Palliative Care & Hospice

Kenneth Brummel-Smith, M.D.
Charlotte Edwards Maguire Professor,
Department of Geriatrics
Florida State University College of Medicine

Diane Meier, MD
Director, Center to Advance Palliative Care

Palliative Care

- Specialized medical care for people with serious illness. Focused on relief from symptoms, pain and stress – whatever the diagnosis. The goal is to improve quality of life for the patient and family. (CAPC, 2013)
- Hospice and Palliative Specialty
  - Family medicine, internal medicine, anesthesia, OB-Gyn, pediatrics, radiology, surgery
  - 1-year training after above residency

Landmark Study

- 3-yr study of non-small cell lung cancer patients receiving intensive chemotherapy
- Randomized patients into palliative care or usual care (both got chemo)
- In the palliative care group:
  - 30% increase in survival (11.6 mos vs. 8.9 mos)
  - Higher quality of life
  - Less depression
  - Less aggressive care at end of life

Temel, 2010

Types of Palliative Care

- Basic – provided by one's usual doctor
  - Usually individual practitioner
- Specialty – provided by someone with advanced training
  - Usually a team – MD, NP, nurse, chaplain
- Unlike hospice, can be provided at the same time as curative care

What Problems Are Treated?

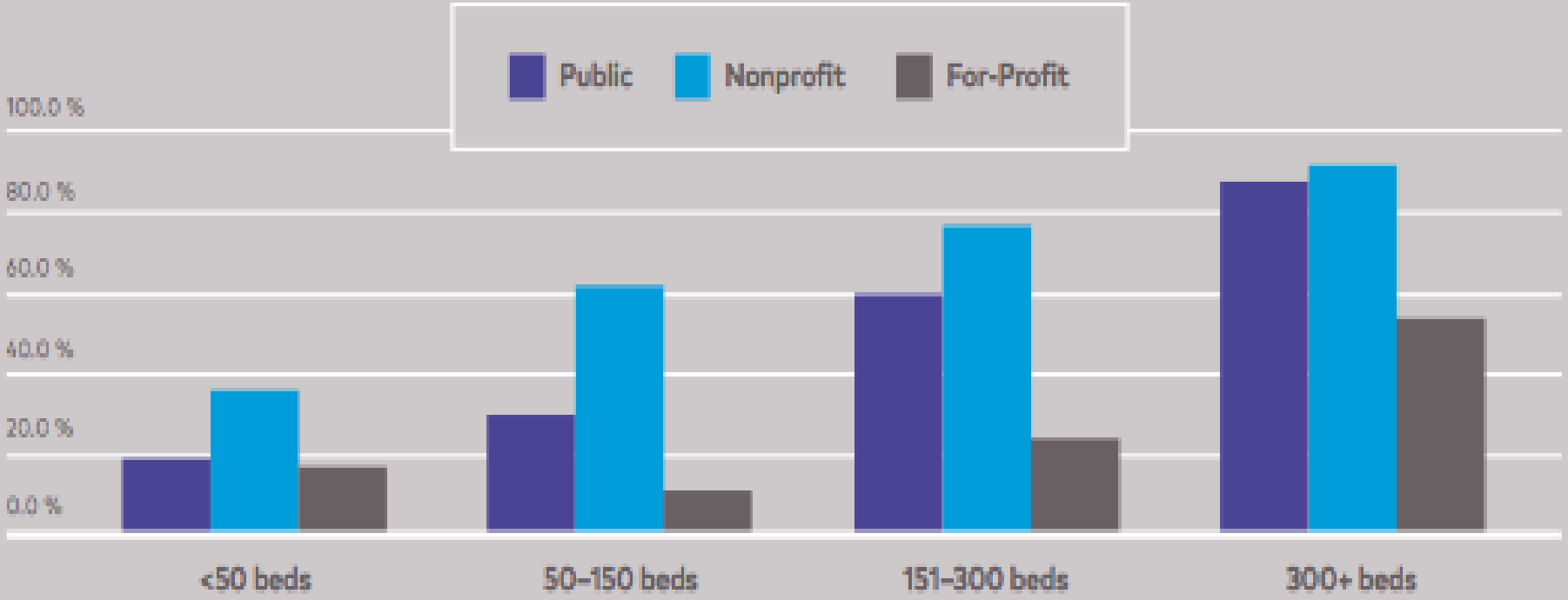
- Pain
  - Often undertreated
  - Even conditions not thought to be painful (e.g., emphysema), often have pain
- Shortness of breath
- Depression
  - Often missed by usual physicians
- Anxiety

Growth of Palliative Care

- 67% of small and 90% of large hospitals
  - TMH – yes, CRMC – no
- Only 26% of for-profit hospitals
- Over 6000 MDs now have specialty certification
  - About 7400 geriatricians
  - 31,500 cardiologists

Graph D. *Percentage of hospitals with a palliative care program by hospital ownership and hospital beds, 2015*

Lower rates of palliative care program prevalence persist in for-profit hospitals across all hospital sizes.



