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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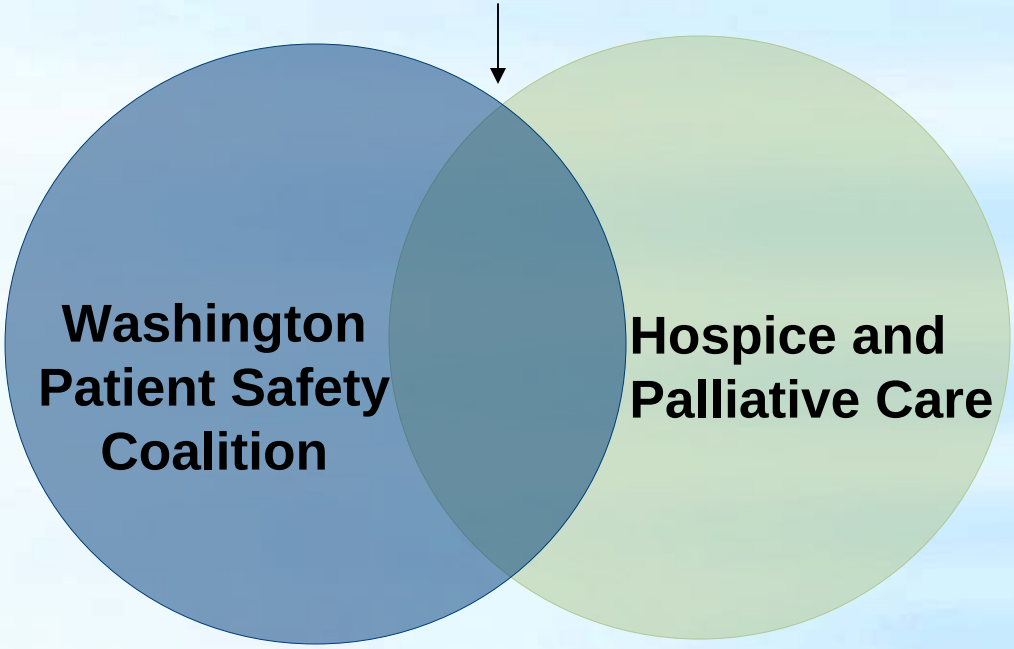
Why this topic?

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



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

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

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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.**

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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

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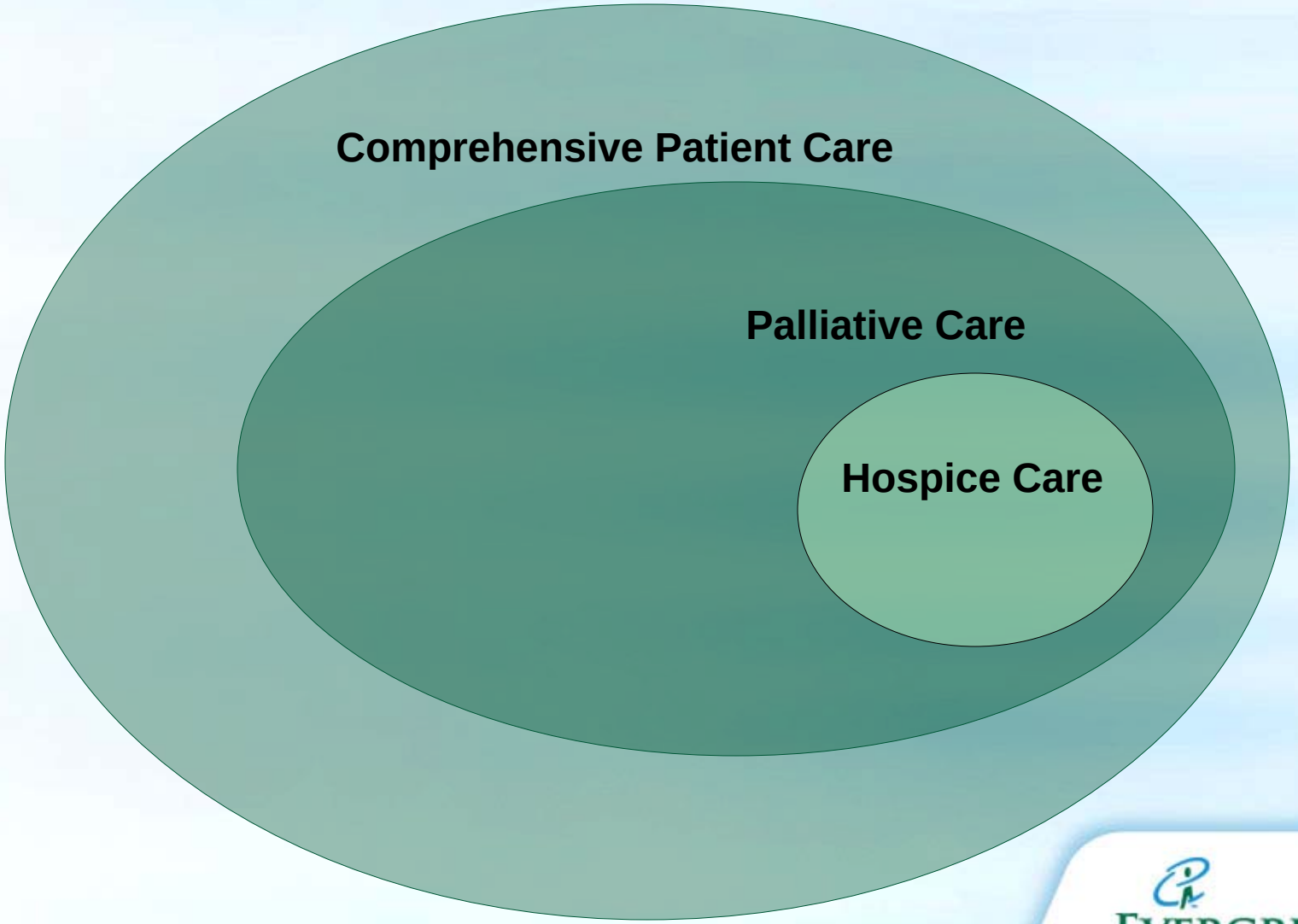
Hospice and Palliative Care



