A MULTI-FACETED VIEW OF HOSPICE

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OBJECTIVES

• The philosophy of hospice and palliative medicine and how it changes
• The types and purpose of hospice care
• Why you need to know even if you’re not a referring physician
• The initial eligibility determination: it’s not just the diagnosis
• Admitting diagnoses- then and now- and what else is involved
• Is your patient ready for hospice?
• The typical hospice trajectories and what they mean
• What hospice can and cannot do for your patient (and their family)
• Measurable data points and what they mean for eligibility
• Whether or not to remain as attending for your hospice patient
"I'm no longer the 'Grim Reaper.' I prefer to be known as an 'end-of-life provider.'"
THE PHILOSOPHY OF HOSPICE AND PALLIATIVE MEDICINE

• HOSPICE—derives from Latin word *hospes*—means both *guest* and *host*
• 11th century—Roman Catholic tradition to refer to a place of hospitality for the sick and dying, travelers, pilgrims
  • First such hospice established during the Crusades
• 1967—British physician Dame Cicely Saunders founded St. Christopher’s Hospice in London
• 1969—Dr. Elizabeth Kubler-Ross—book—*On Death and Dying*
• 1974—the first hospice in US—Connecticut Hospice in Branford, CT
• 1980’s—The Medicare Hospice Benefit—part of Medicare Part A
• 1990’s—hospice became an official medical subspecialty
THE PHILOSOPHY OF HOSPICE AND PALLIATIVE MEDICINE

- How hospice has changed:
  - It used to be primarily cancer patients, and others with imminent terminal diagnoses
    - These patients needed nursing, social workers and chaplains
    - Was run primarily by volunteers because it was founded by them
  - Staffing: includes physicians, nurses, aides, social workers, chaplains, therapists (respiratory, physical, speech and occupational therapy), pharmacists, dieticians/nutritionists, and bereavement specialists
    - The IDT (interdisciplinary team or group) meets regularly to discuss each patient
  - Provides meds and DME: whatever related to diagnosis
THE PHILOSOPHY OF HOSPICE AND PALLIATIVE MEDICINE

- The IDT (or G) develops the POC, meets for every patient in rotation
- Post-death bereavement care and services
- “Welcome to your final journey”: focus is not tx of the disease, but tx of the patient's symptoms, disease burden, and EOL needs’
  - Shifts focus from disease to patient
THE TYPES OF HOSPICE CARE AND PURPOSE OF

- RHC—routine home care
- GIP—general inpatient care
- Continuous Care—also sometimes referred to as Crisis Care
- IRC—inpatient respite care
- When admitting a patient to hospice, know which diagnosis you are using and must write order “admit to hospice for (dx)”
- When admitting to GIP, must write order “admit to GIP for symptom management of ____ (symptoms listed)”
PATIENT/FAMILY RESISTANCE

YES I WANT EVERYTHING DONE! JUST DON'T PUT HIM ON LIFE SUPPORT!

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WHY YOU NEED TO KNOW EVEN IF NOT THE REFERRING DOC

• Any physician involved in a patient’s care needs to know about hospice
• Is the physician ready to let the patient go?
• As a profession, we wait too long to utilize palliative and hospice care
• Hospice provides palliative care and hospice care
• Hospice provides meds/DME/services related to the eligibility diagnosis
INITIAL ELIGIBILITY DETERMINATION, IT’S NOT JUST THE DIAGNOSIS

• “Eligibility is based on prognosis, not diagnosis”; but diagnosis counts too
• “Would you be surprised if your patient died within the next 6 months?”
• Terminal prognosis is most often based on a combination of diagnoses and other comorbid conditions
  • Is the patient terminal, chronic custodial, or chronic? (ex: ED Alzheimer’s referral)
• “Six months or less if the illness runs its normal course”
• LCDs: Local Coverage Determinations
• Two physician signatures for initial eligibility, one for each cert. period beyond initial eligibility narrative
ADMITTING DIAGNOSIS-THEN AND NOW-
WHAT ELSE IS INVOLVED

• Admitting diagnoses then and now
• “Why was my patient discharged from hospice?”
• Florida’s 6 rules:
  • 1) terminal dx within 6 months,
  • 2) serial doc assessments, lab, x-ray, etc.,
  • 3) recent impaired nutritional status related to the terminal dx,
  • 4) clinical progression of the terminal dx
  • 5) recent decline in functional status
  • 6) specific documentation indicating patient has entered end-stage of terminal dx
IS THE PATIENT READY FOR HOSPICE?

- Physically, emotionally, and spiritually
- Are they terminal, or are they chronic dx or chronic custodial?
- They are probably ready before you are.
  - What are you waiting for?
- Talk honestly, don’t say “there’s nothing more we can do”.
  - Be positive, let them know you will stay involved in their care.
- Decide if you want to stay on as attending.
- Whether to consult palliative or hospice: 4 domains to consider
HOSPICE TRAJECTORIES—WHAT THEY MEAN

• Sudden death in a patient with chronic illness
• Steady decline with an expected death no matter what treatment offered
• Steady decline with intermittent crises and unpredictable death point
• Trajectories are affected, in part, due to disease therapy and symptom burden
• Patients can live a very long time at a low level of function
SUDDEN DEATH WITHIN THE CONTEXT OF CHRONIC ILLNESS

- Acute MI
- Fatal Arrhythmia
- Massive Stroke
- Other sudden Physiologic Event
STEADY DECLINE WITH EXPECTED DEATH NO MATTER WHAT TREATMENTS OFFERED

- Neurodegenerative d's.
- Poor Prognosis Cancers:
  - Pancreatic, lung, colon, other metastatic (wks.-months)
- Dementias
- Parkinson’s
- ALS
  - These 4 usually months-years
STEADY DECLINE WITH INTERMITTENT CRISES AND UNPREDICTABLE DEATH POINT

- Advanced Stage Heart Ds.: months-years
- Advanced Stage Lung Ds.: years
- Advanced Stage Liver Failure Ds.: months-years
WHAT HOSPICE CAN AND CANNOT DO FOR PATIENT/FAMILY

• The facts vs. Fiction
• Not designed to replace other medical care and services that may be needed
• Hospice does not do everything for every patient
• Admission is initial 90 day, followed by unlimited 60 day periods as long as eligible
• Provide services/medications/DME for the hospice diagnosis
• They don’t provide 24/7 nursing care (see types of care), but do have RNs on call 24/7 and make emergency visits
• They can help the patient and family/loved ones through the dying process
  • Bereavement programs, volunteers
• Discharges for LLOS or no longer eligible
MEASURABLE DATA

What they mean and why you need to understand them

- PPS—Palliative Performance Scale
- KPS—Karnofsky’s Performance Scale
- FAST—Functional Assessment Staging Test
- NYHA—New York Heart Association
- ADLs—Activities of Daily Living
- BMI—Body Mass Index

- MUAC—Mid Upper Arm Circumference
- ECOG—Eastern Cooperative Oncology Group
- Child-Pugh Score
SHOULD YOU REMAIN AS ATTENDING FOR YOUR PATIENT

• If attending, you maintain some level of control in the patient care
  • Must be available 24/7 for phone calls, orders, other
  • You know the patient and can help the hospice with information
  • Be involved in when to stop certain meds and tx
  • Will know when your patient dies
• If the patient has been with you a while, then your involvement is comforting to all
  • You can continue to see the patient (home visits?) and be paid—send notes to hospice
  • You can help the patient/family through the dying process—someone they know
Everyone wants to go to Heaven; no one wants to die to get there.
QUESTIONS 
AND 
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