

Physician CONNECTION



Helping Patients and Family Understand Hospice Care

By Kalpesh Patel, M.D.

Understanding hospice can be very confusing for patients and family members. It is important that the primary care physician and the team understand who is eligible for hospice care and be able to explain its options and services.

Which Patients are Candidates for Hospice?

- Prognosis of six months or less, given the normal course of an illness
- Elects comfort or palliative care
- Have decided to forego disease-modifying treatments no longer deemed beneficial, or therapies with curative intent in order to focus on maximizing comfort and quality of life
- Exhibits a decreased functional status (Palliative Performance Scale rating of less than 50–60 percent or dependence in three of six ADLs), poor quality of life, physical and psychological distress, and family caregiver burden and heightened stress

- Have an alteration in nutritional status, e.g., greater than 10 percent loss of body weight over last 4 to 6 months
- Observable and documented deterioration in overall clinical condition in the last 4 to 6 months



Medical Guidelines for Appropriateness of Hospice

Medical guidelines for referral to hospice are available for many conditions. A few common

diagnoses include cancer, dementia, heart disease, HIV/AIDS, liver disease, pulmonary disease, renal disease (acute and chronic), stroke or coma, and amyotrophic lateral sclerosis (ALS). There are also medical guidelines for determining appropriateness of hospice referral in non-disease specific guidelines plus comorbidities.

When medical care is futile, it is time to initiate a conversation with the patient and/or family that a patient may be appropriate for hospice care. Sometimes patients and families are not ready. It can take multiple conversations as patients and families need time to digest the information.

Patients and families can meet with hospice representatives at any time to learn more about its benefits and services—they do not have to make a decision right away. It is also important for patients and families to know they can discontinue hospice at any time.

Case Scenarios

It is not always clear-cut to patients or their families who is

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eligible for hospice care or the services offered. Consider the following scenarios.

Scenario #1

An 88-year-old female patient is hospitalized for dyspnea. She has severe dementia and her workup reveals metastatic lung cancer. She is evaluated by hematology and oncology services and is not a candidate for chemotherapy or radiation therapy. You recommend hospice. The son asks you: "Where does hospice take place?"

Scenario #2

A 98-year-old longtime patient has had multiple hospitalizations for COPD over the years and now is at end-stage COPD. However, in the past two months, he has been intubated three times and has declined with each subsequent hospitalization. You mention that he may be a candidate for hospice as extensive medical care appears to be futile. He doesn't want to leave the hospital. He asks "Where would I go? I like the hospital and how I am treated here."

Scenario #3

A 98-year-old dementia patient has been a long-term resident in the dementia/memory unit of an assisted living facility. Recently, he began requiring assistance in choosing proper clothing, dressing, bathing and toileting independently. He has had urinary and fecal incontinence. He can only speak a few words a day, is no longer able to be clearly understood, has secondary loss of all intelligible vocabulary and is no longer ambulatory.

Three weeks prior, the patient was treated for a UTI. His family would like to pursue hospice care but they are unsure if he would qualify.

Discussion

Scenarios #1 and #2 reflect a common misconception among patients and families that hospice is a "place." In reality, hospice is a

model of care and a service that can take place at multiple locations. If a patient needs acute symptom management hospice, for example, hospice can take place at the hospital.

Scenario #3 demonstrates that many people are unaware of who would qualify for hospice. In this instance, the patient would qualify for hospice because he has a diagnosis of dementia and has had at least one medical complication (the UTI) within the past 12 months.

How Hospice Care Works

With inpatient hospice, care is provided 24/7. Patients are discharged from the primary service (medical, family practice, etc.) and readmitted under hospice. The primary physician is encouraged to continue caring for the patient. Hospice is never a substitute for the primary care physician; it is in addition to that care.

Patients can also be offered a choice to pursue hospice care in a hospice home. This is a place where hospice residents stay for short periods of time, typically no longer than two to four weeks. They receive 24/7 care by skilled clinicians.

