Hospice:
myths, facts, & eligibility

Hospice of the Shoals
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Outline

1. Define hospice
2. History of hospice
3. Regulations governing it
4. Myths about hospice
5. Who's eligible and when to ask for it
   - General criteria and disease-specific
6. Summary & Pearls

1. Definitions

Hospice: A Medicare benefit providing palliative care* for those certified with a terminal disease and less than 6 mo. to live if the disease "runs its usual course".

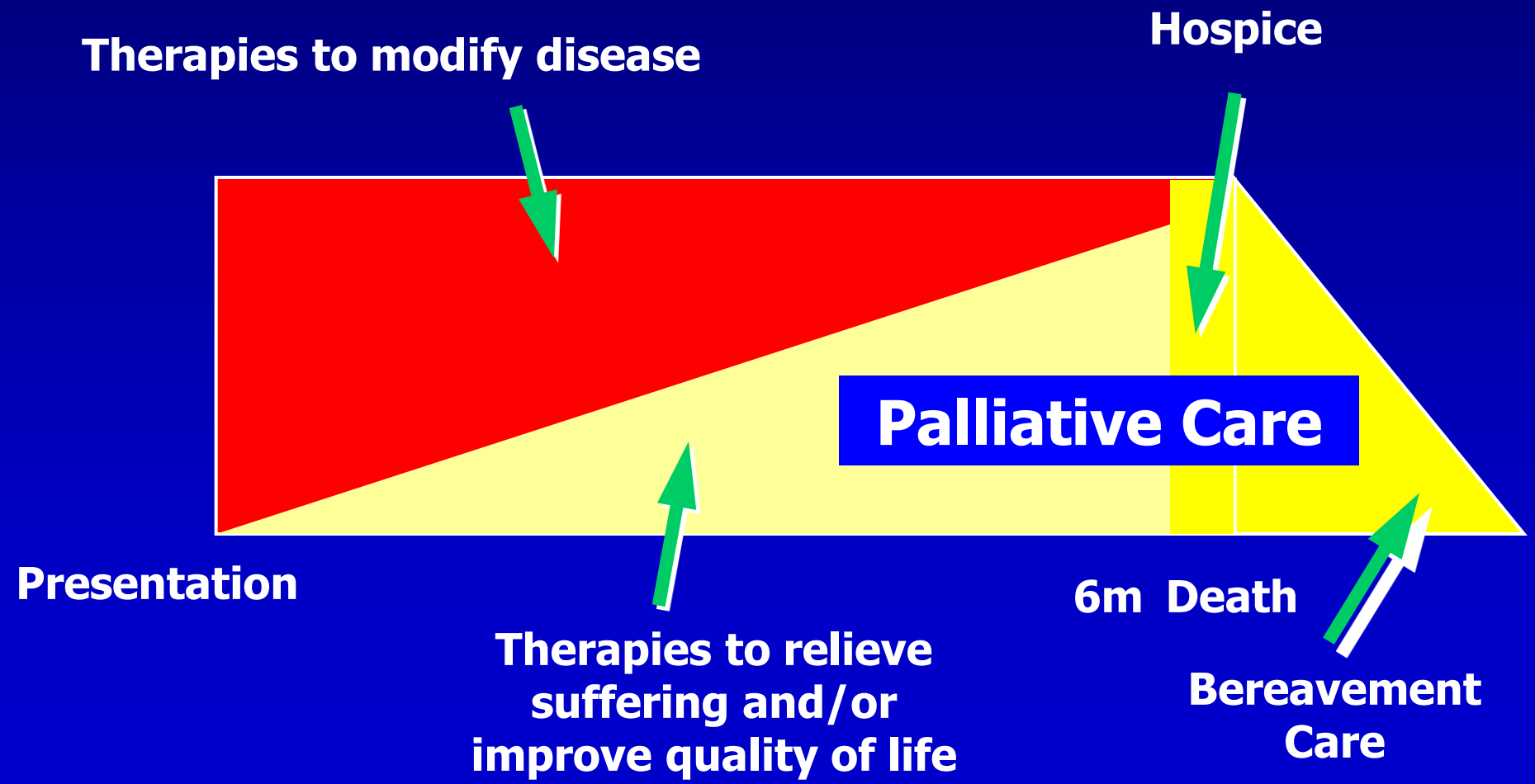
– It is "palliative care for the last 6 mo. of life."

