HOSPICE AND PALLIATIVE MEDICINE ESSENTIALS

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Course Objectives

- Differentiate Hospice Care from Palliative Medicine
- Identify Clinical Triggers for Palliative Medicine Consultation and Hospice Referral
- Identify Inclusion and Exclusion criteria for hospice admission

OVERALL DEATH RATE IN US HAS BEEN STABLE

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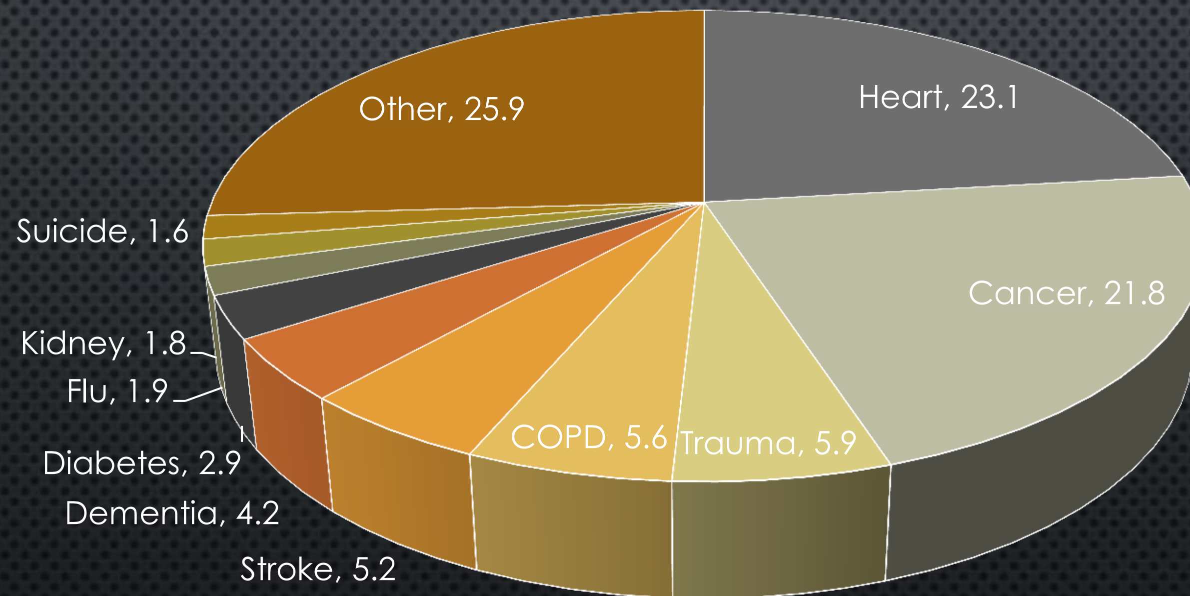
- One per person

HOW WE DIE, AND THE CLINICAL IMPLICATIONS FOR LIFE



Source: “Mortality in the United States, 2016.” NCHS Data Brief No. 293, December 2017, Centers for Disease Control and Prevention, 21 Dec. 2017, www.cdc.gov/nchs/products/databriefs/db293.htm

