Understanding Palliative Care and Hospice

Aziz Ansari DO, SFHM, FACP
Associate Chief Medical Officer, Clinical Optimization and Revenue Integrity
Associate Professor of Medicine
aansar1@lumc.edu
Disclosures

• No significant financial relationships to disclose
Objectives

• Define Palliative Care (PC)

• Understand the impact Palliative Care can have on Quality and Healthcare Delivery

• Differentiate Palliative care from Hospice

• Identify common misconceptions of Hospice Care
Let’s Begin With A Case

• 62 year old woman with metastatic lung cancer

• Receiving second line chemotherapy with an ECOG of 1 (fully ambulatory) but has some dyspnea upon exertion and pain

• The oncologist refers to Palliative Care Clinic for symptom management saying:
  – “I am going to refer you to Palliative Care who specialize in end of life care”
  – “This is a team that will talk about goals of care and help control your pain and shortness of breath”
  – “But don’t worry...it’s not hospice”

• The patient is scared thinking “it is over” because of the conversation and when she Googled “Palliative care”, hospice was almost always mentioned in conjunction with palliative care
What Are The Roadblocks?

- Provider misunderstanding of PC
- Patient/Family fears of PC
- Lack of cultural humility
- Time limitations
- Providers “Fighting” the resistance
- Lack of true dialogue
Palliative Care:
A Real Need For Image Re-Branding
Palliative Care and Proximity Of Words: What Patients See and Hear

Palliative Care is a specialized medical care for people living with *advanced illnesses*. It focuses on symptom management. While *hospice* and palliative care both focus on relief of symptoms, palliative care goes *beyond end-of-life care*. It is *different from hospice, where a patient has to have a 6 month or less prognosis*, in that it can be offered at anytime of an *advanced illness*.
Palliative Care And Proximity Of Words: People will Remember the “Negative”

- Proximity of “Hospice” and “terminal” and “6 month prognosis” with palliative

- “Advanced Illness”
  - Synonymous with “death and dying” or “end stage” or “terminal”

- “Goals of care”
  - Is it not always our goal to care?

Meier, D. Words Matter: Improving the Palliative Care Message AAHPM 2017
What is Palliative Care?
Let’s Try This Again

• A recognized specialty with an expertise in the medical care for people with *serious illnesses* provided by an interdisciplinary team of physicians, advanced practice nurses, and *other specialists*

• It focuses on relief of symptoms, pain and stress of a serious illness

• It is *supportive care in collaboration with the patient’s other physicians* that aims to improve the quality of life for both the patient and family and *ensures that care is being delivered in accordance with the patient’s values and preferences*
Side by Side

“Standard” Definition

Palliative Care is a specialized medical care for people living with *advanced illnesses*. It focuses on symptom management. While *hospice* and palliative care both focus on relief of symptoms, palliative care goes *beyond end-of-life care*. It is *different from hospice, where a patient has to have a 6 month or less prognosis*, in that it can be offered at anytime of an *advanced illness*.

“Revised” Definition

- A recognized specialty with an expertise in the medical care for people with *serious illnesses* provided by an interdisciplinary team of physicians, advanced practice nurses, and other specialists.
- It focuses on relief of symptoms, pain and stress of a serious illness.
- It is *supportive care in collaboration with the patient’s other physicians* that aims to improve the quality of life for both the patient and family and *ensures that care is being delivered in accordance with the patient’s values and preferences.*
What is Palliative Care?
One-Liner

Palliative Care can be delivered at any stage of a serious illness and can be provided together with curative and life prolonging interventions

BOTTOM LINE:
We need to talk about what Palliative Care IS and NOT what it is not
Conceptual Shift for Palliative Care

Old

Life Prolonging Care

Medicare Hospice Benefit

New

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement

Dx

Death

Copyright 2008 Center to Advance Palliative Care. Reproduction by permission only.

