However, palliative care services can be utilized to fill the gap for those who no longer qualify for hospice services but have multiple and complex symptom management needs. A palliative care program can provide these services and assist patients and families in their navigation of the health care system. Fortunately, the availability and access of palliative care programs in the United States have improved and can be a support to those who have a life expectancy of more than 6 months.¹⁴

CHALLENGES ASSOCIATED WITH THE FTF REGULATIONS

Hospice agencies were initially fearful of the regulation's potentially negative impact on growth and patient care. These concerns included the added financial costs associated with hiring providers to assist in meeting the FTF requirements. The Medicare benefit provides no additional funding for this requirement, and hospices have had to provide this service without an increase in Medicare reimbursement. In addition, agencies feared that this regulation may contribute to admission delays secondary to recertification criteria and struggled with the logistics of FTF requirements. Because of these widespread concerns, CMS delayed reviews and enforcements for 3 months.

It was unclear whether these FTF visits would result in numerous discharges. On the contrary, in a retrospective cohort study, there has been a decrease in the rate at which patients were discharged since the 2011 requirement of FTF.¹⁸ Although this was a single study, it included 23 638 patients from 6 US hospices over a 20-month period.¹⁸ One of the explanations for the decrease in rate of discharge or decertification may be that the comprehensive FTF visits identified additional evidence to justify the patient's eligibility and therefore recertification. More research is needed to understand the impact of this regulation on discharges. Continued research is needed to identify strategies to improve prognostication for those who would benefit from hospice care but are referred late in the disease trajectory.

RECOMMENDATIONS TO ENHANCE THE FTF PROCESS

While the impact of the FTF requirement is awaiting further research, there are steps hospice agencies and nursing can take to enhance compliance.^{16,19}

1. Follow medical guidelines to determine appropriateness of hospice recertification, documenting decline and utilizing appropriate assessment tools or scales.
2. Follow medical guidelines to determine appropriateness of non-disease specific baseline data plus comorbidities, as well as disease-specific guidelines.



Planning for a Transition of Care from Hospice to Palliative Care Services

- Educate patients and families about the FTF requirement in the Medicare regulations at the time of admission to hospice services. Review the process and discuss the expected assessment findings honestly.
- An example of how this information may be delivered is: "It has been our experience that sometimes patients who enroll in hospice feel so much better when their symptoms are well managed and patients and families receive support from the hospice team that the patient's disease can stabilize or even sometimes appear to improve. It may be the case that the patient no longer qualifies for hospice services because he/she is doing so well. We are required by federal law to have our physician or nurse practitioner complete an in-person thorough physical re-assessment of how the patient is doing and if the disease is taking its expected course. If the disease is taking its usual course, the patient will most likely qualify for continued services. If the disease has changed course and has stabilized or is not progressing, we will help the patient and family transition to a more appropriate level of care, usually care from a palliative care team rather than a hospice team" (if that is available in the community).

FIGURE 3. Planning for a transition of care from hospice to palliative care services.

3. Evaluate and document assessment of patients over time, such as diagnostic results included at baseline and at every visit. This is an especially important role of the hospice nurse.
4. Eliminate debility not otherwise specified and adult failure to thrive as the primary hospice diagnoses as required by Medicare guidelines August 2013.²⁰ These diagnoses can be used as a supporting diagnosis or secondary comorbid conditions.
5. Establish tracking procedures that capture the required FTF visits in time for scheduling, documentation, IDT review, and physician's signature. This flagging or tracking system can be integrated into the electronic medical record.
6. Begin planning for support with IDT at least 1 month prior to potential decertification. Educate staff including skillful, compassionate communication about decertification.
7. Prepare the patient and family for upcoming FTF encounters at least 1 month in advance. Establish a system for the transition to palliative care for the minority who do not meet the requirements to continue hospice services (Figure 3).
8. Educate hospice nurses and team members how to identify patients who show stabilization and/or improvement and to document accordingly during the hospice benefit to avoid Medicare fraud.

CONCLUSION

Attention must be directed to the best practices in utilization of hospice benefits. While the totality of the impact of the FTF requirements is unknown, palliative care needs

for the seriously ill are certain. Patients with significant disease progression will be carefully evaluated by their hospices to determine Medicare eligibility. Hospice nurses and NPs employed by the hospice for FTF visits play an important role in identifying and caring for patients who need ongoing hospice care. For the minority of hospice patients who do not meet continued hospice eligibility, a palliative care transition plan to address their needs must be put in place, and patients and families must be supported through that transition.