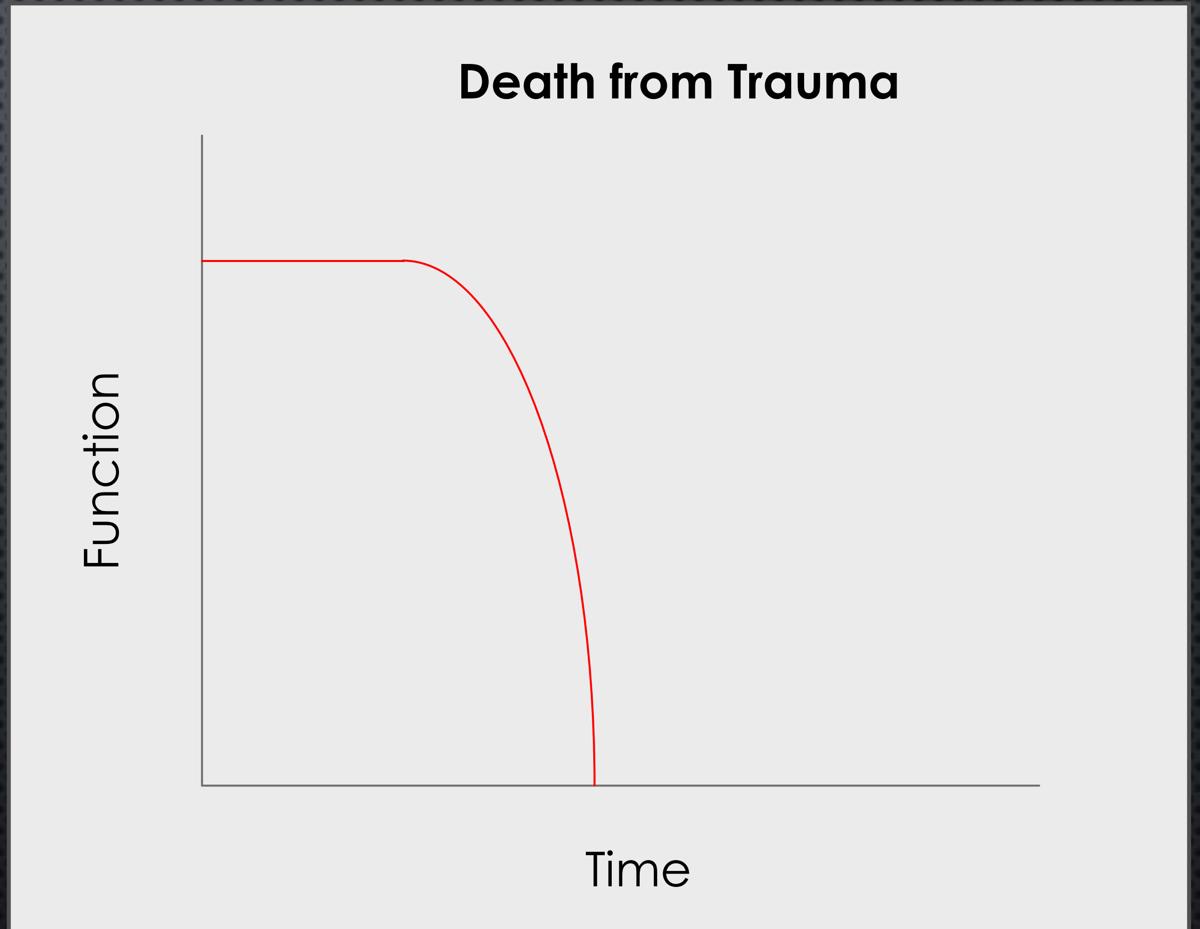
HOW WE DIE, AND THE CLINICAL IMPLICATIONS FOR LIFE

- Roughly 90% of all deaths in the US are from chronic disease.
- Chronic diseases are often managed for years prior to death – often resulting in a long deterioration of function and quality of life.
- 95% of hospice patients are 65 years old or older (Medicare aged)
- In 2015, only 46% of Medicare decedents received care in hospice

NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA:National Hospice and Palliative Care Organization, September 2017.

Death Trajectories

- Trauma
- Cancer
- Organ Failure
- Frailty



Murray, Scott A et al. "Illness Trajectories and Palliative Care." BMJ : British Medical Journal 330.7498 (2005): 1007–1011.