Criteria for Palliative Care

- Surprise question
- Frequent hospital admissions
- Admissions with difficult to control problems
- Complex care requirements
- Decline in function or unintended weight loss

Future of Palliative Care

- Nursing homes
- Home care
- Office consultations

Dame Cicely Saunders, Founder of Hospice

Medicare Hospice Benefit

- Must meet all criteria for hospice eligibility:
  - Medicare Part A
  - Dr. and hospice Dr. certify terminal illness (6 month or less prognosis)
  - "Choose hospice care instead of other Medicare-covered benefits to treat your terminal illness"*
  - Get care from a medicare-approved hospice

***Medicare pays for covered benefits that are not part of hospice services**

Hospice – Covered Benefits

- Doctor and nurse services
- Medical equipment and supplies
- Drugs for pain and symptom control*
- Aide and homemaker services
- PT, OT, SLP, SW, nutrition
- Grief & loss counseling
- Short-term inpatient and respite care

***Often requires a small co-pay**

Hospice – Not Covered

- Treatment to cure the terminal illness
- Drugs to cure the terminal illness
- Room and board (i.e., normal living expenses)
- Care in an ER, hospital or ambulance unless it's arranged by the hospice team

Hospice – Coverage Periods

- Can be longer than 6 months if the hospice doctor certifies terminal illness still exists
- Two 90-days periods, then subsequent 60-day periods
  - Each must be certified by the hospice Dr
- Can stop hospice if the illness remits
  - Can restart hospice if the terminal illness returns

Hospice Finances

Medicare pays the hospice a daily rate (capitation) for each patient

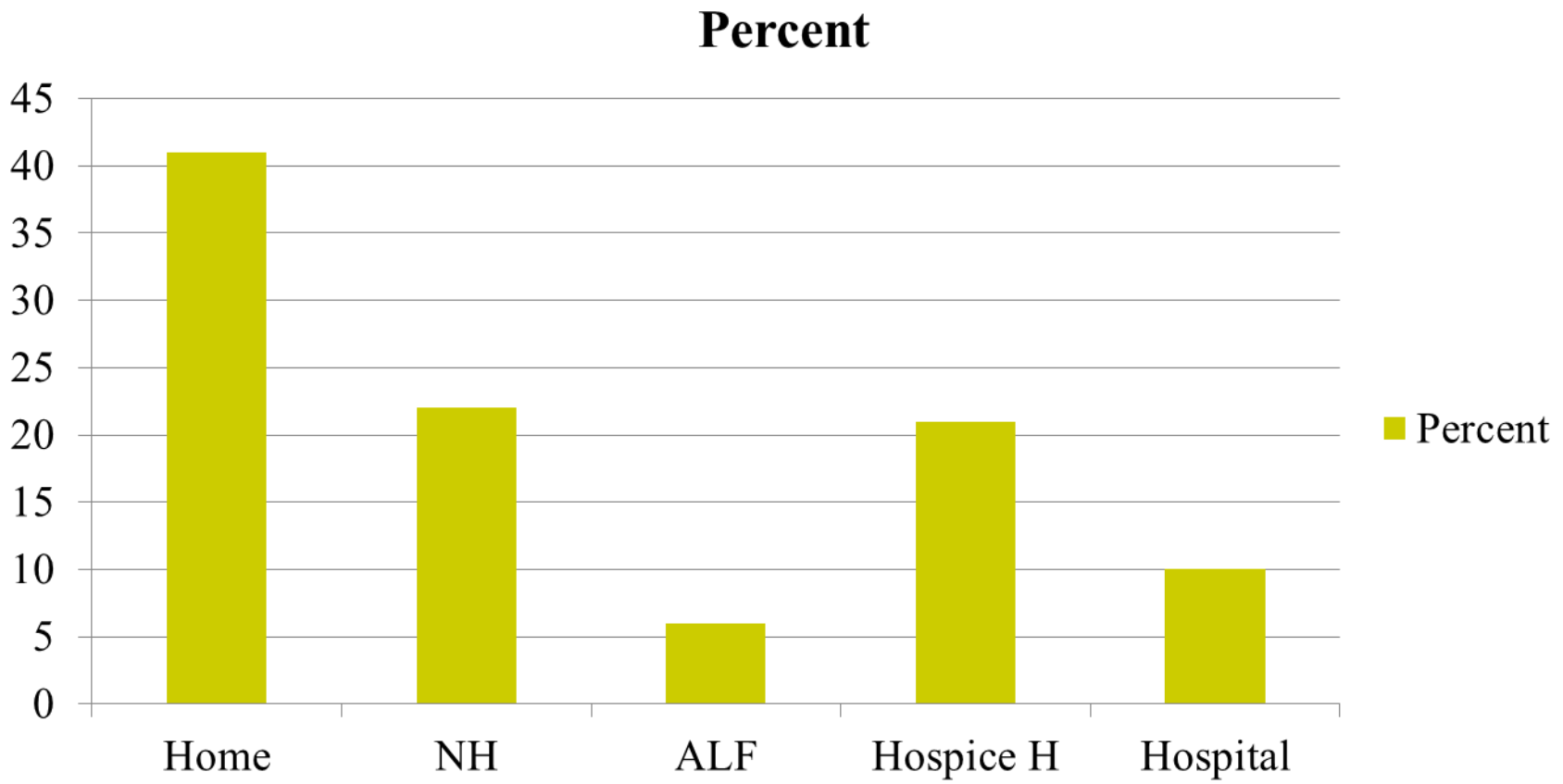
- Routine Home Care $ 156
- Continuous Home Care $ 910
- Inpatient Respite Care $ 161
- General Inpatient Care $ 694

