

## **Impact of DMOST on Hospice and End-of-Life Care**

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The publication of the DMOST (Delaware Medical Orders for Scope of Treatment) regulations on January 1, 2016 is a significant step forward for end-of-life care in the First State. Routinely in hospice care, families find themselves making decisions for loved ones who have not communicated their desires for care at the end-of-life. Several initiatives are culminating that will facilitate the conversations around these decisions more common-place and DMOST is the first step in making the conversations a reality.

The DMOST form covers all major decisions that a patient facing a life limiting illness should be communicating their choices. These areas are:

- Their overall goals of care
- CPR / DNR
- Intubation
- Medical Interventions (full treatment, limited treatment or comfort measures)
- Artificial Nutrition / Hydration
- Hospitalization

DMOST is meant to cover end-of-life decisions across the spectrum of health care, from the home, to the EMS provider, to the doctor's office, to the hospital and through to the long term care facility. No longer will each part of the medical system need to have patient fill out their own forms.

## **Provision of Payment for Physician Conversations on End-of-Life**

Beginning in 2016, Medicare will begin reimbursing physicians and advance practice clinicians for having conversations with patients around their end-of-life goals of care. This additional payment will utilize CPT code 99497 and pay roughly \$86 for discussions of advance directives with the patient, a family member, or surrogate for up to 30 minutes. An additional 30 minutes of discussion will use code 99498 and pay \$75.

The goal of this new opportunity is to ensure that “patients [can] discuss whether and how they would want to be kept alive if they became too sick to speak for themselves. Doctors can advise patients on options for end-of-life care, which may include advance directives to forgo aggressive life-sustaining treatment.”<sup>1</sup>

This conversation is the crux of the goal around DMOST. During the May 21st DMOST seminar held by the Delaware End-of-Life coalition, Dr. John Goodill, M.D., FACP, FCCP said,

“It’s not about filling out a form, it’s not about having another physician order, it’s about a conversation. A meaningful conversation where a physician or mid-level practitioner is

empowered to have a meaningful conversation with a patient and for that patient to make an informed decision.”

That’s what DMOST is in a nutshell. It is meant to make the transitions of patients who are facing life-limiting illnesses easier and to ensure their wishes are respected along the way. DMOST is meant to encourage conversation so that patients can fully express their end-of-life goals while they are still able. This new reimbursement will ideally financially compensate providers for time taken to have these complex conversations with patients and families before they are facing a critical illness.

## **Impact of DMOST on Patients and Families Receiving Hospice Care**

Currently when a transition of care occurs anywhere in medicine, each patient runs the risk of their choices not being honored. This lack of respecting the patient’s autonomy is not due to negligence; however more likely due to lack of knowledge of providers of the choices made, or lack of agreement between the patient and medical decision maker in times of stress.

It is not rare that patients present with a hospice appropriate illness but yet have not fully had a detailed discussion with their health care provider in regards to their end-of-life decisions. Thus, it is often left to the hospice interdisciplinary team of physicians, nurses, social workers and chaplains to help the patient and families ascertain their wishes. Additionally, hospice providers, while providing care, have on-going conversations with patients and families surrounding the desires for end-of-life care as there are often second thoughts or changes in what patients and families want or desire.

The choices are documented in the clinical chart and the patient and families are educated on the impact of the decisions. When these choices are discussed in the moments of calm towards the beginning of care, it is routine that both the patient and family will be in agreement. However, when a symptom exacerbates, and the decision to provide more highly acute care versus allowing the disease to follow its normal course arises there can be a disconnect between the original discussion and the course of treatment followed.

In these times of stress, some families, acting as surrogate decision makers, will make an independent decision to transport the patient to the emergency department of the hospital and, through no ill-intent, neglect to inform the ED staff of the patient’s hospice election. They will make comments such as “do everything possible,” or worse, put the burden of the decision on the medical professionals and fail to communicate with those professionals the decisions previously made. In M.M. Shultz’s 1985 article she shares,

“Decision making by competent professionals does not provide adequate substitute for patient choice. Injuries that arise from invasion of patients’ interest in medical choices are both substantial and distinct.”<sup>2</sup>

Often due to fear by surrogate decision makers, end-of-life choices are overridden despite the patient’s original goals. If implemented effectively within each hospice organization, DMOST will significantly change this experience for patients and families. If DMOST is completed before the patient has an acute change in condition, it allows their wishes to be better recognized and respected across the continuum of health care.

## Goal of the DMOST form and the Hospice Face-to- Face Encounter

The hospice face-to-face encounter is a Medicare requirement for patients entering their third benefit period. Medicare covers hospice services for individuals who elect to receive hospice care instead of aggressive treatment of a terminal illness. Upon admission, a patient's physician and the hospice medical director must certify that the patient's life expectancy is six months or less if the illness runs its normal course. This starts the benefit period cycle where patients are eligible for two 90-day hospice benefit periods followed by an unlimited number of 60-day benefit periods.

The Medicare Hospice Conditions of Participation state that "as part of the certification requirements for a hospice patient's 3rd or later benefit period, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with the patient to gather clinical findings to support continuing eligibility for hospice care." This encounter creates the perfect environment for a physician to have the conversation around end-of-life choices.

The hospice face-to-face visit by the physician or advanced practice clinician now can be a catalyst to ensuring each patient understands the value of the DMOST form and if they so choose, completes one within the scope of that visit.<sup>3</sup>

While the ideal is for conversations around goals of care to be held prior to the patient nearing the end-of-life, the reality is that the majority of patients are not prepared to have these significant conversations while still hospitalized. When the patient is home and comfortable they often will be more prepared to have the conversations. The hospice face-to-face encounter is another opportunity to have that discussion in an environment where the patient may feel more autonomy to make decisions.

Naturally, those hospice patients who have not made a decision as far as DMOST is concerned and whose illness may be shorter than 180 days may need a hospice physician or nurse practitioner visit earlier in the course of the illness. This often can be accomplished under the routine care given under the Medicare Hospice Benefit.

These are the decisions that are made in times of calm but are routinely forgotten in times of stress. The implementation of DMOST within hospice care will significantly improve the follow through of patient wishes and goals of care.

## References

1. Pear, R. (2015, Oct 30). New Medicare rule Authorizes 'end-of-Life' consultations. *New York Times*, p. A14.
2. Shultz, M. M. (1985, December). From informed consent to patient choice: A new protected interest. *The Yale Law Journal*, 95(2), 219–299. [PubMed https://doi.org/10.2307/796352](https://doi.org/10.2307/796352)
3. The Delaware End-of-Life Coalition. (2015, May 24). Understanding DMOST. Selbyville, DE, USA.

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