There is Something More We Can Do:

An Introduction to Hospice and Palliative Care

presented to the
Washington Patient Safety Coalition
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Why this topic?

Washington Patient Safety Coalition

Goal: to reduce medical errors and improve safety for people receiving healthcare in Washington State

- Patient-centered care
- Improved outcomes
- Increased patient/family satisfaction
- Avoidance of harm

Hospice and Palliative Care

Goal: to improve care for all patients at the end of life

- Patient-centered care
- Improved outcomes
- Increased patient/family satisfaction
- Avoidance of harm
**First, some basics**

_Hospice_ is a *system* that provides care to patients with a prognosis of 6 months or less. Included benefits are:

- Medications related to the terminal diagnosis
- Medical equipment related to the terminal diagnosis
- Nursing care
- Social work care
- Physical therapy and/or occupational therapy
- Home health aide care
- Spiritual care
- Volunteer care
- Oversight by a pharmacist
- Oversight by a medical director
- Bereavement for survivors for up to 13 months following the patient’s death

Nationally, **84.3%** of Hospice care is paid for by *Medicare.*
First, some basics

**Palliative Care** is an internationally-recognized **approach** to the care of patients with progressive, life-limiting illnesses that emphasizes patient goals and quality of life, but does not exclude curative treatments.

Exists in many different forms, including:
- Inpatient service
- Outpatient office-based service
- Home/residential facility-based service
Hospice and Palliative Care

Comprehensive Patient Care

Palliative Care

Hospice Care
Hospice care is well-recognized as a program that provides end-of-life care that increases patient satisfaction and reduces costs.

- 98% of families of patients who died on Hospice would recommend it to friend or family member in need.
- Average cost savings to Medicare are $2309 per Hospice patient.
- The use of hospice decreases Medicare expenditures for cancer patients until the 233rd day of care and until the 153rd day of care for non-cancer patients.

The Challenge

BUT

- Only **38.5%** of Americans die with Hospice care
- Benefit is intended for the last **180 days** of life
- Median length-of-stay (LOS) in US: **21.3 days**
- Average length-of-stay (LOS) in US: **69.5 days**
- Hospice patients who are referred to Hospice in the last 7 days of life: **35.4%**

WHY?

Misunderstandings regarding Hospice and Palliative Care occur among:

- Patients
- Families
- Providers
- Institutions
Criteria for receiving Hospice care:

1. Two physicians (the patient’s Attending Physician and the Hospice Medical Director) agree that the patient has an illness that, should it run its normal course, is more likely than not to result in death in 6 months or less.

2. The patient is no longer pursuing **curative** treatment for the terminal illness.

That’s it.
Misunderstanding #1: Death’s Doorstep

*For example:*

Guidelines for Hospice Eligibility for HF Patients:

- Functional NYHA Class IV (i.e. symptomatic at rest)
- Symptomatic despite maximum medical management tolerable to the patient
- Treatment resistant arrhythmia
- Ejection fraction <20%
- History of cardiac arrest
- Cerebral embolism of cardiac origin
- Persistent resting tachycardia
Misunderstanding #1: Death’s Doorstep

The Guidelines are *Guidelines*, not Criteria

Safeguards for referring physicians and patients:

- Routine review of patient’s clinical status and trajectory at 3 months, 6 months, and every 2 months thereafter.
- Home visits by Hospice physician for patients with LOS > 180 days will be required beginning 2011.
- No penalty to referring physician or patient for patient living > 6 months!
- Built-in recognition of difficulty of prognostication
Misunderstanding #2: They only give you Morphine on Hospice, nothing else.

For example:

**HF meds routinely covered by Hospice**
- Antihypertensives
- Anti-arrhythmics
- Nitrates
- Oral inotropes
- Diuretics
- Oral anticoagulants
- Opioids

**HF meds/devices may be covered/managed by Hospice**
- Intravenous inotropes
- Intravenous diuretics
- BiPAP/CPAP
- AICDs
Misunderstanding #2: They only give you Morphine on Hospice, nothing else

Other palliative treatments often covered by Hospice:

- Palliative radiation
- Thoracentesis/paracentesis/indwelling drainage systems
- Intravenous analgesics and antiemetics
- Nerve blocks
- Epidural analgesia
Misunderstanding #3: You have to “give up” to be on Hospice

It is illegal for any Hospice to make DNR status a requirement for a patient to receive Hospice services.
Misunderstanding #4: The sooner you go on Hospice, the sooner you’ll die.

In fact, mean survival is **29 days longer** for patients receiving Hospice care than for comparable patients not receiving Hospice care.