However, patients often surprise us. End-of-life care is no exception to this rule, and patients may stabilize from the acute symptoms for which they were admitted to hospice. In this instance, once the patient is clinically stabilized, discharge from hospice should be expected. The interdisciplinary team will educate the patient and family regarding options for care after discharge. Nonetheless, it is not uncommon for a patient to decline again and later be readmitted to a hospice home.

There are several options to consider when discharge from hospice is being recommended. In-home hospice help can offer intermittent care with nursing and other related visits. Some patients may need a 24/7 live-in caregiver and may choose to move into a

The Hospice Concept— An Overview

The concept of hospice started during the middle ages when hospices were set up as places of rest for pilgrims and other travelers. By the end of the 19th century, hospices were designated specifically to care for the dying. (www.uptodate.com/contents/hospice-philosophy-of-care-and-appropriate-utilization-in-the-united-states)

Dr. Cicely Saunders advanced the modern hospice movement, otherwise known as comprehensive care for the terminally ill or dying, to reflect patient centered care, pain management, research and education. Hospice need not be a place but rather a service that offers support, resources, and assistance to terminally ill patients and their families.

(www.medicinenet.com/hospice/article.htm)

There has been a dramatic increase in hospice use. Approximately 41.9 percent of all deaths in the U.S. in 2010 took place under the care of a hospice program. This reflects a change from one in 12 deaths of Medicare beneficiaries in 1992 to two in five deaths in 2009. More for-profit hospices appear to be operating. The number of for-profit hospices has increased by 300 percent from 1992 to 1998. (www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care)

Hospice programs generally use a multidisciplinary team approach, including the services of a nurse, doctor, social worker and clergy in providing care. Additional services provided include drugs to control pain and manage other symptoms; physical, occupational, and speech therapy; medical supplies and equipment; medical social services; dietary and other counseling; continuous home care at times of crisis; and bereavement services.

(www.medicinenet.com/script/main/art.asp?articlekey=24267).

The Institute of Medicine (IOM) report published in 2011, *Relieving Pain in America*, stated among its guiding principles that there is a “moral imperative to treat pain, and that all those in the healing professions have ethical duties and obligations to do so.”

Unfortunately, in the current healthcare environment, many translate “treating pain” to mean “prescribing opioids.” The World Health Organization has described opioids as “essential medications” for managing the health of a society, and these medications can be critically important to people struggling with complex chronic illnesses and/or struggling with issues at the end of life. It is well known, however, that these medications can also be dangerous when used inappropriately and for purposes other than those prescribed.

Addressing Psychosocial and Spiritual Needs

Less than half of all physicians indicated they were comfortable with addressing spiritual and/or religious concerns of their patients who are seriously ill. Yet, data demonstrate that addressing this aspect of care for the seriously ill is important to both clinical outcomes and quality of life.

An observational study by Winkelman, et al. showed that patients with cancer who had unmet spiritual concerns were more likely to have significantly worse psychological quality of life compared with those who had their spiritual needs addressed. (*Journal of Palliative Medicine*. 2011; 14:1022-1028)

Chaplains, clergy and other spiritual leaders can be helpful. Unfortunately, at this time, their training and education about care of the dying is also limited. In health systems, especially academic health systems, psychologists, social workers and ombudsmen

may also be helpful to patients grappling with existential and religious questions.

Growth in Palliative Care

Over the past two decades hospital-based palliative care programs have grown rapidly. Today two-thirds of all hospitals with at least 50 beds report having a palliative care team, and among hospitals with 300 or more beds, 85 percent have palliative care consultation available to their clinical staff, patients and their families. (IOM Report, *Dying in America*, 2015)



Although most specialty palliative care programs are hospital based, that is not exclusively the case. Ideally, palliative care should be available in nursing homes, community-based clinics, and at home, and there are some models emerging worthy of following. At Bon Secours in Richmond, Virginia, the palliative medicine program is organized as an outpatient medical practice within the Bon Secours Medical Group. According to its director, Leanne Yanni, M.D., this model “provides flexibility and a focus on the entire continuum of care” — not just on those patients who are hospitalized. (AHA, Circle of Life 2016)

There are two major barriers to even more growth and utilization of palliative care services:

1. Lack of knowledge and understanding about palliative care and equating it with hospice and/or end-of-life care
2. Absence of adequate

reimbursement for palliative care services

However, the tide is turning for a variety of reasons, including concerns about the financial impact of end-of-life care.