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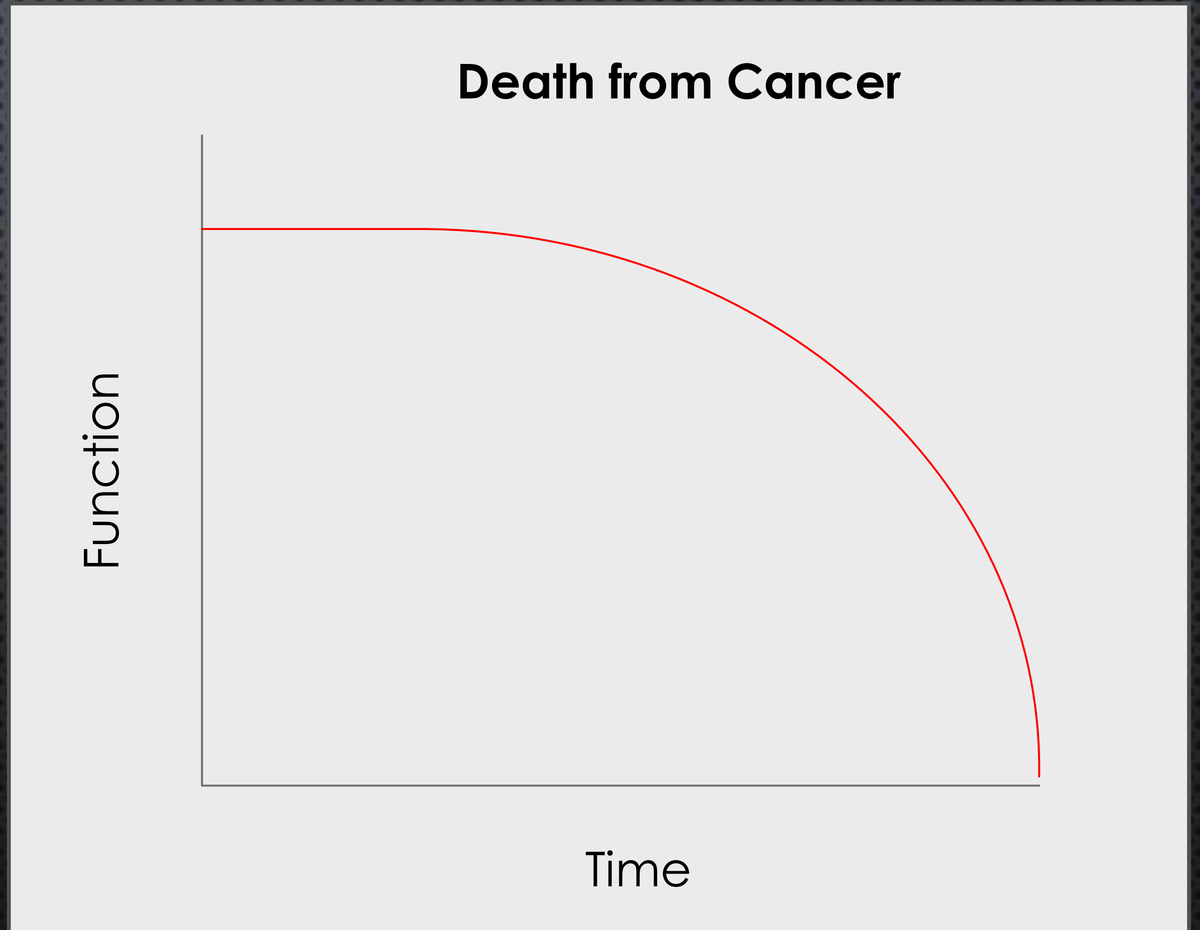