*Palliative care is interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.

- It can be offered while receiving usual appropriate medical curative therapies, and

- is NOT only for those who are dying [that's *hospice*]

Palliative Care's Place in the Course of Illness



Palliative Care is Comfort-focused

1) Helps patients clarify their goals in the face of a LLD*, to make informed decisions and avoid non-beneficial treatments; which…
2) Improves their quality of life so they can live comfortably (soothing symptoms) as long as possible; and then,
3) when they are at the very end of life, PC ensures a natural death w/ comfort and dignity.

*LLD = Dementias, cancers, end-stage organ disease (e.g. lung/ heart/renal/liver), ALS, AIDS

PC & Hospice Benefits

- PC does NOT accelerate dying
  - Cost Savings Impact Study 2009 at ECM
    - patients in both the control group (94%) and the PC consult group (100%) died in the same 12 mo. (while saving hospital $386,000)

and…

- PC improves survival & QOL in lung cancer
  - Patients receiving chemotherapy and PC lived 3mo longer (11.6mo v 8.9mo) than those on just chemoRx. *[Temel. NEJM 2010.]*

and…

…PC & Hospice Benefits

- Cancer pts who discuss EOLC wishes w/ MD have better QOL and lower costs in final wk of life
  - Less aggressive care/admissions to hospital
  - Improved QOL w/ more peaceful death

  ** Zhang B. Health care costs in the last week of life. Arch Intern Med. 2009*
- Pts who choose hospice live ~29 days longer than those not in hospice

  ** Connor S. Comparing hospice & non-hospice patient survival among patients who die within a three-yr window. J Pain Symptom Manage 2007*

Why so beneficial?

Implementing PC principles can help to…

- Stop all/most non-comfort tx/meds
- Aggressively control symptoms which helps them to feel better and eat/socialize/exercise more and fight illness
- Encourage patient/family-driven goals
  - Avoid futile/unnecessary treatment & hospitalizations
- Encourage EOLC planning
  - helps accept limits to life

[that confronts the *illusion of certainty*…]

Historically, always had PC:

Physician's Traditional Role = PC

- To cure sometimes
- To relieve often
- To comfort always

- anonymous 16th century aphorism [?Hippocrates]

A Purpose of Palliative Care & Hospice: avoid "Futile" Care!

Futile Care is:

- "when desired goals not met or desired results cannot be achieved" [qualitative], or
- "clinical care that has a <1 - 5% chance of survival" [quantitative]

[Davila F. The infinite costs of futile care… Physician Exec. 2006.]

[Schneiderman L. Beyond futility to an Ethic of Care. Am J Med. 1994;96:110-14.]

Avoiding Non-beneficial Care

- "To continue to fight for a cure when there is no reasonable hope for one may cut off the true growth and comfort that can come from going on this journey together with those we love."

  Hank Dunn. Hard Choices for Loving People. 2001

The only thing worse than "no hope" is "false hope"!

Avoiding Futile Care

- Only 10% people die suddenly
- 90% need some form of terminal [EOLC] care
- During EOLC, we can be primary cause of suffering or, primary cause of its relief !

- Thus, we need PC & Hospice to relieve suffering !