In 2010, a landmark study published in the *New England Journal of Medicine* (NEJM) found that palliative care not only improves quality of life, but it also leads to longer life (Temel, J.S., et al., NEJM, 363 (8):733-742). A more recent report in the *NEJM* concluded “Palliative care is now a rapidly growing medical specialty in the United States, and a mounting body of evidence shows that palliative care teams enhance the quality of healthcare for persons living with serious illness and for their families, while reducing medical expenditures.”

(<http://nejm.org/doi/full/10.1056/NEJMra1404684?af=R&rss=currentIssue#t=article>)

Increasingly, studies validate these claims. For years, palliative care programs in large academic centers have been able to demonstrate significant “cost savings.” However, as one health system leader said to me, “Cost savings don’t show up on my bottom line.”

As we shift from a fee-for-service model to a value-based or bundled reimbursement model, however, the benefits of palliative care will be more tangible to those watching the bottom line. A recent survey indicated that 90 percent of adults in the United States could not define palliative care. However, when it was described to them, 90 percent said they wanted it.

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What's the Difference Between Palliative Care and Hospice?

By Myra J. Christopher

When asked if Virginians were Southerners, Thomas Jefferson reportedly said, "Sir, all Virginians are Southerners; unfortunately, not all Southerners are Virginians." To paraphrase Jefferson, hospice is palliative care, but palliative care is not hospice.

Many definitions of palliative care are bantered about. The Center to Advance Palliative Care (CAPC, www.capc.org) has provided the most substantive and useful definition:

Palliative care, and the medical subspecialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of palliative care doctors, nurses, social workers and others who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Like hospice, palliative care is focused on symptom control and pain management and is delivered by an interdisciplinary team. Palliative care focuses on both the patient and the family, and like hospice can be delivered in a variety of settings.

So what's the difference?

Hospice, as it is organized and reimbursed in this country, is a model of care available to those who are actively dying. To be eligible for Medicare hospice benefits, two physicians must certify that death is expected within six months, and once a patient has accepted the hospice option, they are no longer eligible for life-saving acute care measures. Palliative care, however, as the CAPC definition says, is available and appropriate to any person with a serious illness *at any stage of their illness*. Palliative care also emphasizes communication and value-based treatment planning, quality of life and advance care planning, and ideally, it will begin early in the course of treatment for serious chronic or terminal diseases.

There are two types of palliative care: *basic or primary palliative care* delivered by primary care providers, healthcare specialists such as oncologists and cardiologists who do not have specialized training in palliative medicine, advance practice nurses and others. *Specialty palliative care* is delivered by healthcare professionals who have received specialized training in palliative care, e.g., physicians who are board certified in palliative medicine. This model of palliative care is currently most often hospital based. There is a strong effort to make specialty palliative care available in community-based settings. Whether primary or specialty palliative care, the core components of this model include the following:

Direct and Honest Communication

Alarming, there is still data indicating that many patients with serious life-limiting illnesses are not clear about their diagnosis and/or prognosis and have not done advance care planning, including naming a durable power of attorney for healthcare decision making. Without this exchange of information, i.e., clinical information and patient values, hopes and expectations, it is impossible for shared decision making, which is at the core of palliative care, to occur. Without this discussion, it is impossible to establish patient-centered goals of care and plan of treatment.

Historically, physicians have not been well trained in communication skills. One of the benefits of interdisciplinary teams is that if the physician is uncomfortable with such conversations, he or she can be supported by a nurse, social worker or chaplain. Some argue that, in fact, these other members of the palliative care team can substitute for the physician in these circumstances. The role of the therapeutic relationship is so strong that I believe the physician must be involved in these conversations but does not necessarily have to take the lead.