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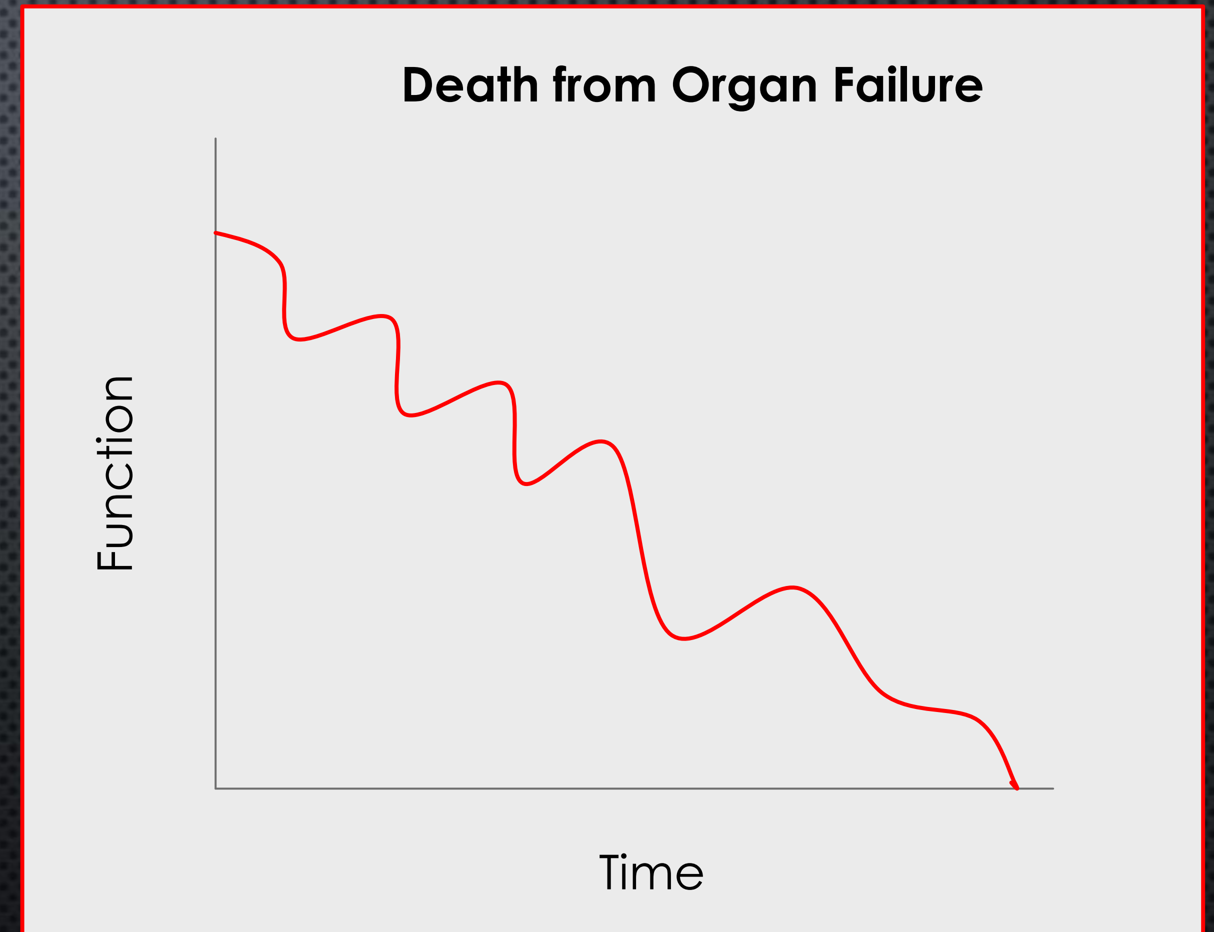