2. Hospice History

- Hospice = ‘hospitality’; for travelers, foundlings, destitute; organized by churches
- 19thC., Madame Garnier, Lyon, France
- Early 20thC, Catholic nuns
- First formal program, England 1967
  - St.Christopher’s, London
  - Dame Cicely Saunders
    - Speaks to Yale School of Nursing, 1965

…Hospice History

- Medicare Benefit since 1982 - provides palliative care to the terminally ill at "home"
- 1989 - LTCF recognized as 'home'
  - 22% hospice care now in LTCF [2008]
- in 2009: 41% all deaths w/ a "terminal prognosis" in USA were in hospice, in 5000 programs [from 31 in 1984]

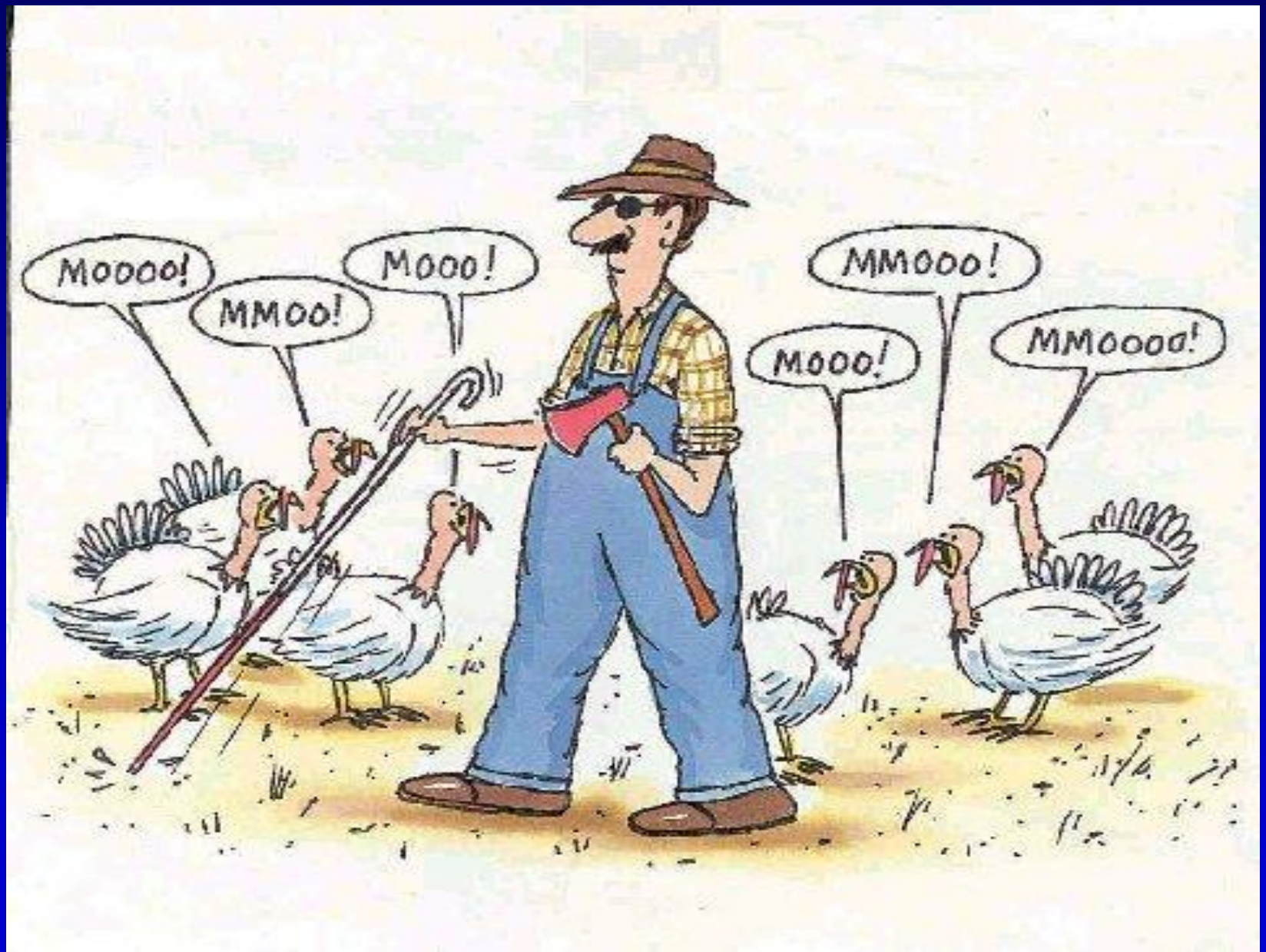
…History & Facts

- Incentive for patients: no cost = increase demand
  (and incentive for business – per diem payments)
  - From 1997 <500k pts, to 2007 >1million;
  –Medicare cost from $2.9B to $10B
- Increasing admissions for non-cancer dx
  –In 1998: 47% hospice = non-cancer dx
  –In 2008: 69% pts = non-cancer dx
- With increasing ALOS
  –In 2000: 62 days; in 2006: 82 days
- Alabama 2011: 184 licensed providers (121 certified) = 1 agency/37,506 pop; US = 1 / 61,401 pop.

…Hospice History

- Agency can be for-profit or not-for-profit
- Increasing number for-profit corporations, leading to more of business model of care, which may be resulting in higher costs and LOS *[Cefalu CA. The medicare hospice benefit: a changing philosophy of care? Ann LTC.Jan.2011]*
  - Leading to investigations by OIG…

OIG cuts out ‘poor’ hospices?



3. Hospice Regulations

- Covered Services:
  - all diagnosis & comfort-related meds /services
  - RN visits, care aides, chaplain, social worker, PT/OT/SP/Dietician, Medical Director
    - Visits based on POC + 'core' mandated unless patient/family refuse
  - Supplies and equipment
- Should prevent hospital admissions
- Reimbursed by Medicare on per diem basis

