A MULTI-FACETED VIEW OF HOSPICE

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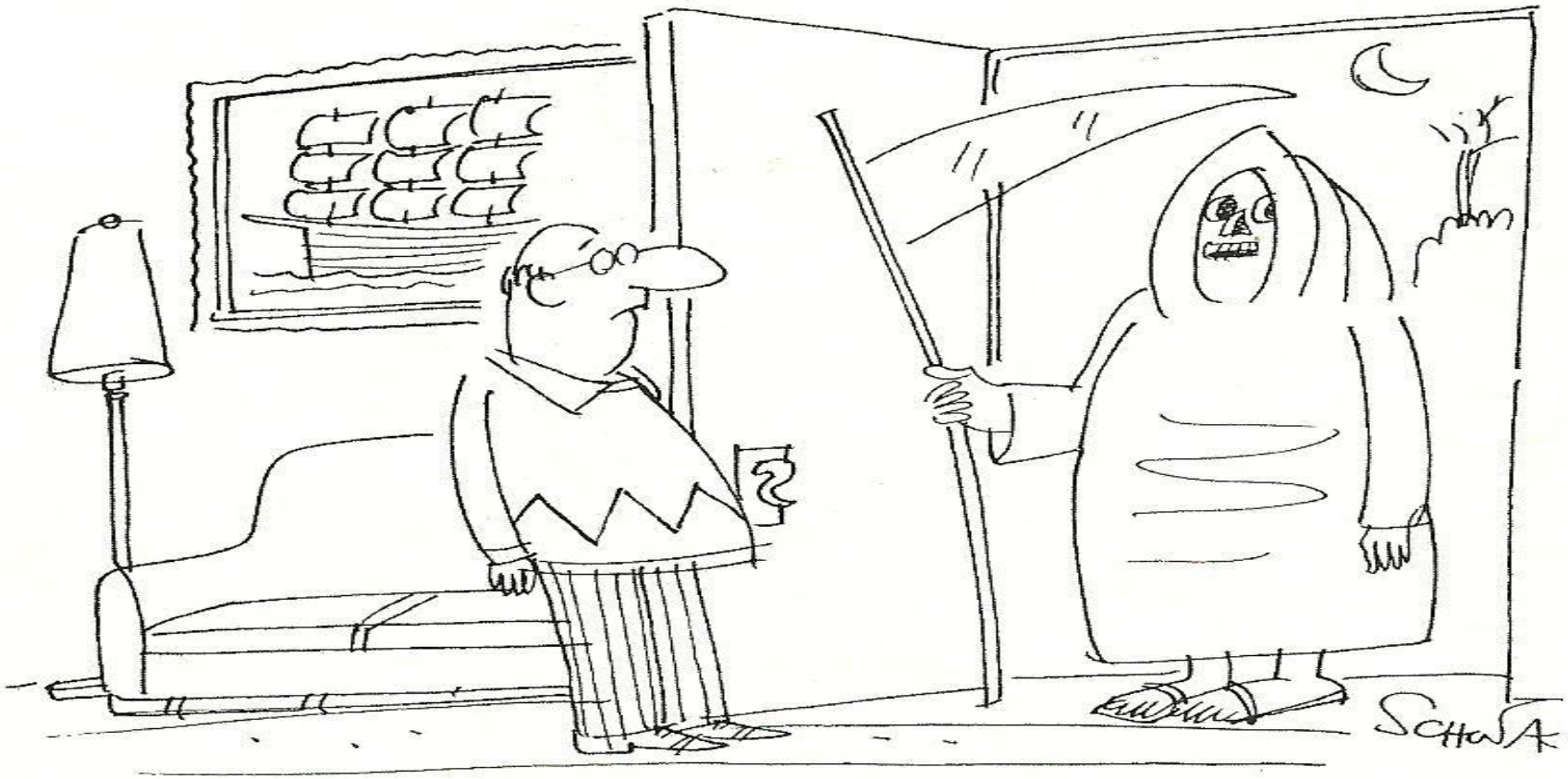
OBJECTIVES

- 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

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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?

