Hospice Care

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Disclosure

I have no actual or potential conflict of interest in relation to any product or service mentioned in this program or presentation.

Learning Objectives

- Distinguish the differences between Palliative Care and Hospice Care.
- Describe the requirements for Hospice Care in the U.S.
- Identify the main goals of Hospice Care.
- Discuss the benefits and limitations of Hospice Care.

Hospice Care

- Provides palliative care to patients with life-limited illnesses
- Focuses on palliation of pain and other symptoms
- Attends to the person's and family and loved ones
  - Emotional and spiritual need
  - Provides support to caregivers

History

- Hospice started in the middle ages as places of rest for pilgrims and travelers
- End of the 18th Century specifically care for the dying
  - First in Ireland then in England
  - Christopher's Hospice in London opened in 1967
    - Dr. Cicely Saunders - a nurse, social worker and a physician
    - Philosophy has spread worldwide

Hospice Services in the U.S.

- Patients with serious medical illnesses and a prognosis of six months or less
- Covered by Medicare, Medicaid and other payers

Hospice in the U.S.

- Initially grass roots and volunteer response
  - Patient centered care
  - Avoiding unnecessary medical intervention
  - 1982-Medicare Part A hospice benefit authorized
- Located in all 50 states, Washington D.C. and U.S. Territories
- Size varies
  - 34.5% - care for less 50 patients
  - 18.5% - care for 101 to 200 patients
  - 12.5 % - greater than 500 patients

U.S. Hospice

- In 2018:
  - 70%: For profit
  - 27%: Non-profit
  - 3.4%: Government owned
- For profits have grown rapidly since 2014

Hospice 2018

- 4,639 hospice programs
  - 1.55 Million Americans
- 50.7 percent of Medicare deaths utilized hospice at some point
  - 22 percent in 2000
- Approximately 50 % of all deaths we under hospice care
  - 2010: 41.9 %
  - 1992: 1 in 12 Medicare deaths (8.33%)

Types of Patients Receiving Hospice Care

- Death from cancer in the US:
  - In the 1990's: 53%
  - 2018: 29.6%
    - Majority have a combination of chronic debilitating diseases
      - Heart and cardiovascular
      - Dementia
      - Lung Disease
      - Cerebrovascular (Stroke)
    - Related to causes of death
      - Cancer deaths: 22% in 2014

Hospice Model of Care

- General Principle a comfortable death with dignity
- Based on the patient's and their family/ loved one goals and values

Total Pain

- Combination of symptoms and impairments
- Disrupts:
  - Physical
  - Psychological
  - Spiritual
  - Social equilibrium
  - Patients with unrelieved suffering experience: demoralization, question the meaning of life, loss of freedom, loss of identity and dignity, grief and a fear of dying

Hospice Team

- Specially trained clinicians and support staff
  - Registered nurse
  - The primary case manager
    - Skilled nursing care and coordination of team
    - Ideally certified
    - Visit patients regularly; daily to weekly
  - Hospice physician
    - Medical and administrative role
    - Ideally board-certified
    - Liaison and assists with symptom management
  - Primary Attending Physician
    - Encouraged to remain involved
    - Ideally collaborates with the hospice and hospice physician

Hospice Team

- Social worker
  - Provides psychosocial support, housing, nutrition, transportation and family and caregiver support
- Chaplain
  - Oversees spiritual needs of patients and their families and loved ones
  - Both formal and unstructured religious beliefs
  - Liaison for those with formal beliefs
- Home heath aides
  - Provides assistance to the patients and their caregivers in the home

Hospice Team

- Bereavement counselors
  - Available for 13 months after a patient's death
- Community volunteers
  - Receive training and support
  - Provide extra support

Candidates

- Patients
  - Entering the last to weeks of life
  - Decision to forego disease-modifying therapies
- May occur
  - Disease– modifying treatments no longer are beneficial
  - The burdens of the treatments outweigh the benefits

Candidates

- Clinicians should consider erring on the side of a hospice referral:
  - A decreased functional status spending more than half of their time in bed
  - Poor quality of life
  - Physical and psychological stress
  - Family/caregiver burden and increased stress
  - Increasing frequency of medical and symptom crises
  - Multiple hospitalizations