Hospice as Business

- Reimbursed on per diem basis – 4 types [*NW Alabama region rates 2011*]
  - Home care: $130/day (range $120-$136. based on county)
  - Inpatient Respite care: $138/day, max 5days/certif.period
  - Continuous home care: $ 31 /hr, nursing 12hr/day min, at home, to manage symptoms
  - General Inpatient care: $583/day, hospitalization for uncontrolled symptoms, or caregiver crisis

Hospice Regs: CAPS

- Inpatient days cap: max 20% of total patient care days
- Aggregate Financial cap (rate adjusted annually); 6mo. max – total reimbursements divided by total patients, limited to $23,874 avg per patient

If hospice exceeds either cap, must repay Medicare any excess

Hospice Regs

Admissions:

- Pt must be evaluated within 48hrs of referral
- Primary doctor & medical director must sign

Certifications [i.e. that <6mo life expectancy]:

- Initial certification (90 days) by PMD & M.Director
- 2nd 90 day recert by M.Director
- 3rd recert (@ 180days, for next 60days) requires face-to-face visit by M.Director [or CRNP]
- Subsequent recerts q 60days – "unlimited"
- Must include written narrative

Hospice Regs

Discharges:

- Patient must be discharged if not declining or not likely to die in next 6mo.
  - Patient/family can appeal discharge [AQAF]
- Patient can ‘revoke’ hospice at any time
  - To go with another hospice; or moving;
  - To resume ‘curative’ therapies

Hospice Regs

- NOT required to provide 24hr personal care
- Usually doesn't cover "non-terminal" therapies or drugs
- In NH, hospice responsible for POC and must ensure NH staff oriented to hospice
- Obligated to provide grief support for 13 months after the death

4. Myths about Hospice

Myths:

i. There are ‘two’ kinds of hospice
ii. Patient must have DNR [AND]
iii. They cannot be admitted to hospital
iv. Patients must be discharged if they don’t die in <6mo.