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The Challenge

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.

Taylor D et al Social Science & Medicine 65 (2007) 1466–1478.

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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%**

NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, October 2009.

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WHY?

Misunderstandings regarding Hospice and Palliative Care occur among:

- Patients
- Families
- Providers
- Institutions

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Misunderstanding #1: Death's Doorstep

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.

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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

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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 $\geq$ 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

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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

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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

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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.

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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.

Connor SR et al. Comparing hospice and nonhospice patient survival among patients who die within a three year window. J Pain Symptom Management. 2007. Mar. 33 (3)238-46.

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

Survival of Patients with Terminal Disease **in days**

	Non-hospice	Hospice	p-value
CHF	321	402	p=0.05
Lung cancer	240	279	p<0.0001
Pancreatic cancer	189	210	p=0.01
Colon cancer	381	414	p=0.07
Breast cancer	410	422	p=0.61
Prostate cancer	510	514	p=0.83

Connor SR et al. Comparing hospice and nonhospice patient survival among patients who die within a three year window. J Pain Symptom Management. 2007. Mar. 33 (3)238-46.

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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.

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Misunderstanding #7: If you're in a Nursing Home, you can't have Hospice care...

Location of Death of Hospice Patients in US

Patient's place of residence	68.8%
– Private residence	40.7%
– **Nursing Home**	**22.0%**
– Residential facility	6.1%
Hospice Inpatient Facility	21.0%
Acute Care Hospital	10.1%

NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, October 2009.

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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%**

Miller SC et al. Hospice enrollment and hospitalization of dying nursing home patients. Am J Med 2001;111(1):38e44.

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

Miller SC et al. Does receipt of hospice care in nursing homes improve the management of pain at the end of life? J Am Geriatr Soc 2002;50(3):507e515.

Miller SC et al. Hospice and palliative care in nursing homes. Clin Geriatr Med 2004; 20(4):717e734. vii.

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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."

Wright AA et al. Patient mental health, medical care near death and caregiver bereavement adjustment. JAMA. 2008; 300 (14): 1665-1673.

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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	
Cancer Patients	233 days
Non-cancer patients	154 days

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

Taylor DH et al. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? Soc Sci Med. 2007 Oct;65(7):1466-78.

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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**

  Zhang et al. Health care costs in the last week of life" Arch Int Med 2009; 1689:480-88.

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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**

"Cost savings associated with US hospital palliative care consultation" Morrison R et al; Arch Int Med 2008; 168: 1783-90.

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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?

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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?

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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?

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So, now what?

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?*

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Getting in touch

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