Palliative Care and Hospice

Virginia A. Boothe M.D.
Assistant Professor of Palliative Medicine
University of Virginia Health System
Palliative Care and Hospice

A multidisciplinary approach to care with a particular emphasis on quality-of-life involving the physical, psychological, spiritual and social aspects of well-being in patients with life-limiting, life-threatening or terminal illnesses.
Definitions

Palliative Care – provided at any stage of illness from diagnosis through cure or remission to death

Hospice – provided to those with a terminal diagnosis and life expectancy of ≤ 6 months
Life-Threatening Illness

- Potentially, but not necessarily, fatal

- Severe infection, early stage breast cancer, major trauma from MVA

- May go to the brink of death and be saved by medical care

- Return to normal quality of life

Blackhall 2011
Life-Limiting Illness

- Incurable, progressive illness leading to eventual death
- End-stage CHF, end-stage COPD, Alzheimer’s dementia, advanced cancer
- Medical treatments – no cure; may prolong or improve quality-of-life

Blackhall 2011
Terminal Illness

- Life-limiting illness with death anticipated within months
- Limited options, if any, to prolong life

Blackhall 2011
Relationship- Palliative Care and Hospice

• Palliative Care - provided to those suffering from a life-limiting or life-threatening illness at any stage of that illness from diagnosis through treatment to cure or remission to death.

• Hospice - provided to patients with a terminal diagnosis when life expectancy is ≤ 6 months.
Traditional Model of Care

Curative Care
(= disease-specific, restorative)

Palliative Care
(= supportive, symptom-oriented)

Person with Illness
Disease Progression
Integrated Model of Care

- Curative Care
  (= disease-specific, restorative)

- Palliative Care
  (= supportive, symptom-oriented)

- Bereavement

- Diagnosis
- Dying
- Death

- Person with Illness
- Family
- Caregivers
- Disease Progression

Support services for families and caregivers
Models of Palliative Care

A

Curative-Restorative Care

Palliative Care

Onset of Disease

Time

Death

B

Curative-Restorative Care

Palliative Care

Onset of Disease

Time

Death

C

Curative-Restorative Care

Palliative Care

Onset of Disease Symptoms

Time

Death

Hospice

Bereavement
Natural History – Incurable Cancer
Natural History - Dementia

- **Prolonged dwindling**
- **High**
- **Low**

Function:
- Most frailty and dementia
- Onset could be deficits in functional capacity, speech, cognition
- Quite variable - up to 6-8 years

Time →
Natural History – Chronic, Life-Limiting Illness

Long term limitations with intermittent serious episodes

Function

High

Mostly heart and lung failure

Low

Sometimes emergency hospital admissions

2-5 years, but death usually seems “sudden”

Time →
Palliative Care Assessment Components

- **Pain/Symptom Assessment**
  - Are there distressing physical or psychological symptoms?

- **Social/Spiritual Assessment**
  - Are there significant social or spiritual concerns affecting daily life?

- **Understanding of illness/prognosis and treatment options**
  - Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?

Weissman 2011
Palliative Care Assessment Components

- Pain/Symptom Assessment
  - Are there distressing physical or psychological symptoms?

- Social/Spiritual Assessment
  - Are there significant social or spiritual concerns affecting daily life?

- Understanding of illness/prognosis and treatment options
  - Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?

Weissman 2011
Palliative Care Assessment Components

- **Identification of patient-centered goals of care**
  - What are the goals for care, as identified by the patient/family/surrogate?
  - Are treatment options matched to informed patient-centered goals?
  - Has the patient participated in an advance care planning process?
  - Has the patient completed an advance care planning document?

- **Transition of care post-discharge**
  - What are the key considerations for a safe and sustainable transition from one setting to another?
When Do I Refer to a Palliative Care Specialist?
Palliative Care Definitions

• Primary Palliative Care
  • Basic skills and competencies required of all physicians and other health care professionals

• Specialist Palliative Care
  • Specialist clinicians that provide consultation and specialty care
Palliative Care Screening Tool

• Basic Disease process (2 points)
  – Cancer (metastatic/recurrent)
  – Advanced COPD
  – Stroke (↓ fxn status at least 50%)
  – ESRD
  – Advanced cardiac disease
  – Other life-limiting illness
Palliative Care Screening Tool

• Concomitant disease process (1 point)
  - Liver disease
  - Moderate renal failure
  - Moderate COPD
  - Moderate CHF
  - Other condition complicating care
Palliative Care Screening Tool

- Functional status of patient (ECOG)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>fully active</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>limited strenuous activity</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>not working</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>limited self-care</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>disabled</td>
<td>3</td>
</tr>
</tbody>
</table>
Palliative Care Screening Tool

- Other criteria (1 point)
  - Not candidate for curative tx
  - Chooses to forego life-prolonging tx
  - Uncontrolled pain > 24 hours
  - Uncontrolled sx
  - Frequent ED visits
  - > 1 hospitalization for same dx in 30 days
  - Prolonged hospital stay, no progress
  - ICU with poor or futile prognosis
Palliative Care Screening Tool

• Scoring:
  total score = 2  No intervention needed
  total score = 3  Observation only
  total score = 4  Consider Palliative Care Consult
When Do I Refer to Hospice?
Who is Eligible for Hospice?