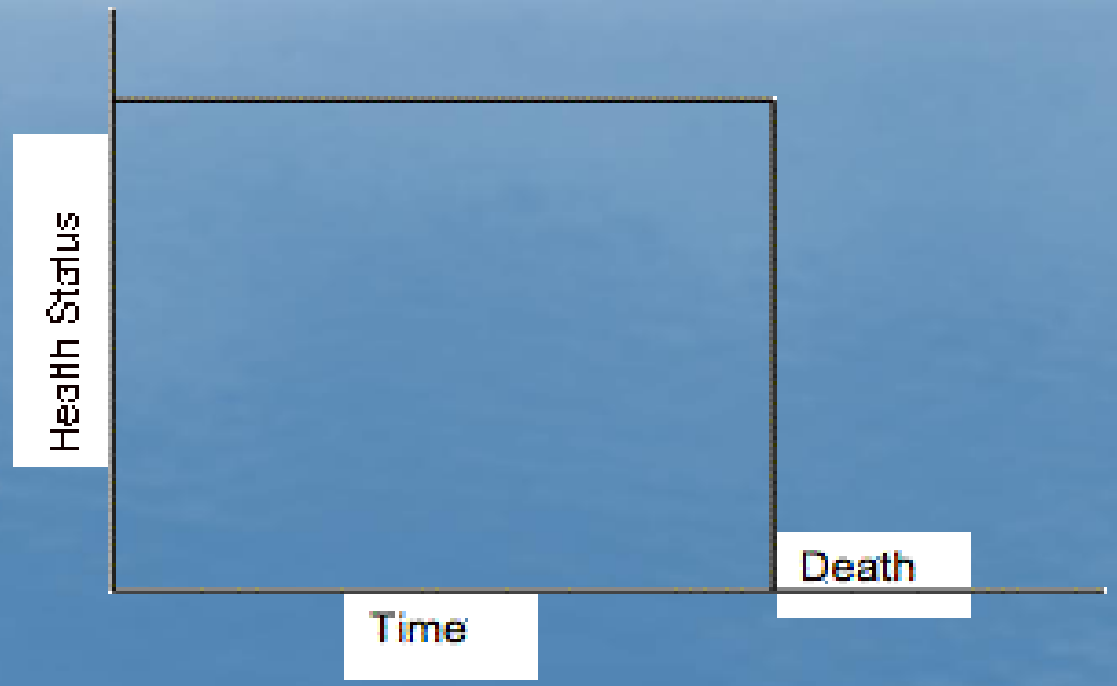
- Physically, emotionally, and spiritually
- Are they terminal, or are they chronic dx or chronic custodial?
- They are probably ready before you are.
  - What are you waiting for?
- Talk honestly, don’t say “there’s nothing more we can do”.
  - Be positive, let them know you will stay involved in their 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 mater 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