Candidates

- Median hospice stays are short
  - Range
    - 8 days: Chronic kidney disease
    - 18 days: Cancer
    - 55 days: Dementia

Prognostic Assessment

- Clinical presentations for:
  - Cancer
    - More time in bed or chair
  - Failure to thrive
  - Liver
  - CVA or coma
  - Neurological disease
  - HIV/AIDS
  - End Stage kidney failure

Eligibility

- There are eligibility guidelines available for various diagnosis
  - Cancer
    - Increasing time spent in bed or chair
    - Advancing stage
    - Metastasis
    - Cancers with poor prognosis
  - Dementia
    - Stage 7 and beyond, with
    - One major complicating disease

Eligibility

- Individual prognostications are difficult for non-cancer diagnoses
- If the patient outlives the estimated six-month prognosis the benefit can be renewed
  - Provided there is evidence of continued decline with disease progression
- A significant number of patients stabilize with hospice as they receive support from the stresses of hospitalization or complications from treatment
  - If stabilization is longer than six months, the patient may need to be discharged from hospice

Common Questions

- Is hospice a place?
- What types of treatments can patients receive in hospice?
- Can a patient leave hospice care?
- Do patients have to be actively dying
- Do patients have to have a declared DNR status?
- What happens if the patient lives longer than six months?
  - Roughly 21% of hospice patients survive longer than six months
    - Mostly those with non-cancer diagnoses
    - Continued care requires disease progression and decline
    - Of those discharged a high percentage are hospitalized and/or die soon thereafter

Questions

- Do patients receiving hospice care die earlier than those who don’t?
- Will I have to give up my PCP?

Symptom Control

- A variety of symptoms: pain, dyspnea, nausea and vomiting, anorexia, fatigue, agitation, anxiety and depression
- Attending physician signs standing orders on admission
- Ability of the nurse to adjust medications within defined parameters
- Comfort kit
  - Family is given clear written guidance on medication administration

Psychosocial and Spiritual Care

- Humanistic approach
- Sensitive to cultural issues and religious and spiritual beliefs
- Family support

Nursing Care

- Primary responsibility is family members, loved ones, informal caregivers and may include paid caregivers
- Hospice team visits as needed-weekly on average

Short-term Services

- Intensified needs:
  - Wound care
  - Poorly controlled symptoms
  - Complicated psychosocial issues
  - Family/lived one exhaustion
  - Extra support during active dying phase

Additional Levels of Nursing Care

- Inpatient hospice
  - Hospice facility
  - Hospital
  - Shilled nursing facility
- 24-hour support or continuous care services-LPN in the home
- Temporary respite care

Bereavement Care

- Provided for 13 months after the patient's death

Adaptations for COVID-19

- Telehealth available since March 6, 2020
- Audio
- Audio and visual
- Counselling and coordination of care
- Symptom management
  - Modifier 95
  - Certifications and Recertifications not billable

Benefits of Hospice Care

- Better quality of life for patients and their families and loved ones
- Benefits
  - Comprehensive interdisciplinary care
  - 24-hour access, seven days a week
  - Reduction of out-of-pocket expenses-
    - Medications
    - DME
  - 80 % of Americans prefer to die at home
    - Only 25 % do
    - 81% of hospice patients die at home or long-term care facility

Limitations

- Coverage
- Medicare fixed sum, paid on per diem basis
  - May present a challenge to smaller hospice providers
  - 1916-Medicare Care Choices Model (MCCM)
    - Disease non-specific rates

Considerations

- Early education
  - Acknowledgement of a serious life limiting disease
- Barriers
  - Eligibility requirements both six months prognosis and signing away insurance coverage for curative treatments
  - Clinician's comfort level

Approach

- Initial discussion
  - Understand current medical condition and future expectations
  - Establish priorities
  - Time to consider benefit and burdens of different treatment options
- Stepwise approach
  - Educate
  - Follow-up
- Assess the patient’s understanding
  - Define priorities, concerns and hopes
- Family/ lived one needs

Discussion and Q&A