References

1. Centers for Medicare & Medicaid Services (CMS) Manual System. Pub 100-02 Medicare Benefit Policy. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2011-Transmittals-Items/CMS1244970.html>. Published March 2, 2011. Accessed March 22, 2015.
2. Centers for Medicare & Medicaid Services (CMS) Manual System. Pub 100-02 Medicare Benefit Policy. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188BP.pdf>. Published May 1, 2014. Accessed January 21, 2016.
3. Institute of Medicine Report. The Future of Nursing: Leading Change, Advancing Health. <http://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Report-Brief-Scope-of-Practice.aspx>. Published 2010. Accessed May 2, 2015.
4. Egan City KA, Labyak MJ. Hospice palliative care for the 21st century: a model for quality end-of-life care. In: Ferrell BR, Coyle N, eds. *Oxford Textbook of Palliative Nursing*. 3rd ed. Oxford: Oxford University Press; 2010:13-52.
5. National Hospice and Palliative Care Organization (NHPCO). *NHPCO Facts and Figures: Hospice Care in America*. Alexandria, VA: National Hospice and Palliative Care Organization; 2015. <http://www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care>. Accessed January 23, 2016.
6. Hurley SL, Colling C, Bender L, et al. Increasing inpatient hospice use versus patient preferences in the USA: are patients able to die in the setting of their choice? [published online ahead of print November 13, 2014]. *BMJ Support Palliat Care*.
7. Medicare Payment Advisory Commission. Reforming Medicare's hospice benefit. Report to the Congress: Medicare payment policy (pp. 345-376). 2009. www.medpac.gov/chapters/Mar09_ch06.pdf. Accessed January 23, 2016.
8. SUPPORT Principle Investigators A controlled trial to improve care for seriously ill hospitalized patients: the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT). *JAMA* 1995;274(20):1591-1598.
9. Institute of Medicine Report. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. <https://iom.nationalacademies.org/~media/Files/Report%20Files/2014/EOL/Report%20Brief.pdf>. Published 2014. Accessed November 2, 2015.
10. Kelley AS, McGarry K, Fahle S, Marshall SM. Out-of-pocket spending in the last five years of life. *J Gen Intern Med*. 2013; 28:304-309.
11. Kelly AS, Deb P, Du Q, Aldridge Carlson MD, Morrison RS. The Care Span hospice enrollments saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Aff*. 2013;32(3):552-561.
12. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients and metastatic non-small cell lung cancer. *N Engl J Med*. 2010;363:733-742.
13. Coyle N. Introduction to palliative nursing care. In: Ferrell BR, Coyle N, Paice J, eds. *Oxford Textbook of Palliative Nursing*. 4th ed. New York, NY: Oxford University Press; 2015:1-10.



14. Meier DE. The development, status, and future of palliative care. In: Meier DE, Isaacs SL, Hughes RG, eds. *Palliative Care: Transforming the Care of Serious Illness*. San Francisco: CA: Jossey-Bass; 2010:4-48.
15. Center to Advance Palliative Care (CAPC). Improving care for people with serious illness through innovative: payer-provider partnership. https://www.capc.org/media/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider toolkit-2015.pdf. Published 2015. Accessed March 22, 2015.
16. Uptodate. Medical guidelines for determining appropriateness of hospice referral: disease specific guidelines. http://www.uptodate.com/contents/image?imageKey=ONC%2F61282&topicKey=PALC%2F2200&rank=1%7E150&source=see_link&search=hospice+referral&utdPopup=true. Published 2015. Accessed July 7, 2015.
17. Owens D, Eby K, Burson S, et al. Primary palliative care clinic pilot project demonstrates benefits of a nurse practitioner-directed clinic providing primary and palliative care. *J Am Acad Nurs Practit*. 2010;24(1):52-58.
18. Harold J, Harris P, Green D, et al. Effect of the Medicare face-to-face visit requirement on hospice utilization. *J Palliat Med*. 2013;16(2):163-166.
19. Uptodate. Hospice: philosophy of care and appropriate utilization in the United States. <http://dwww.uptodate.com/contents/hospice-philosophy-of-care-and-appropriate-utilization-in-the-united-states?source=machineLearning&search=hospice+palliative+medicine&selectedTitle=3%7E150§ionRank=2&anchor=H691082#H691082>. Published 2015. Accessed July 7, 2015.
20. Centers for Medicare & Medicaid Services, HHS. Hospice wage index and payment rate update; hospice quality reporting requirements; and updates on payment reform. *Fed Regist*. 2013;78(152):48233-81.