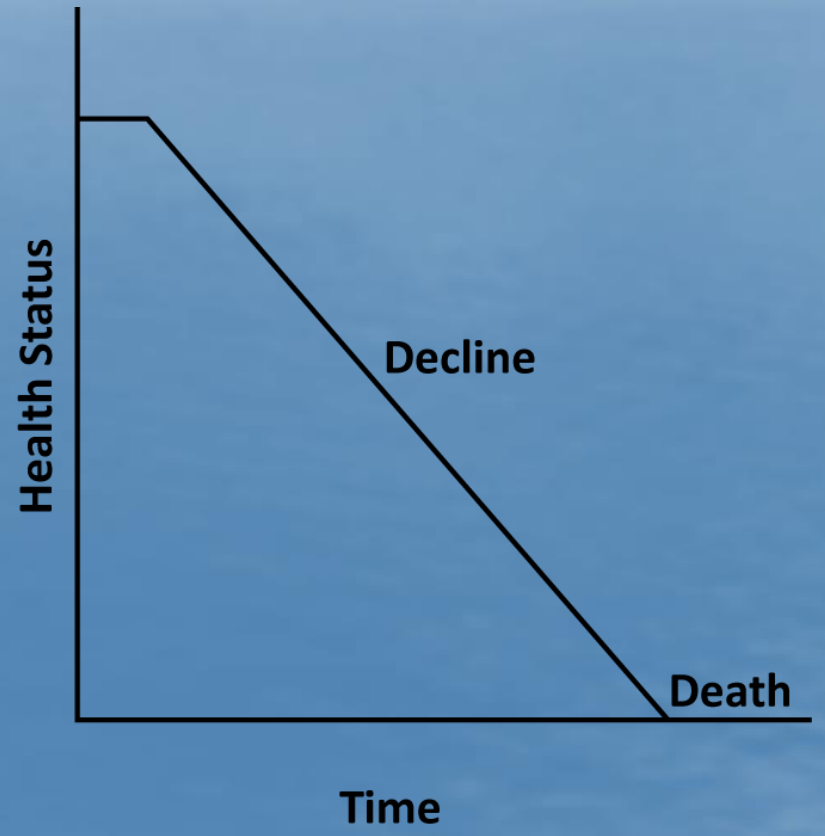
SUDDEN DEATH WITHIN THE CONTEXT OF CHRONIC ILLNESS

- Acute MI
- Fatal Arrhythmia
- Massive Stroke
- Other sudden Physiologic Event



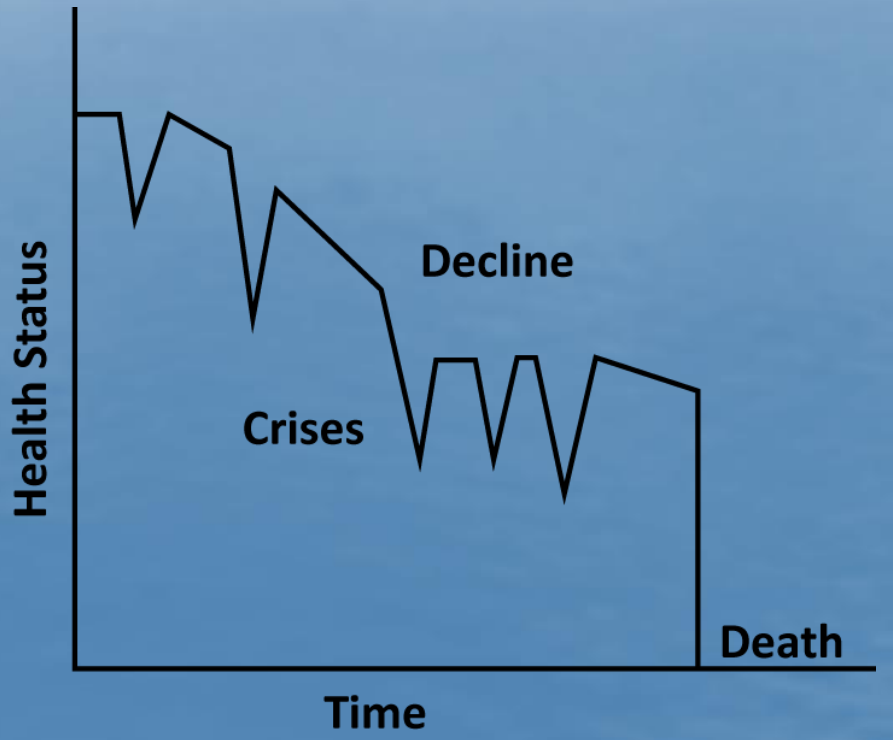
STEADY DECLINE WITH EXPECTED DEATH NO MATTER WHAT TREATMENTS OFFERED

- 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.

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