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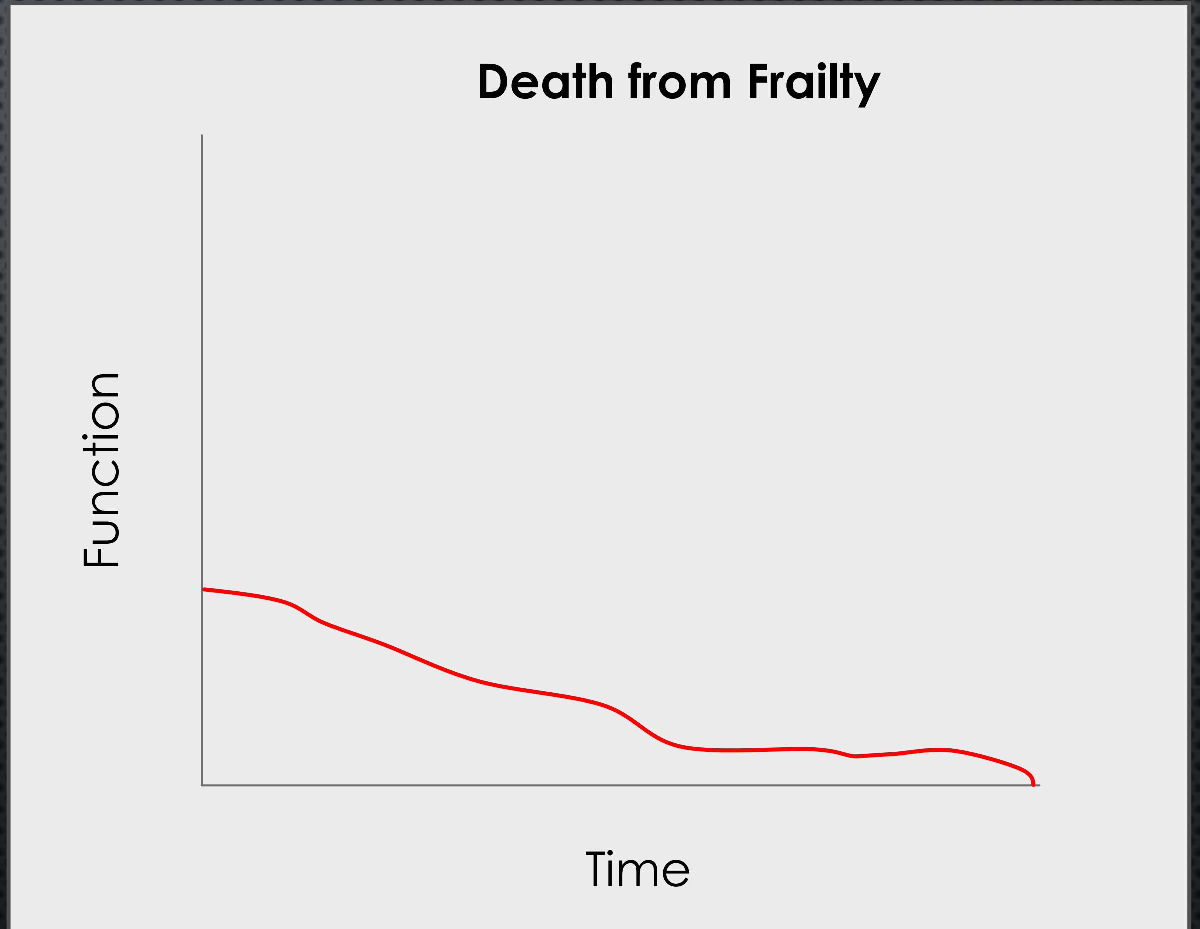

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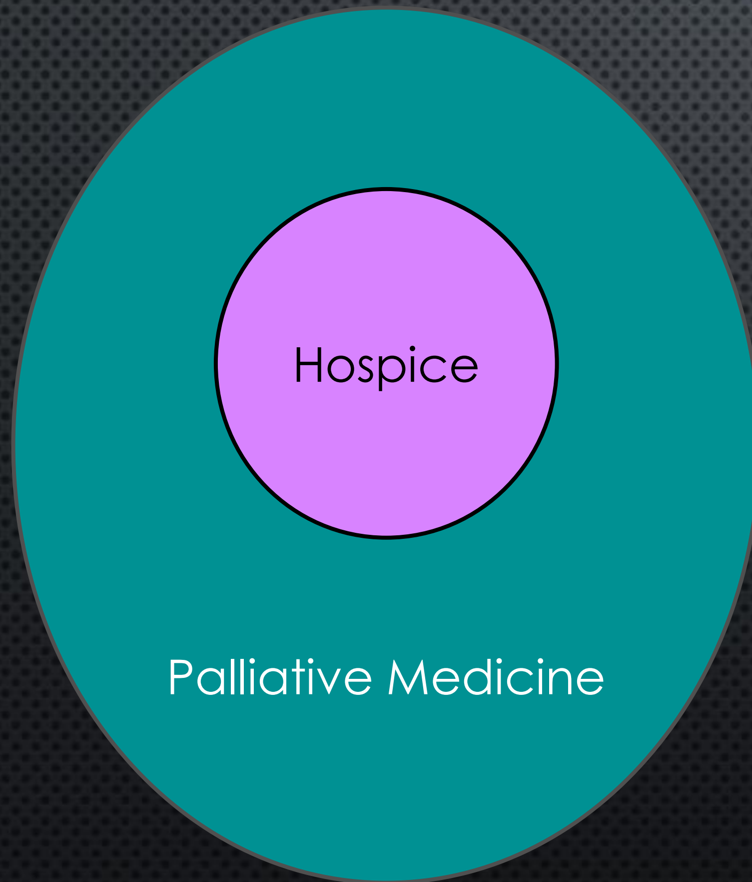
PALLIATIVE MEDICINE & HOSPICE CARE