- Life expectancy of $\leq 6$ months as certified by two physicians
- Patient/ family have been informed of terminal diagnosis
- Patient/ family have elected palliative course of treatment
Medicare Hospice Benefit

- Eligible for Medicare Part A (hospital payments)
- Pt or agent chooses hospice care; signs off Part A and elects MHB
- Terminally ill (within six months of death) as determined by attending MD and hospice Medical Director
- Care provided by a Medicare-certified hospice program
- Does NOT have to be DNR/DNI
Medicare

- **Part A** – hospital insurance
  - hospitalizations, hospice, SNF, home health
- **Part B** – medical insurance
  - preventative care, physician office visits
- **Part C** – Medicare Advantage Plans
  - available through private companies
- **Part D** – prescription drug coverage
Hospice Treatment Team

- RN
- CNA
- SW
- Chaplain
- Volunteer
- Physician
Hospice – Places of Care

- Home 95%
- Long-Term Care Facility
- Hospice Inpatient Units
- Hospital
Levels of Hospice Care

• Routine home care
  • Patient’s home
  • Assisted living facility
  • Skilled nursing facility (BUT will not cover room and board)

• Continuous home care
  • Acute around-the-clock nursing for crisis to avoid hospitalization

• General inpatient care
  • For management of symptoms related to terminal diagnosis, impending death, psychosocial issues

• Inpatient respite care
  • Up to 5 consecutive days
Length of Medicare Hospice Benefit Coverage

- Initial certification period of 90 days
- Recertification period of 90 days
- Unlimited 60 day recertification periods (as long as patient continues to meet eligibility criteria)
- Patient may revoke benefit at any time
- Patient may re-elect benefit at any time
Who Pays for Hospice?

- Medicare
- Medicaid
- Private insurance
- Indigent patients
Medicare Per Diem Reimbursement Rates for Hospice Care (2011)

Routine home care: $146.63/day
Continuous home care: $855.79/day
Inpatient respite care: $151.67/day
General inpatient care: $652.67/day

Annual cap total reimbursement/patient: $23874.98
What Does Hospice Pay For?

- Medicines and biologicals
- DME
- Medical supplies
- Laboratory services
- X-ray and radiation therapy
- Emergency services
- Ambulance and transport services
- Short-term inpatient stays for acute symptom management
- 5-day respite placement
- Bereavement support and counseling services
- Use of interdisciplinary team
Costs

- **Milrinone $215.00/ day**
  - 0.5 mcg/kg/ml for 80 kg pt via pump
- **TPN $335.00/ day**
  - protein 80 gm, lipids 50 gm, dextrose 350 gm
  - 2000 ml via pump
- **Xifaxin $1,019.89/ 30 day supply**
  - 200 mg TID
Cancer

- Palliative Performance Scale ≤ 70
  - Reduced ambulation, unable to do normal work

  **AND**

- Requires assistance with ≥ 2 ADL’s

  **WITH**

- Disease with distant metastases at presentation

  **OR**

- Progression from earlier stage of disease to metastatic disease:
  - Decline in spite if tx
  - Patient declines further disease directed therapy
Pulmonary Disease

• Disabling dyspnea at rest
• Progressive pulmonary disease
• Hypoxemia at rest on supplemental O2
  – pO2 ≤ 55 mm Hg
  – O2 sat ≤ 88%

  OR

• Hypercapnia
  – pCO2 ≥ 50 mm Hg
Heart Disease

- NYHA Class IV
- Optimally treated with diuretics and vasodilators
- EF $\leq 20\%$
- Symptomatic arrhythmias
- Hx cardiac arrest and CPR
- Unexplained syncope
- Embolic CVA of cardiac origin
- HIV disease
Dementia

• FAST Stage 7C or above
  – Unable to walk, dress or bathe without assistance
  – Urinary and fecal incontinence
  – Unable to speak more than 5 intelligible words per day

• Severe co-morbid condition within past 6 months

• Unable to maintain fluid/caloric intake to sustain life

• If feeding tube in place:
  – Wt. loss > 10% in 6 months
  – Serum albumin < 2.5 g/dL
Liver Disease

- End-stage cirrhosis
- INR > 1.5 and albumin < 2.5 g/dL
- At least one of the following:
  - Refractory ascites
  - SBP
  - Hepatorenal syndrome
  - Hepatic encephalopathy despite tx
  - Recurrent variceal bleed
Renal Disease

- CRF: not HD candidate or stopping HD
- CC < 10 cc/min (< 15 cc/min DM) AND serum creatinine > 8 mg/dL (> 6 mg/dL DM)
- Associated conditions:
  - Uremia
  - Oligura: < 400 cc/24 hours
  - Intractable hyperkalemia: > 7.0
Adult Failure to Thrive

- Irreversible nutritional impairment
  - BMI \( \leq 22 \)
  - Declines enteral/parenteral nutritional support or not responding to such support

- Significant disability: Palliative Performance Scale \( \leq 40\% \)
  - Mainly in bed
  - Extensive disease
  - Requires assistance with most ADL’s
  - Normal or decreased intake
# Medicare Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Hospice</th>
<th>HHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homebound</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>100% med.</td>
<td>yes</td>
<td>no (80%)</td>
</tr>
<tr>
<td>100% DME</td>
<td>yes</td>
<td>no (80%)</td>
</tr>
<tr>
<td>HHA</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Inpt. Respite</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Skilled Cont. care</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Dietary Counseling</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Service</td>
<td>Hospice</td>
<td>HHC</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>Bereavement</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Volunteers</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Pastoral care</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Consulting MD $</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>24/7 on-call RN, MD, SW, counselor</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Service</td>
<td>Hospice</td>
<td>HHC</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>Medical SW</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>CNA</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Medications</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Services to NH residents</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
Local Hospices

• Hospice of the Piedmont
• Legacy Hospice
• Hospice of the Rapidan
• Good Shepherd Hospice
• Hospice of the Shenandoah
• SouthernCare Hospice
UVA Palliative Care

• Inpatient Consult Service
  – UVA Medical Center
  – TCH

• Palliative Care “Unit”
  – 3 East

• Clinics
  – Emily Couric Clinical Cancer Center
  – Radiation-Oncology Clinic
  – ALS Multidisciplinary Clinic