Hospice Realities/Facts

i. Only ‘one’ kind of treatment hospice
   - there are “Not-for-profit” & “For-profit” businesses

ii. Patients do not need a DNR/AND
   - But, mixed messages - false hope - ?fraud

iii. Patients can be admitted to hospital
   i. Hospice related dx
   ii. Non-hospice problem

iv. After the initial 6 mo. certification, if the doctor believes death will still occur within the next six months, patients can continue in hospice

Grass (w/o hospice) not always greener!

5. Hospice General Eligibility*

- Medicare beneficiary, entitled to Part A;
  - Or: have another insurance contract; indigent
- Certified as having life expectancy <6mo "if illness runs its normal course." [by PMD and hospice Medical Director]
- Patient waives rights to all curative care for the terminal illness

* *Eligibility and Guidelines for Determining Prognosis taken from NHPCO*

When to ask for Hospice?

- Estimated life expectancy less than 6 mo
- Cure no longer possible or made decision to stop attempted cure
- Symptoms [e.g. pain, shortness of breath] not controlled and hoping to relieve suffering - "tired of fighting it"
- Don't leave it "too late"
  - 35% patients die in <7days from admission *[2008]*

Hospice Eligible Diseases

- Cancers
- ALS [Amyotrophic Lateral Sclerosis]
- CVA [Stroke & Coma]
- Dementia
- General Debilitation
- Heart
- HIV/AIDS
- Lung
- Liver
- Renal

Cancers

- When to begin hospice, determined by individual cancer prognosis, and by speed of decline in ADL's
- Will discuss in next session "Prognosis"

Non-Cancer Diagnoses *

- Prognostication much more difficult than with cancers
- Need to adhere to national guidelines/ criteria *
  - Avoid potential OIG investigation and charges

[from NHPCO guidelines]*

Eligibility: ALS (Lou Gehrig's Disease)

Must fulfill 1, 2, or 3.

1) Impaired breathing [all present in prior 12mo]
   - VC <30%;
   - Dyspnea at rest;
   - declined ventilator
   - O2;
2) Rapid progression of ALS & nutrition [all present]
   - From independent walk & ADL's to w/c or BB + assist
   - Normal speech to barely intelligible
   - Normal diet to pureed
   - Oral intake insufficient to sustain life
   - no PEG
   - Continuing wt loss
   - Evidence of dehydration/hypovolemia

ALS cont'd

3) Rapid progression of ALS [above], and Life-threatening complications [1 of]:
   i. Recurrent aspiration pneumonia
   ii. Pyelitis
   iii. Sepsis
   iv. Recurrent fever after antibiotics

Eligibility: Stroke & Coma (acute)

- Coma, persistent vegetative state >3days
- Severe myoclonus >3days
- Persisting Coma after 3 days, w/ any 4 of:
  - Abnormal brain stem response
  - No verbal response and No response to pain
  - S.Creatinine >1.5mg/dl
  - Age >70
- Dysphagia sufficient to not sustain life
  - PEG declined or not a candidate
- MRI/CT suggesting decreased survival
- NIHSS helpful re prognosis

Stroke & Coma (chronic)

- Karnofsky <50 [PPS <50]
- Wt loss >10% in 6 mo; or, Albumin <2.5
- Meets criteria for Dementia
- Age >70
- Medical complications
  - Aspiration pneumonia
  - Pyelitis/sepsis/fever after abx
  - Refractory Decubiti stg 3-4

Eligibility: Dementia

FAST [Functional Assessment Staging Scale] = 7c

- 7a – speaks < 6 intelligible words /day
- 7b – speaks only 1 word clearly/day
- 7c – bed-bound (2 person max. assist OOB)
- 7d – cannot sit unsupported
- 7e – no longer smiles
- 7f – cannot hold head up

AND…

…Dementia eligibility

AND, at least one of following in prior 6mo:

- COPD
- CHF
- Recurrent aspiration pneumonia
- Decubitus ulcers Stg.3-4
- Age >70
- Serum albumin <2.5
- Progressive wt loss >10% previous 6mo
- Recurring fever after antibiotics; septicemia; pyelitits

Eligibility: General Debilitation

- Have a life-limiting condition
- Patient accepts comfort focus only
- Documented clinical deterioration in ADL, or

  Documented wt loss >10% in prior 6mo.
  - may be supported by albumin <2.5gm/dl]

Eligibility: Heart Disease

- Class IV by NYHA
  - Symptoms at rest [angina, dyspnea]
- Supportive documentation
  - SaO2 <89%/RA - EF <20%
  - CP.Arrest - V.arrhythmias
  - Unexplained syncope - cardiogenic brain embolism
- Receiving optimal treatment
  - ACE inhibitors
  - Diuretics/vasodilators
  - nitrates

Eligibility: HIV/AIDS

- CD-4 count <25, or viral load >100,000copies/ml
- Karnofsky score <50 [PPS <50]
- Chronic diarrhea, albumin <2.5, age >50; CHF
- Plus [one of opportunistic conditions]
  - CNS lymphoma
  - Wasting worsening
  - Persistent MAC bacteremia
  - Systemic lymphoma, failing chemoRx
  - Visceral Kaposi unresponsive to treatment
  - Cryptosporidium or toxoplasmosis

Eligibility: Liver Disease

- Not liver transplant candidate
- PT >5sec above control [INR >1.5]
- Albumin <2.5
- One of:
  - Refractory ascites or noncompliance
    - [to furosemide & spironolactone]
  - Spontaneous bacterial peritonitis
  - Hepatorenal syndrome
  - Refractory hepatic encephalopathy/noncompliance
  - Recurrent variceal bleeding despite tx

Eligibility: Pulmonary Disease

- Dyspnea at rest; HR 100+/min; wt loss
  - Bed-to-chair existence, fatigue, cough
- FEV1 <30% expected [post-bronchodilator]
- Increasing ER visits/hospitalizations or decreasing FEV1 >40ml/yr
- Cor pulmonale [RHF]
- PO2 <55mmHg [SaO2 <89% on O2]
  - Or PCO2 >50

Eligibility: Renal Disease

- Patient decided to stop/forego dialysis
- S.creatinine >8mg/dl [>6 if DM]
- Creat.clearance [~GFR] <10cc/min
- Clinical signs of: uremia [confusion, n/v, pruritus, restlessness]; oliguria; hyperkalemia; uremic pericarditis; HR Synd; fluid overload

Summary & Pearls

- PC improves QOL, being comfort-focused
- Hospice is PC for the last 6mo of life
- Hospice requires certification of <6mo survival if disease runs usual course
- Hospice doesn’t require DNR/AND order
- Patients can be in hospice >6mo
- Patients can be admitted to hospital

…Summary & Pearls

- Non-cancer diagnoses now the majority of hospice patients;
  - need good documentation to justify admission and recertification
- Hospice benefits patients/families more, when enrolled at least 3 mo

Information Resources for Hospice & Palliative Care

- OneSlideProject – engagewithgrace.org
- nhpco.org [National Hospice & Palliative Care Organization]
- CAPC [Center to Advance Palliative Care]
- Comfortcarechoices.com [RJ Webb's website]
- The Five Wishes – agingwithdignity.org

Success & Aging

Hospice offers Hope. Like hope, definition of success changes as we age: life is a circle.

- At age 4, success is…not peeing your pants
- At age 12, success is…having friends
- At age 16, success is…a driver's license
- At age 20, it's…having sex
- At age 35, it's having money

Success cont'd

- At age 50, success is…having money
- At age 60, it's…having sex
- At age 70, it's…having a driver's license
- At age 75, it's…having friends
- At age 80, success is not peeing your pants!

“Growin’ old ain’t for sissies”

- Bette Davis

THANK YOU !