- **PALLIATIVE MEDICINE IS** A MEDICAL SPECIALTY FOCUSED ON THE TREATMENT OF PHYSICAL AND NON-PHYSICAL SYMPTOMS OF SERIOUS ILLNESS, REGARDLESS OF THE STAGING, TIME FROM DIAGNOSIS OR THE TREATMENT PLAN.
- **HOSPICE IS** A SERVICE PROVIDED TO PEOPLE WHO ARE TERMINALLY ILL AND DESIRE ONLY PALLIATIVE TREATMENT OF THEIR SYMPTOMS.

Center for Medicare Services. Palliative Care vs. Hospice Care: Similar but Different, 2015

Comparing Hospice and Palliative Care

Hospice

- Patient must be terminally ill (6 months)
- Only care to address symptoms (physical and non-physical) is considered
- Curative care is not continued (except for patients under the age of 18)
- Services are provided where the patient lives
- Paid for by Medicare, Medicaid, or insurance
- Offers complex symptom management
- Offers Psychosocial Support to reduce stress and anxiety
- Offers Bereavement support

Palliative Care

- Patient must have a serious, potentially life threatening illness
- Coordinated care to address complex symptoms (physical and non-physical) while curative care is continued
- Works to align the medical team and the patient's goals of care and treatment
- Services are usually provided in the hospital
- Paid for by insurance or the patient
- Offers complex symptom management
- Offers Psychosocial Support to reduce stress and anxiety

Center for Medicare Services. Palliative Care vs. Hospice Care: Similar but Different, 2015

THE INTEGRATED MODEL OF PALLIATIVE CARE

Adapted from "the integrated model of care proposed by the World Health Organization (WHO).
[No authors listed] (1990) Cancer pain relief and palliative care. Report of a WHO Expert Committee. World Health Organ Tech Rep Ser 804: 1-75.

Is this a serious illness that will benefit from palliative medicine?

- Incurable / Unlikely to be cured
- Progressive
- Life limiting – typically within a few years or less
- High physical and emotional disease burden

Examples

- Likely to Benefit
  - Advanced or Recurrent cancer
  - Cardiopulmonary disease resulting in multiple admissions
  - Patients who have disease progression or worsening despite life supportive measures, such as dialysis, mechanical ventilation or artificial nutrition and hydration

- Unlikely to Benefit
  - Chronic Back Pain (not life limiting)
  - Uncomplicated Sickle Cell Disease (life expectancy may be decades)
  - Low stage cancer likely to respond to treatment
  - Otherwise healthy elderly patients

PALLIATIVE MEDICINE CONSULT TRIGGERS

- On Admission, the presence of a potentially life threatening condition and:
  - The surprise criteria (Wouldn't be surprised if patient dies within 12 months)
  - Admission prompted by difficult to control symptoms (moderate to severe for 48+ hours)
  - Complex care requirements
  - Significant decline (Functional, Nutritional, Cognitive, Disease specific)
- Secondary factors
  - Admission from a facility
  - Elderly patient with cognitive decline and acute hip fracture
  - Chronic home oxygen use
  - Out of hospital cardiac arrest
  - Prior Hospice Admission

Weissman, David E., and Diane E. Meier. "Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting. A Consensus Report from the Center to Advance Palliative Care." Journal of Palliative Medicine, vol. 14, no. 1, 2011, pp. 17–23., doi:10.1089/jpm.2010.0347.