Courtesy of Diane Meier, MD, Making The Case 2010
Objectives

• Define Palliative Care (PC)

• Understand the impact Palliative Care can have on Quality and Healthcare Delivery

• Differentiate Palliative care from Hospice

• Identify common misconceptions of Hospice Care
True or False:
Early Palliative Care Involvement may Improve Mortality
The Effects of PC on Quality of Patient Care: A Systematic Review of the Evidence

• Improved pain and symptom distress
• Improved quality of life
• Higher patient satisfaction
• Decreased hospital utilization and costs
• Improvement in Advance Care Planning
• Increased likelihood of death occurring outside the hospital
• No change in mortality and possible improvement in mortality rates

Kavalieratos JAMA 2016
Disparity of Healthcare Costs

- As of 2011, 5% of patients in the United States accounted for 60% of healthcare spending.
- 30% of Medicare expenditures are attributed to 5% of beneficiaries who die each year.
- About 1/3 of the expenditures in the last year of life is spent in the last month.

Truffer, et al. CMS; 2008
Meiier, DE. Going the Scale, CAPC 2011
Zhang, B. et al. Archives 2009
Economics of Palliative Care

• Meta analysis looking at six studies

• 93% of patients analyzed discharged alive

• PC Consultation within 3 days of admission and estimated direct cost savings per case:
  – $4251 per case for cancer diagnoses
  – $2105 per case for non cancer diagnosis
  – Greater reduction in costs with 4 or more co-morbidities

May et al. JAMA Internal Medicine 2018
Early vs. Late Palliative Care

- UCSF study looking at outcomes on solid tumor cancer patients receiving early PC (> 90 days) or late PC (< 90 days) before death

### Table 2. Quality and Utilization Measures Among Decedents (n=922)

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Early palliative care, n=93 (%)</th>
<th>Late palliative care, n=204 (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization in the last month of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admission</td>
<td>31 (33)</td>
<td>135 (66)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Intensive care unit admission^a</td>
<td>5 (5)</td>
<td>40 (20)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Emergency department visit</td>
<td>32 (34)</td>
<td>110 (54)</td>
<td>0.02</td>
</tr>
<tr>
<td>Emergency department, &gt;1 visit^a</td>
<td>5 (5%)</td>
<td>28 (14)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hospital</td>
<td>14 (15)</td>
<td>70 (34)</td>
<td>0.001</td>
</tr>
<tr>
<td>30-day mortality cases</td>
<td>31 (33)</td>
<td>135 (66)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Within 3 days of hospital discharge</td>
<td>15 (16)</td>
<td>80 (39)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Direct costs in the last 6 months of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>$19,067</td>
<td>$25,754</td>
<td>0.006</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>$13,040</td>
<td>$11,549</td>
<td>0.85</td>
</tr>
<tr>
<td>Combined inpatient and outpatient care</td>
<td>$32,095</td>
<td>$37,293</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

^aNational Quality Forum Measure/
Bold p value = statistically significant.
Consequences of a Late Referral to Palliative Care

Serious Adverse Outcomes for Bereaved Caregivers:

Compared to care at home with hospice,

- Care in ICU associated with 5X family risk of Post Traumatic Stress Disorder; and

- Care in hospital associated with 8.8X family risk of prolonged grief disorder

— Wright A et al. Place of death: Correlation with quality of life of patients with cancer and predictors of bereaved caregivers mental health. JCO 2010; Sept 13 epub ahead of print
### Does Having a EOL Discussion Help with Use of Burdensome Interventions?

**Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion**

<table>
<thead>
<tr>
<th></th>
<th>Total (N=332)</th>
<th>End-of-Life Discussion</th>
<th>Adjusted OR (95% Confidence Interval)⁸</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes (37.0)</td>
<td>No (63.0)</td>
<td></td>
</tr>
<tr>
<td>Medical care received in the last week</td>
<td>332</td>
<td>123</td>
<td>209</td>
<td></td>
</tr>
<tr>
<td>ICU admission</td>
<td>31 (9.3)</td>
<td>5 (4.1)</td>
<td>26 (12.4)</td>
<td>0.35 (0.14-0.90)</td>
</tr>
<tr>
<td>Ventilator use</td>
<td>25 (7.5)</td>
<td>2 (1.6)</td>
<td>23 (11.0)</td>
<td>0.26 (0.08-0.83)</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>15 (4.5)</td>
<td>1 (0.8)</td>
<td>14 (6.7)</td>
<td>0.16 (0.03-0.80)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>19 (5.7)</td>
<td>5 (4.1)</td>
<td>14 (6.7)</td>
<td>0.36 (0.13-1.03)</td>
</tr>
<tr>
<td>Feeding tube</td>
<td>26 (7.9)</td>
<td>11 (8.9)</td>
<td>15 (7.3)</td>
<td>1.30 (0.55-3.10)</td>
</tr>
<tr>
<td>Outpatient hospice used</td>
<td>213 (64.4)</td>
<td>93 (76.2)</td>
<td>120 (57.4)</td>
<td>1.50 (0.91-2.48)</td>
</tr>
<tr>
<td>Outpatient hospice ≥1 wk</td>
<td>173 (52.3)</td>
<td>80 (65.6)</td>
<td>93 (44.5)</td>
<td>1.65 (1.04-2.63)</td>
</tr>
</tbody>
</table>