Medicare sets an annual cap on total reimbursement per patient which is $26,157.50 for 2013.

Hospice Utilization

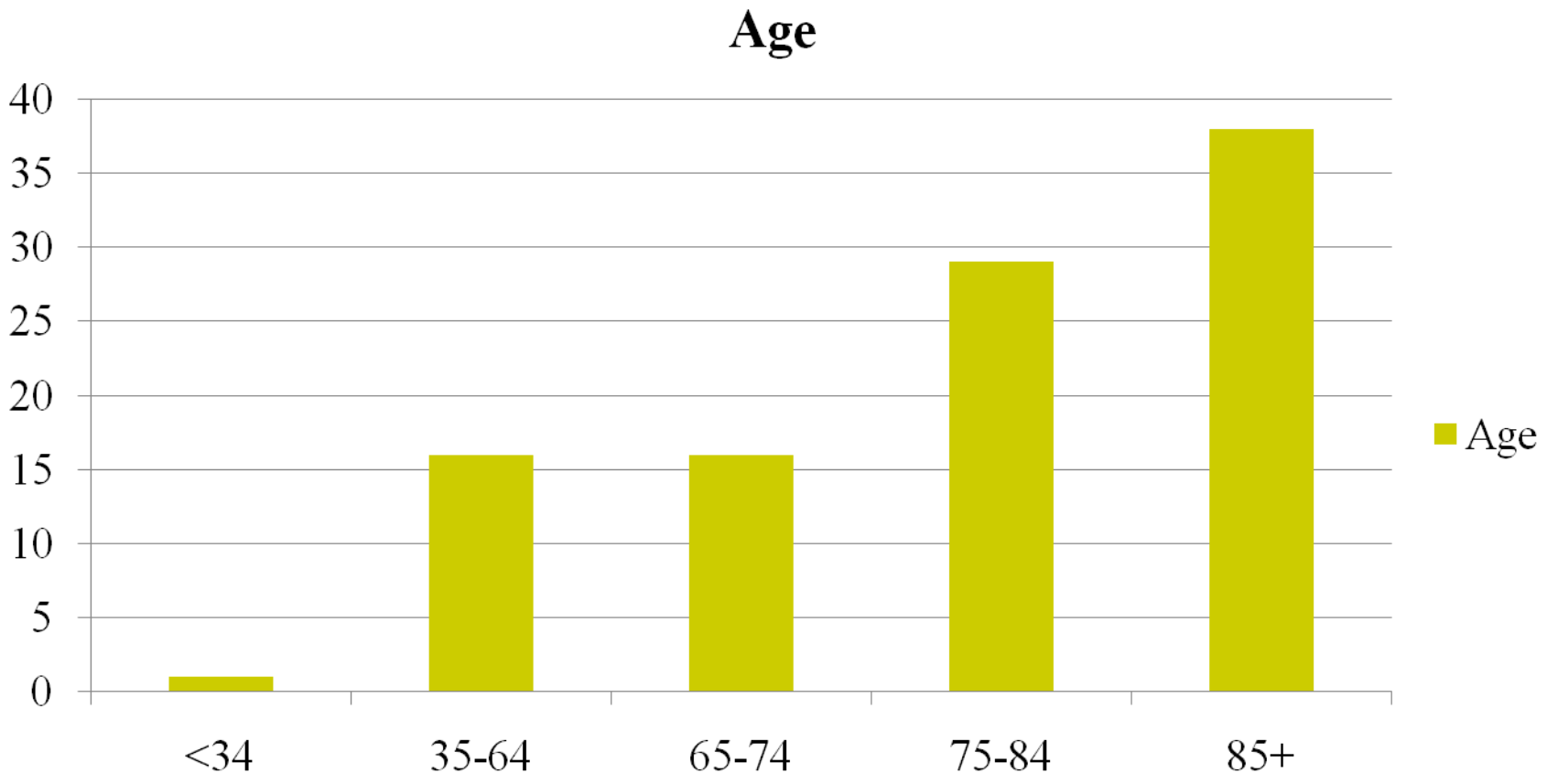
- About **45**% of Americans who die use hospice
  - 2008- 212,000 patients discharged alive
- Median 19 days (average 83 days)
  - 36% - less than 7 days
  - 11% - greater than 180 days
- Patients in hospice live 1 month longer than similar patients not in hospice
- 16% of hospices have an inpatient facility