Palliative Medicine Consult Triggers

- During Hospitalization, the presence of a potentially life threatening condition and:
  - The surprise criteria (Wouldn't be surprised if patient dies within 12 months)
  - Difficult to control symptoms (moderate to severe for 48+ hours)
  - ICU stay 7 days or more
  - Need for Goals of Care Discussion
  - Disagreements between family and / or staff on major treatment decisions, resuscitation preferences, use of non-oral feeding or hydration
- Secondary factors
  - Awaiting or deemed ineligible for organ transplant
  - Patient / Family emotional distress or request for hospice services
  - Consideration of feeding tube placement, tracheostomy, AICD, LTACH disposition, initialization of renal replacement treatments, ethical concerns

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Hospice Criteria (Medicare)

- Patient must be certified as being terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course, **as determined by the certifying physician.**
- Patient must consent to hospice services

42 CFR §418.20

Domains of Decline

- Physical / Functional
- Cognitive
- Nutritional
- Disease specific

Physical / Functional Decline

- No longer independent in at least 3 ADLs
- Sitting / laying down at least half the day due to illness burden
  - ECOG 3
  - Karnofsky Performance 50%
  - Palliative Performance Scale 50%

Kinzbrunner, B. & Policzer J. (2011). End-of-Life Care: A Practical Guide, 2nd Ed. New York, McGraw Hill.

Cognitive Decline

- Memory loss
- Disorientation
- Loss of decision making capacity
- Reversion to primary language

Kinzbrunner, B. & Policzer J. (2011). End-of-Life Care: A Practical Guide, 2nd Ed. New York, McGraw Hill.

NUTRITIONAL DECLINE

- Loss of 5% lean body weight in one month
- Loss of 10% lean body weight in 6 months
- Developing or worsening Dysphagia
- Dehydration
- Albumin below 2.5 mg/dl

Kinzbrunner, B. & Policzer J. (2011). End-of-Life Care: A Practical Guide, 2nd Ed. New York, McGraw Hill.

DISEASE SPECIFIC

- Neurologic
- Cardiopulmonary
- Renal
- Hepatobiliary
- HIV
- Malignancy related

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Neurologic Diseases

- Examples: Dementia, Parkinson's Dz, CVA
  - Loss of independent ambulation / Chair-bound / Bed-bound
  - Dependence in most or all ADLs
  - Recurrent aspiration or infection (UTI, Pneumonia, etc.)
  - Skin breakdown
  - Loss of meaningful communication is common
- ALS Specific: FVC under 30%

Kinzbrunner, B. & Policzer J. (2011). End-of-Life Care: A Practical Guide, 2nd Ed. New York, McGraw Hill.

Cardiopulmonary Diseases

- NYHA Class IV symptoms – Despite maximal treatment
- Weight loss
- Reduced ejection fraction
- Room Air Findings of spO2 under 88% AND spO2 of under 55mmHg or spCO2 of under 50 mgHg
- Resting Tachycardia
- Inoperable critical valvular disease

Kinzbrunner, B. & Policzer J. (2011). End-of-Life Care: A Practical Guide, 2nd Ed. New York, McGraw Hill.

RENAL DISEASE

- GFR under 15% and refusal to consent to dialysis
- Decision to terminate dialysis

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Hepatobiliary Disease

- Elevated PTT (5 seconds longer than control) or INR (1.5 or more)
- Refractory ascites
- Hepatorenal syndrome
- Hepatic Encephalopathy
- Spontaneous Bacterial Peritonitis
- Recurrently bleeding esophageal varicies

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HIV Disease

- Opportunistic infection
- CD4+ count under 25
- Persistent viral load > 100,000 despite or refusing HAART

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Cancer Related Diseases

- Less aggressive cancers recurrent or refractory to treatment, typically with distant metastasis, and poor functional status, and evidence of decline **or** significant comorbidity (eg, Prostate)
- Moderately aggressive cancers recurrent or refractory to treatment, typically with distant metastasis, and poor functional status (eg, Colon)
- Highly aggressive cancers as an alternative to treatment, or refractory to treatment, and early functional decline (eg, Pancreatic)
- Life threatening complications of treatment

HOSPICE CARE IS MEDICAL CARE WITH A DIFFERENT GOAL

"Regular" Medical Care

- Goal is to get better
- May make patient feel worse, even if the patient gets better

Hospice Care

- Goal is to feel better
- **Recognizes that disease will progress regardless of care**

QUESTIONS?

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