Abbreviation: ICU, intensive care unit; OR, odds ratio.

⁸ The propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients’ treatment preferences, desire for prognostic information, and acceptance of terminal illness.

Changes in Health Care Utilization: Did We Really Improve?

**Increase in burdensome interventions:**
- **Transitions in last 3 days of life**
  - 70% of these transitions were to hospice
  - 1/3 of these hospice admissions were to General Inpatient hospice care
- **Increase in multiple hospitalizations in last 90 days of life from 2000 to 2009**

Teno et al. 309:5, JAMA 2013
Terminal Cancer Patients
Do early PC interventions help improve QOL and Survival?

• Those assigned to earlier intervention had statistically significant improvement in QOL scores and decreased levels of depression

• Even with less aggressive end of life care, the PC group had a longer survival
  • Median survival 11.6 months vs. 8.9 months (p=0.02) → 2.7 months

Case Continued

- Disease progresses despite chemotherapy

- Your patient has a great rapport with the palliative care team and is seen regularly in clinic and opts out of more chemotherapy

- 3 months later her performance status is worse with an ECOG of 3 (>50% of time in bed) and she is asking if she should enroll in hospice
Objectives

• Define Palliative Care (PC)

• Understand the impact Palliative Care can have on Quality and Healthcare Delivery

• **Differentiate Palliative care from Hospice**

• Identify common misconceptions of Hospice Care
HOSPICE IS NOT A PLACE

It is *intense palliative care* that requires a terminal condition and a physician certification of a 6 month prognosis.

It is an insurance benefit that allows more services and medications to be provided in the home to improve quality of life.
### Table 1. Palliative Care as Compared with Hospice.*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Palliative Care</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model of care</td>
<td>Interdisciplinary team, including physicians, nurses, social workers, chaplains, and staff from other disciplines as needed; primary goal is improved quality of life</td>
<td>Interdisciplinary team, including physicians, nurses, social workers, chaplains, and volunteers, as dictated by statute; primary goals are improved quality of life and relief of suffering (physical, emotional, and spiritual)</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Patients of all ages and with any diagnosis or stage of illness; patients may continue all life-prolonging and disease-directed treatments</td>
<td>Patients of all ages who have a prognosis of survival of ≤6 mo, if the disease follows its usual course; patients must forgo Medicare coverage for curative and other treatments related to terminal illness</td>
</tr>
<tr>
<td>Place</td>
<td>Hospitals (most common), hospital clinics, group practices, cancer centers, home care programs, or nursing homes</td>
<td>Home (most common), assisted-living facilities, nursing homes, residential hospice facilities, inpatient hospice units, or hospice-contracted inpatient beds</td>
</tr>
<tr>
<td>Payment</td>
<td>Physician and nurse practitioner fees covered by Medicare Part B for inpatient or outpatient care; hospital teams are included within Medicare Part A or commercial insurance payments to hospitals for care episodes; flexible bundled payments under Medicare Advantage, Managed Medicaid, ACOs, and other commercial payers</td>
<td>Medicare hospice benefit; standard hospice benefit from commercial payers is usually modeled after Medicare; Medicaid, although coverage varies by state; medication costs are included for illnesses related to the terminal illness</td>
</tr>
</tbody>
</table>

* ACO denotes accountable care organization.