Place of Death for Hospice Patients

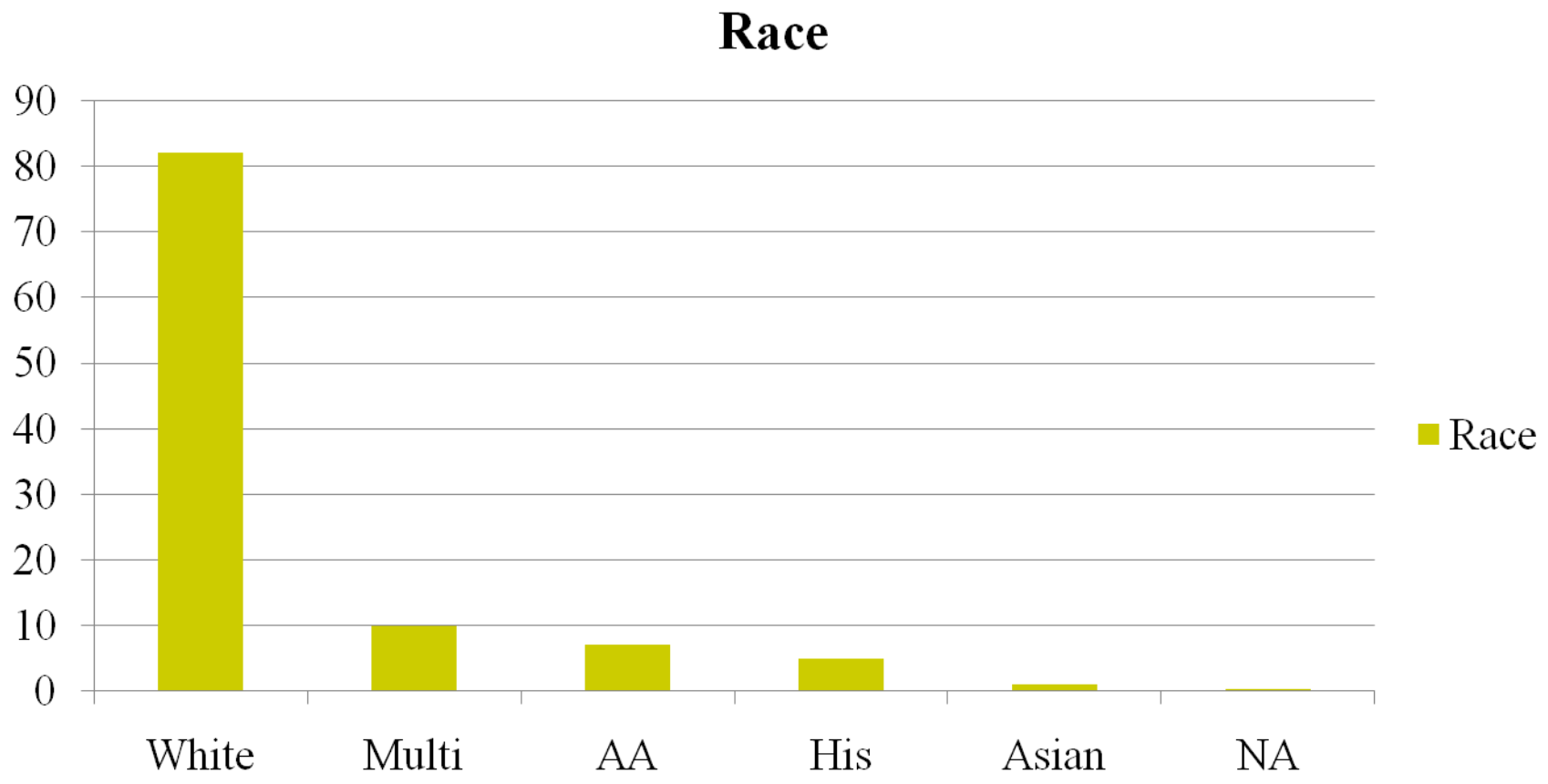


2010

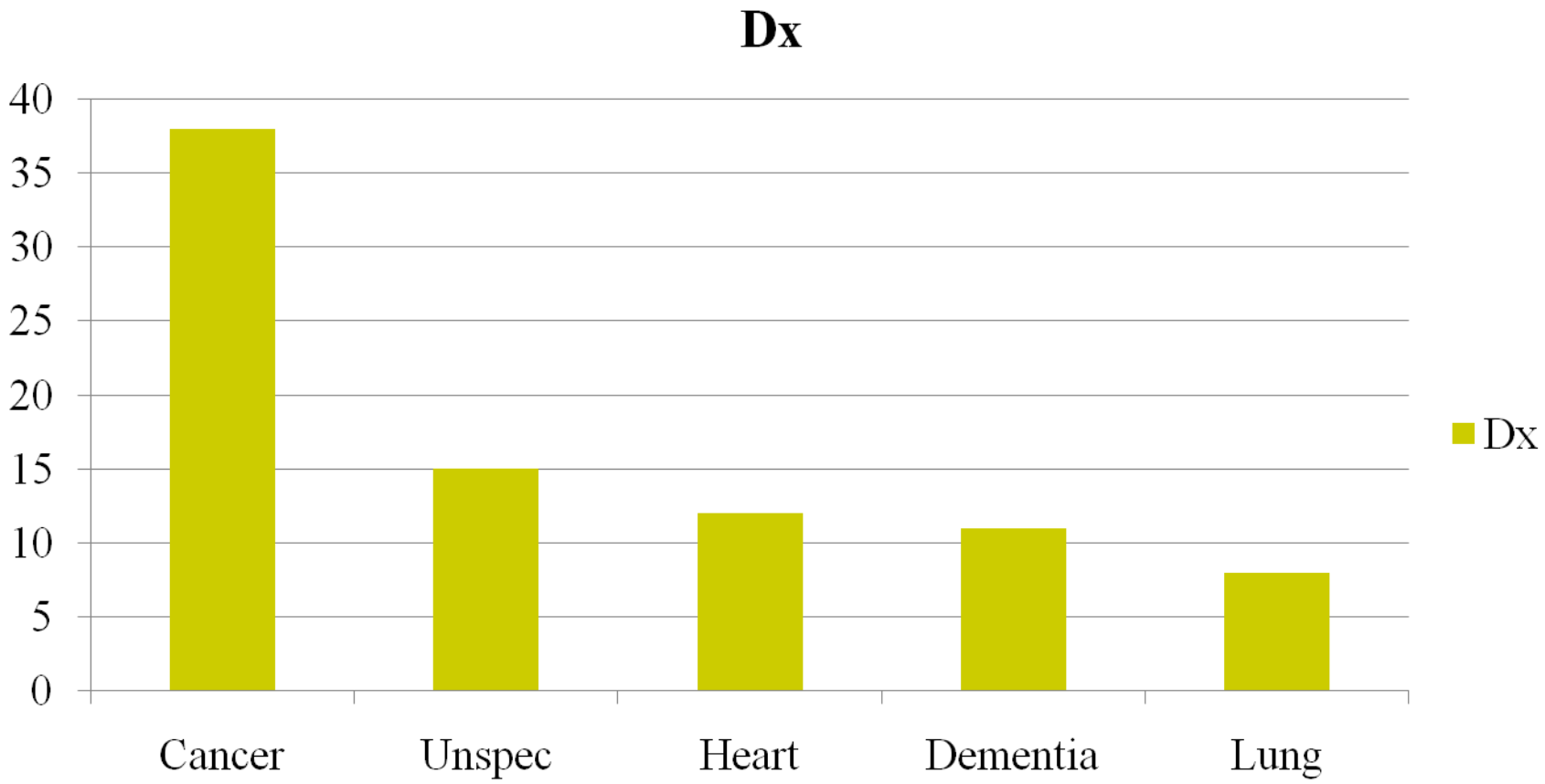
Hospice Age



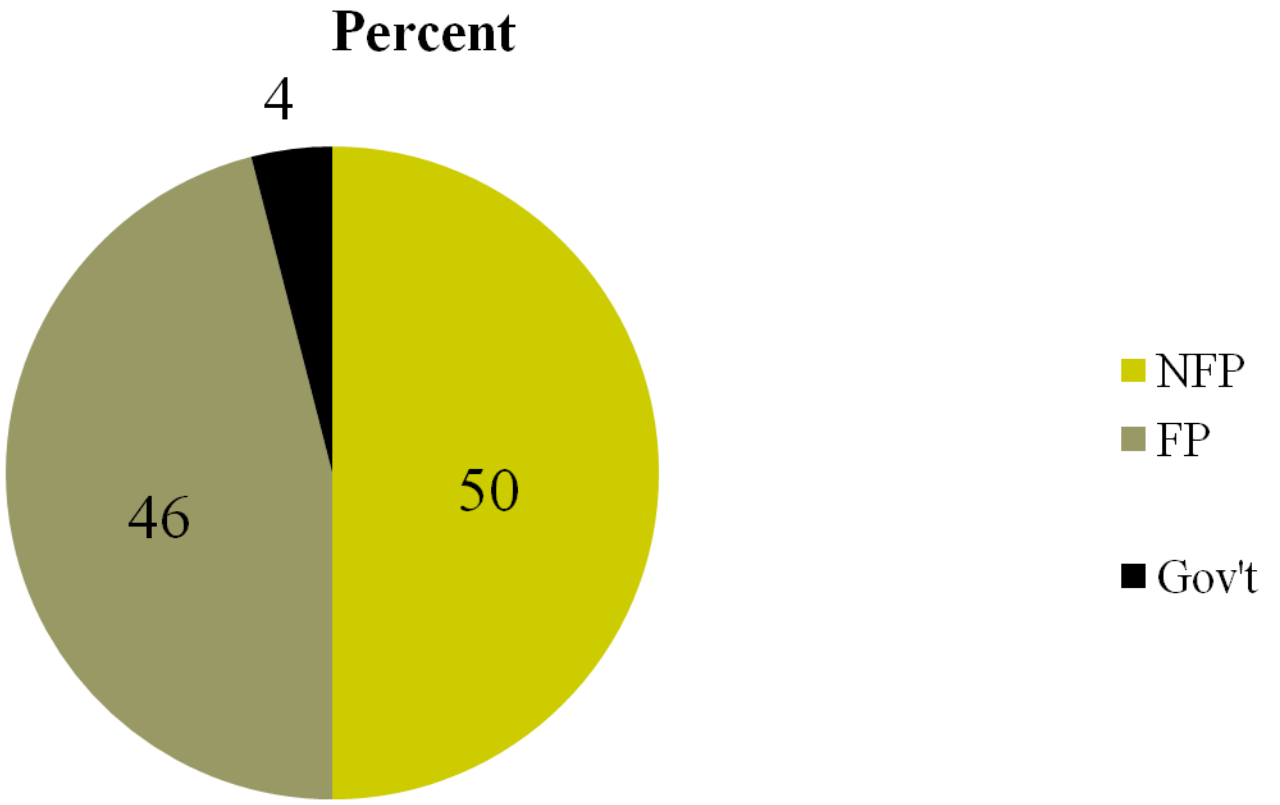
Culture/ethnicity Rates



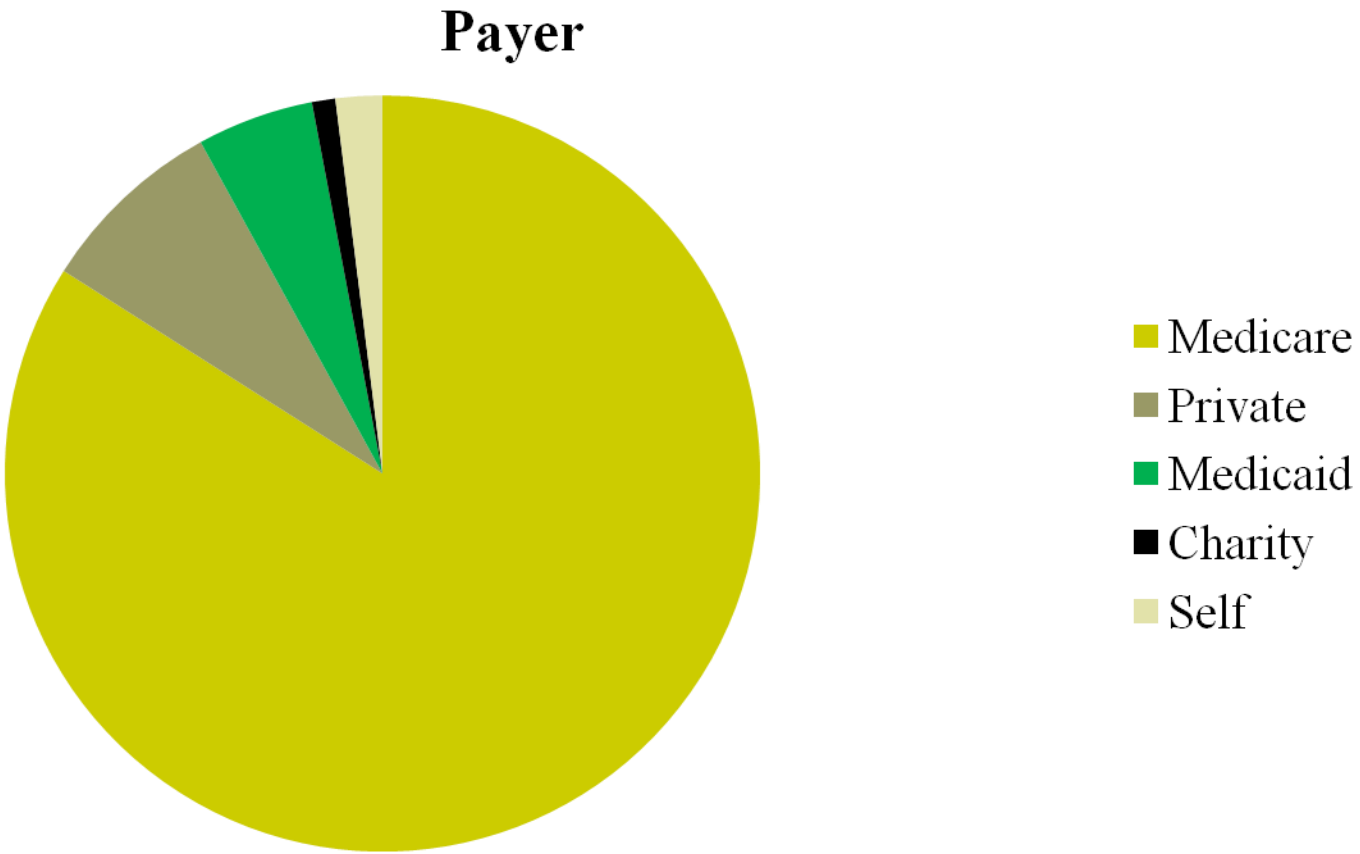
Hospice Diagnoses



Hospice Ownership



Who Pays For Hospice



What Is Provided?

- Manage pain and other symptoms
- Manage emotional aspects of dying
  - Patient and family
- Provide medications, supplies and equipment
- Family training
- Special services – therapies
- Short term inpatient care
- Bereavement care

Levels of care

- Home-based care
  - Routine – main way care is provided
  - Continuous – short term during crises
- Inpatient care
  - General inpatient care – when symptoms can not be managed in the home
  - Respite care – admit to patient to give the caregiver a rest

Problems with Hospice

- Long stays
  - Stays longer than 154 days for CHF and 233 days for cancer cost more than usual care
- Short stays (<7days)
  - Late referrals
- Fraud and abuse
  - Long stays
  - For-profit

