“Life is pleasant. Death is peaceful. It’s the transition that’s troublesome.”
Isaac Asimov (1920-1992)
Objectives

• Palliative care versus hospice care.
• Admission guidelines to hospice services.
• Having the conversation
• Role of the community Nurse Practitioner with a patient on palliative/hospice care.
Dying and Death in America

Disparity between the way people want to die and how they die

ELNEC, 2013
CHCF, 2013
Illness Trajectory

- Unexpected cause – sudden death
- Steady decline, short terminal phase - death
- Slow decline, periodic crisis – death
- Lingering, expected death
Palliative Care
pronounced pal-lee-uh-tive
Why would you refer someone to palliative care?
physical
social
spiritual
psychological
Palliative Care vs Hospice Care

- Life threatening illness
- Anytime during illness
- Alongside curative care
- Includes End of Life care
- Payor: billed to medical insurance

- Terminal illness
- Less than 6 months
- No curative care
- Focus on End of Life care
- Payor: Hospice benefit (private or Medicare)
Continuum of Care

- Disease-Modifying Treatment
- Palliative Care
- Hospice Care
- Bereavement Support
- Terminal Phase of Illness
- Death
Why would you refer someone to hospice?

Prognosis:

Six months or less if disease runs its natural course

Would I be surprised if this person died in the next six months?
Hospice Eligibility Criteria

These guidelines are divided into three parts:

• Part I – Decline in Clinical Status
• Part II – Poor Baseline
• Part III – Guidelines for Specific Diseases
A patient meets hospice prognosis guidelines if he meets criteria in:

• Part I

  or

• Part II & Part III
Part I

Decline in Clinical Status
Part II: Poor Baseline

Poor Functional Status (< 70 on PPS, Karnofsky) and dependent for 2+ ADLs

Additional Co-morbidities support eligibility …
Part III

Disease Specific
Alzheimer’s Dementia

FAST Stage 7A or worse
PLUS
Serious Complication

Slam Dunk:
FAST 7 + Event in past year
» Also consider debility criteria
Cancer

Metastatic Disease

or

Malignancy with poor prognosis (e.g. Small Cell lung, Brain, Pancreatic)

Slam Dunk:

Metastatic Aggressive Disease (pancreatic, brain cancer)
Heart Disease

Class IV Symptoms
and
Attempts have been made to optimally treat patient
Additional factors to support eligibility ...

Slam Dunk:
Class IV symptoms & failed optimal treatment
Lung Disease

Dyspnea at rest
and
Disease progression as evidenced by multiple ER visits, hospitalizations, or physician visits
and
O2 sat ≤ 88% on room air or pCO2 > 50

Additional factors to support eligibility ...

**Slam Dunk:**
Dyspnea at rest, progression,
    hypoxia or hypercapnea
Renal Disease

Discontinuing dialysis (or not starting)

or

Severe disease: CrCl <10 or <20 with DM & CHF

Slam Dunk:
Severe disease and No Dialysis
or stopping Dialysis
Liver Disease

INR >1.5 and Albumin <2.5
and
>1 of additional syndromes ...

Slam Dunk:
INR >1.5 and Albumin <2.5
and Refractory ascites
or Encephalopathy
ALS

No Plans for Mechanical Ventilation
and
No Plans for Tube Feeding
and either
Severe Nutritional Insufficiency
or
Impaired Breathing, evidenced by >3 of the following ...

**Slam Dunk:**
No mechanical ventilation, No tube feeding
and
Nutrition or Breathing impaired
HIV

CD4+ < 25 or Viral Load > 100,000 for two months
Plus one additional indicator ...
and
Karnofsky no better than 50%
Additional factors to support eligibility ...
Stroke

At best bed bound and total dependence for self-care and
Inability to maintain hydration and nutrition with > 1 of the following ...
Debility

Difficult prognostication
Weight loss 10% x 6 months
Functional Decline
Events
Also consider:
Progressive symptoms, co-morbidities
PEDIATRICS
The Patient Protection and Affordable Care Act (ACA) requires all state Medicaid programs to pay for both curative and hospice services for children under age 21 who qualify.
California

- Care coordination
- Home respite care
- Expressive therapies
- Out of home respite care
- Family counseling
- Family training
HOMELESS

Song et al, 2007
Psychiatric Co-morbidity
Continuum of Care

- Disease-Modifying Treatment
- Palliative Care
- Hospice Care
- Bereavement Support
- Terminal Phase of Illness
- Death
Case Study 1:

39 year old orthopedic surgeon with progressive neurological decline. Diagnosed with ALS. Married with a 4 year old.

Palliative Care

Wheelchair bound, dependent for all ADL’s, dysphagia but does not want a feeding tube, escalating pain

Hospice Care
Case Study 2:


Palliative care
Unable to tolerate chemotherapy, not a transplant candidate
Hospice care
Case Study 3:

89 year old man with Alzheimer’s Disease - FAST 6, escalating aggressive behavior

Palliative care

Hospitalized for pneumonia, develops a Stage II PU, lost 10% of body weight in last six months

Hospice care
Continuum of Care

- Disease-Modifying Treatment
- Palliative Care
- Hospice Care
- Bereavement Support
- Terminal Phase of Illness
- Death
Advance Care Planning

- ADVANCE DIRECTIVE
- POLST

necessitates a conversation

http://www.capolst.org/
http://www.agingwithdignity.org/five-wishes.php
COMFORT

Communication
Orientation and Opportunity
Mindfulness
Family
Openings
Relating
Team

Wittenberg-Lyles, Goldsmith, Ferrel & Ragan, 2013
NURSE PRACTITIONER ROLE

Identify appropriateness for services
Remain the Primary Care Provider
Palliative Care:
  Reimbursable as usual, Medicare Part B or private
NP Role

Hospice Care:
  Able to sign orders if Attending
  Bill Medicare Part B, modifier GV for services related to terminal diagnosis
  Modifier GW for services not related to terminal diagnosis

Cannot sign POLST
Cannot sign Certification of Terminal Illness
Cannot sign Death Certificate
Don’t cry because it’s over, smile because it happened

Dr Suess