Conceptual Understanding of Hospice

• Hospice is a philosophy and concept of care
  – Not a place or a building

• Hospice will not seek to hasten death

• The clinical goals are symptom relief and comprehensive support of the patient and family as a whole unit

• Psychological and spiritual pain are as significant as physical pain

• Bereavement care is critical to supporting surviving family members and friends

Slide Adapted from Kevin Henning, MD, “Hospice in the United States 2011”
AAHPM Hospice Medical Director Course, February 2011
What Does the “Medicare Hospice Benefit” Cover?

• Interdisciplinary team care enacted in 1982

• Medical equipment related to the palliation of the terminal illness

• Medications for symptom management related to the terminal illness

• Around the clock availability of staff for phone consultation

• Hospice Agencies do NOT provide for 24 hour in-home care or caregiver support
Hospice Interdisciplinary Team Members

- Hospice Nurse
- Hospice Medical Director
- Attending Physician
- Social Worker
- Counseling services:
  - Bereavement
  - Spiritual Counseling
- Home Health Aide
- Therapists
- Volunteers
Levels of Hospice Care

• Routine Home Care

• Continuous Home Care

• Respite Inpatient Care

• General inpatient care
Levels of Hospice Care: Routine Home Care

• Family and friends remain primary caregivers

• Hired caregivers
  – Cost NOT covered by hospice or medical insurance

• Home can be at a nursing home

• Nurse can visit as many times in the week as necessary based on medical necessity
Hospice in a Nursing Home
Why the Barriers?

• Long term care facilities
  – Services = Home services
  – Therefore Medicare Hospice Benefit does **NOT** pay room and board expenses at a skilled nursing facility since the routine care benefit is intended for HOME use

• Medicaid pays for custodial care so a nursing home (room and board) is covered if a patient is enrolled in hospice
Levels of Hospice Care: Continuous Home Care

- Periods of *intense* nursing needs in a patient’s home > 8 hours
- 51% of this care MUST be provided by a RN and the rest can be provided by home health aides
Levels of Hospice Care: Respite Care

• To relieve family members who are caring for the individual

• No more than 5 consecutive days at a time

• Often this takes place in a nursing home
Levels of Care

General Inpatient Care (Inpatient Hospice)

• Can be provided in a hospital or free standing inpatient hospice facility
  – Hospitals can have a dedicated “unit”

• Must require a SKILLED need that necessitates being in the hospital like uncontrolled pain or terminal agitation that can not be managed at home
  – Custodial issues are NOT a skilled need
  – Imminent death is NOT appropriate for inpatient hospice
Different types of Hospice Physicians

• Medical Director
  – Direct relationship with the hospice

• Attending of record
  – Physician most involved with the treatment of the hospice diagnosis
  – Hospice medical director can fill in as the Attending of record
Objectives

• Define Palliative Care (PC)

• Understand the impact Palliative Care can have on Quality and Healthcare Delivery

• Differentiate Palliative care from Hospice

• Identify common misconceptions of Hospice Care
Hospice: Fact or Fiction

• Patients can not be on inotropes for advanced heart failure on hospice

• Hospice means giving up hope

• Hospice is a place where there are rows of patients in cots waiting to die
Hospice: Fact or Fiction

• Once a patient opts out of hospice, they can not re-enroll in hospice

• Patients MUST be DNR

• Patients can not be on tube feeds nor get IV fluids

• Patients can not see their PCP or specialist in clinic
Hospice: Fact or Fiction

• Infections can not be treated on hospice

• Only medications used in hospice are opiates, benzodiazapines and anti-psychotics

• Hospice patients cannot get dialysis

• Patients need to be home bound
Hospice: Fact or Fiction

• Patients can never come back to the hospital

• Patients must opt out of hospice to get hospitalized for an unrelated condition to the terminal illness

• Physician goes to jail if they certify patients that live past 6 months
In Summary

• Remember to divorce palliative care from hospice in the same sentence

• Palliative care should be offered at any stage of a serious illness

• Hospice is simply a form of palliative care for patients who have a terminal illness allowing for more benefits to be delivered at home
Questions or Comments?