Referrals to Hospice

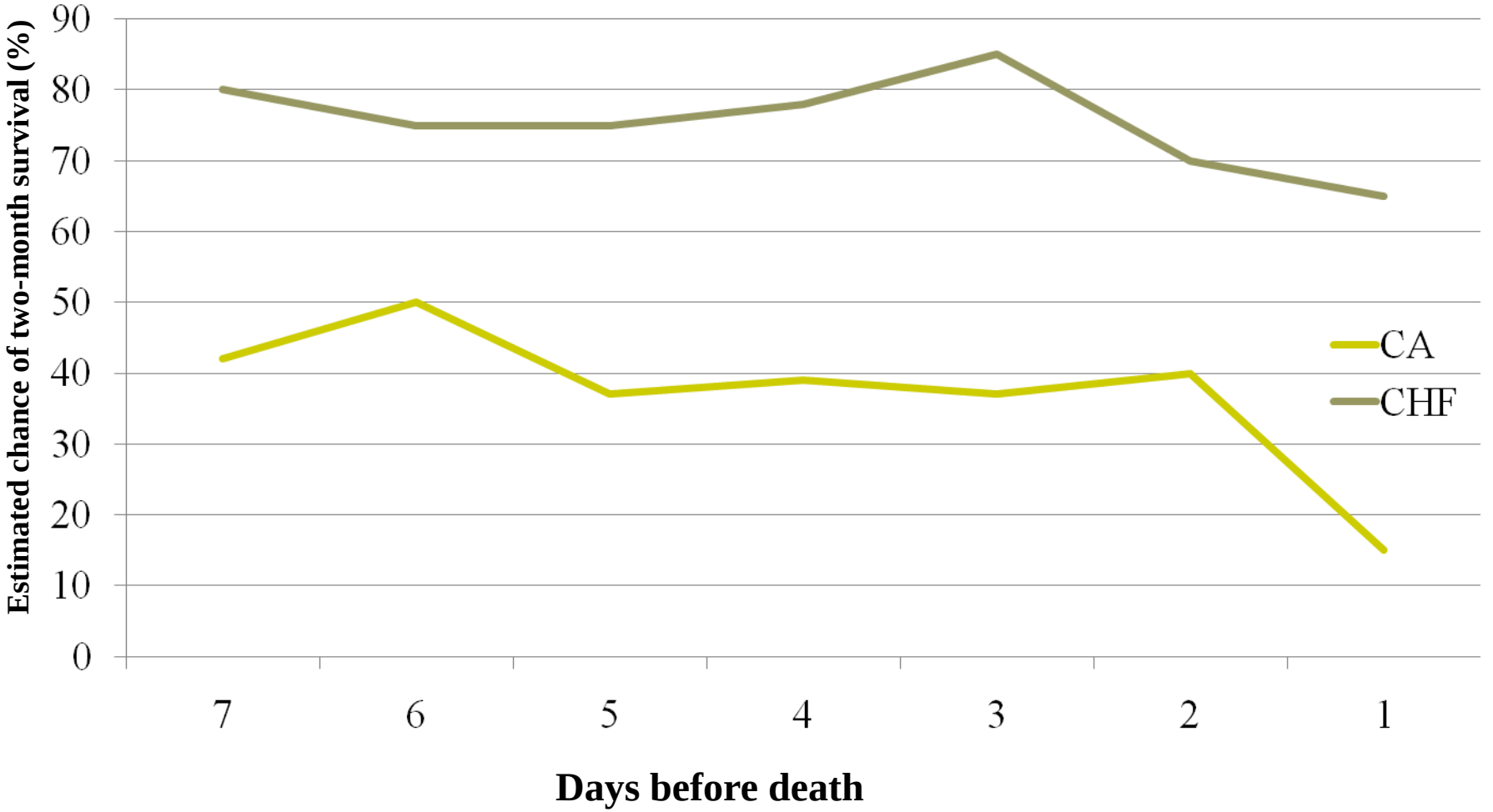
- 50% of cancer patients receive hospice services
- Difficulty in predicting mortality in others leads to lower referral rates
  - Even on the day of death CHF patients had a 50-50 chance of surviving 6 months
  - Survival in "eventually fatal chronic illness" is determined by aggressiveness of care

EFCI – more accurate term than "terminal"

Main Problem With Hospice

- 6 month rule
- Doesn't fit type of most deaths (long decline with intermittent crises)
- A new model is needed ("Medicaring")
  - 2 – 4 year coverage
  - Focus on "eventually fatal chronic illness"
  - Focus on palliative care and advanced decision-making
  - @Home Support - Michigan

Predicted Likelihood of Survival



Voluntary Stopping of Eating and Drinking (VSED)

- Principle of autonomy
  - Generally for use by persons with terminal illness
  - Legal in all states
- Common?
  - Netherlands – 2% of deaths per year
  - US – FM survey – 46% had been asked for VSED
- Most hospices will provide guidance and support (if hospice eligible)

VSED Reasons

- Patients state:
  - Readiness to die
  - Life perceived as being pointless
  - Poor quality of life
  - Desire to die at home
  - Wish to control circumstances of death
- Ensure a palliative care consult before final choice

Ivanovic N, BMJ Pall Care, 2014

Special Attributes

- Not physician-ordered or physician-directed
- Requires commitment and strength
- Requires supportive environment
- Decision can be reversed at any time by the patient
- Patients actively dying from a disease often have no appetite and may have little desire for fluids

Palliative Management

- Suffering is usually minimal with good symptom management
- Control symptoms
  - Pain - morphine
  - Nausea - proclorperazine
  - Dry mouth – mouth swabs
  - Anxiety/shortness of breath – lorazepam
  - Constipation
  - Skin care and massage

VSED Process

- Stopping drinking will result in death sooner (few days to a week) than stopping eating (weeks)
- Involve hospice (if appropriate)
- Make a conscious decision to continue every day
- Stop all medications (except for comfort)
- Hunger and thirst are usually present for 1-3 days
- A laxative or enema should be done at the beginning
- Decreased consciousness usually in 4-5 days
- Death occurs in 5-10 days (median – 7 days)