**Misunderstanding #4: The sooner you go on Hospice, the sooner you’ll die.**

### Survival of Patients with Terminal Disease in days

<table>
<thead>
<tr>
<th>Disease</th>
<th>Non-hospice</th>
<th>Hospice</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>321</td>
<td>402</td>
<td>p=0.05</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>240</td>
<td>279</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>189</td>
<td>210</td>
<td>p=0.01</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>381</td>
<td>414</td>
<td>p=0.07</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>410</td>
<td>422</td>
<td>p=0.61</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>510</td>
<td>514</td>
<td>p=0.83</td>
</tr>
</tbody>
</table>

Misunderstanding #5: If I refer to Hospice, I’ll lose control of my patient’s care.

Patients enrolled on Hospice can continue to see their Hospice attending physicians/ARNPs without any restrictions.

MDs/ARNPs can visit patient at home, or request home visit from Hospice Medical Director.
**Location of Death of Hospice Patients in US**

<table>
<thead>
<tr>
<th>Type of Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s place of residence</td>
<td>68.8%</td>
</tr>
<tr>
<td>- Private residence</td>
<td>40.7%</td>
</tr>
<tr>
<td>- <strong>Nursing Home</strong></td>
<td>22.0%</td>
</tr>
<tr>
<td>- Residential facility</td>
<td>6.1%</td>
</tr>
<tr>
<td>Hospice Inpatient Facility</td>
<td>21.0%</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

Misunderstanding #7: ...and anyway, you don’t need Hospice in a Nursing Home.

Likelihood of hospitalization in last 30 days of life
Nursing Home residents receiving hospice care 24%
Nursing Home residents not receiving hospice care 44%


Compared to those not receiving hospice care, nursing home residents who receive hospice care are:
– more likely to be assessed for pain
– twice as likely to receive daily treatment for pain, given its presence
– more likely to receive pain management in accordance with clinical guidelines


Misunderstanding #8: If I say “Hospice,” I’ll be abandoning my patients and they’ll be upset.

“End of life discussions are associated with less aggressive medical care near death and earlier hospice referrals. Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.”

Misunderstanding #9: Hospice wastes taxpayers’ money.

On average, Hospice saves Medicare $2309 per patient.

# of Days of Hospice Care that provide Cost Savings to Medicare

<table>
<thead>
<tr>
<th>Category</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Patients</td>
<td>233 days</td>
</tr>
<tr>
<td>Non-cancer patients</td>
<td>154 days</td>
</tr>
</tbody>
</table>

Medicare costs would be reduced for 7 out of 10 hospice recipients if hospice was used for a longer period of time.

Misunderstanding #10: There’s no way we can afford a Palliative Care program

The “Thousand Dollar Conversation”

603 participants at 5 cancer centers
188 (31.2%) reported EOL discussions at baseline

- Cost difference in care in final week of life: $1041
- Higher cost correlated with worse quality of death as rated by family members and caregivers

Misunderstanding #10: There’s no way we can afford a Palliative Care program

Review of 48,000 patients in 2002-2004
4908 received palliative care consultations
3 academic centers, 5 community hospitals

Direct-cost savings:
- Patients who left the hospital alive: $1696/admission
- Patients who died: $4908/admission

So, now what?

Physicians, ARNPs, PA-Cs:

1. Consider your patient panel. Which patients have shown a decline over the last three months, and would not surprise you if they died within the next year?
2. Among these patients, whom do you think might benefit from an intervention that may increase longevity, that increases patient and family satisfaction, and that saves money?

Medical Staff: (RNs, MSWs, MAs, etc.)

1. Which patients are you seeing who are “frequent flyers” in the hospital or clinic? Do they have Advance Directives? Have you discussed overall status and prognosis with them, their family members, or their care providers?
So, now what?

Hospital administrators:

1. What is in place in your hospital to facilitate end-of-life discussions? What is your hospital’s system for ensuring that patients’ Advance Directives are followed?

2. Do you have Palliative Care MDs/ARNPs on staff? What is the access to Palliative Care consultation for all patients, not just those on Oncology floors?
So, now what?

Facilities administrators:

1. What barriers to getting Hospice care might your patients face as their clinical status declines?

2. Are your medical directors well-versed in options for end-of-life care? Are your clinical staff members well-versed in options for end-of-life care?
So, now what?

Insurance company physicians and administrators:

1. Are the physicians who are participating providers with your company aware of end-of-life care options for their patients? What kind of education might you be able to provide for them, since few physicians learned this in medical school?

2. Do you have any pathways instituted for end-of-life care, as you might for Diabetes, Hypertension or Asthma?
All of us:
Are we discussing issues of end-of-life care with our colleagues, our families, and our friends?

When we talk about end-of-life care with our patients, do we emphasize that this is really about *HOW WE LIVE*?
Getting in touch

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