Pain and Symptom Control

Although pain management is the dominant concern of persons with serious illness, studies suggest that it is one of many challenges facing those with serious illness. Other symptoms include anorexia, constipation, anxiety, dyspnea, nausea, fatigue, depression and anxiety, and others. However, unless pain is appropriately managed, it is almost impossible for seriously ill patients to achieve quality of life and make this phase of their lives meaningful.

skilled nursing facility. Other patients may wish to die at home and request to be discharged to their home or a home of a family member.

Hospice Care Is Not Always Appropriate

Some situations may be unsuitable for the patient. Consider the following scenario:

Scenario

A 70-year-old pancreatic cancer patient is undergoing active treatment including all modalities (surgery, chemotherapy and radiation therapy) and is a full code. She is in a severe amount of pain and states she would like to continue with treatment for as long as she can. She asks about hospice. You explain to her she is not a candidate for hospice as she is choosing to continue active treatments. She asks you if there are any other services for which she may qualify.



The patient in this scenario is more appropriate for a palliative care referral. Palliative medicine focuses on symptom management, support

and assistance with communication, and provides such care to a wider group of patients including those who are not dying or who cannot receive or choose not to receive hospice services.

Palliative care aims to relieve suffering in all stages of disease and is not limited to end-of-life care. Palliative care is provided at the same time as curative or life-prolonging treatments. A physician or nurse practitioner will help control symptoms and focus on improving quality of life for the patient as much as possible. Visits are symptom driven.

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The Hospice Team

Primary care physicians should never feel as if they are abandoning their patients after placing them in hospice service. The primary care provider is often the first point of contact for patients with questions about hospice and typically provides a leadership role within hospice care.

The **registered nurse** is the primary case manager and is responsible for skilled nursing care and coordination of other members of the interdisciplinary team. An admission RN will come to meet the

patient/family in their home, skilled nursing facility, assisted living facility or hospital room. He/she will explain the benefits of hospice care and determine clinical appropriateness for hospice admission by consulting with the physician.

The **hospice physician** plays both a medical and administrative role. The hospice physician acts as a liaison to the primary attending clinicians and can assist with symptom management. Two physicians are required to certify the patient's condition is clinically appropriate for hospice services. The primary attending physician may work directly with the primary nurse and also in collaboration with the

hospice medical director to monitor symptoms and order interventions.

The **social worker** provides psychosocial and practical support for patients and families, including counseling, bereavement support and/or referrals to other support systems. Bereavement support for family members can continue after the patient dies.

The **chaplain** oversees the spiritual and bereavement needs of patients and families for 13 months or more. The chaplain typically meets with families weekly or as needed and may facilitate meetings between the team and family to improve communication.

From the Physician Learning Center



CDC Releases Guidelines for Prescribing Opioids for Chronic Pain

In an effort to help combat the opioid epidemic, the Centers for Disease Control and Prevention has released guidelines for prescribing opioids for chronic pain. This post contains a link to these guidelines, as well as other resources for implementing the recommendations.

<https://www.psicinsurance.com/posts-articles/physicians/risk-management/cdc-releases-guidelines-for-prescribing-opioids-for-chronic-pain.aspx>



Informed Consent—What Does it Really Mean?

Have you ever wondered how to get the most out of informed consent and informed refusal at your medical practice? Attorney Linda Hay presented a webinar on this topic. Here are a few of the responses attorney Hay provided to questions posed by attendees.

<https://www.psicinsurance.com/posts-articles/physicians/risk-management/informed-consent-what-does-it-really-mean.aspx>



Weigh In or Waist In? The Importance of Documenting Cardiometabolic Risk Factors

Who is considered healthy? It's not just about how much a person weighs after all. Does your documentation support that you have fully assessed cardiometabolic risk factors that are linked to healthy or not-so-healthy patients?

<https://www.psicinsurance.com/posts-articles/physicians/risk-management/weigh-in-or-waist-in-the-importance-of-documenting-cardiometabolic-risk-factors.aspx>



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