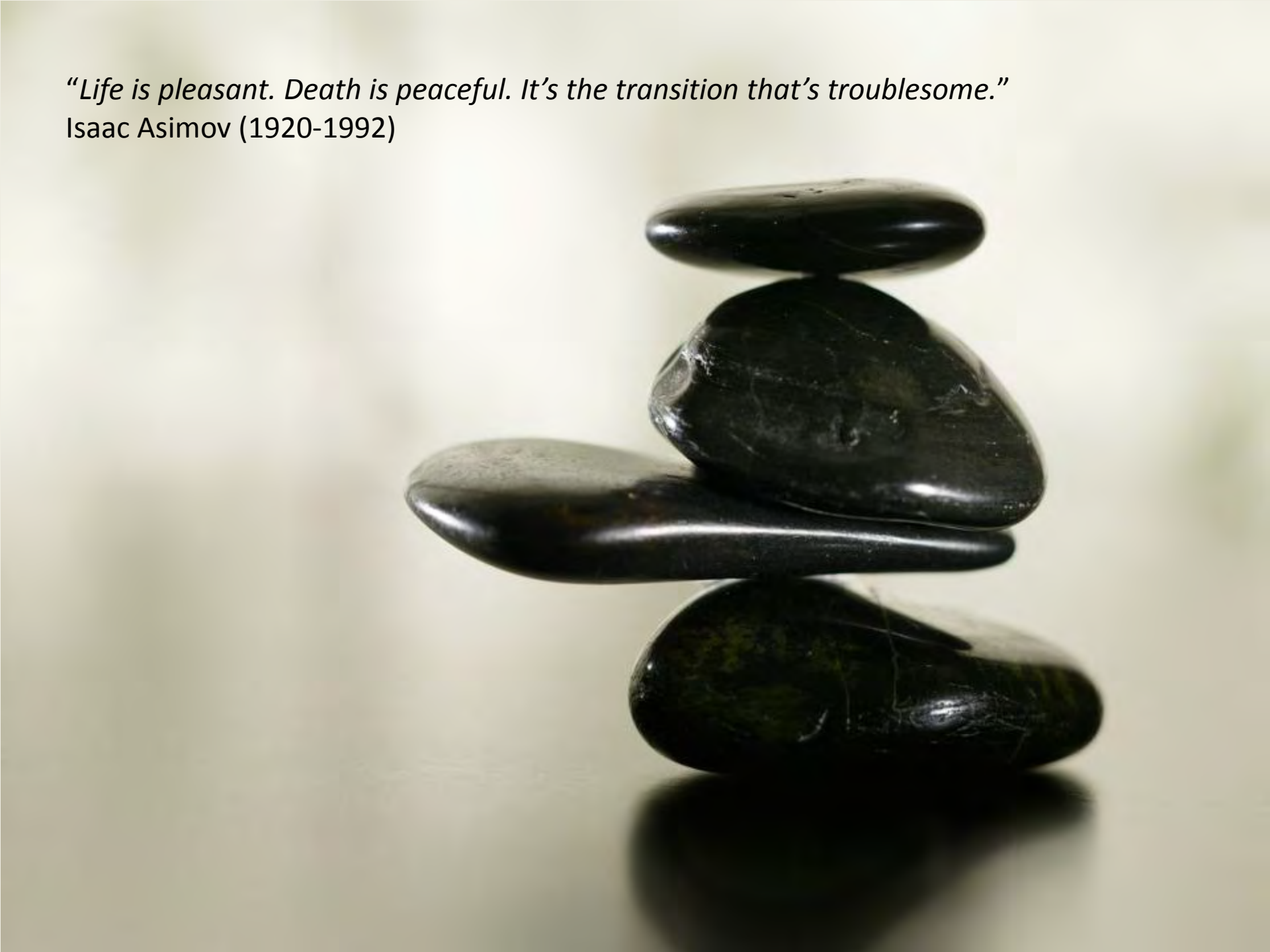
"Life is pleasant. Death is peaceful. It's the transition that's troublesome."
Isaac Asimov (1920-1992)



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


Dop-99

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?


Hospice Care

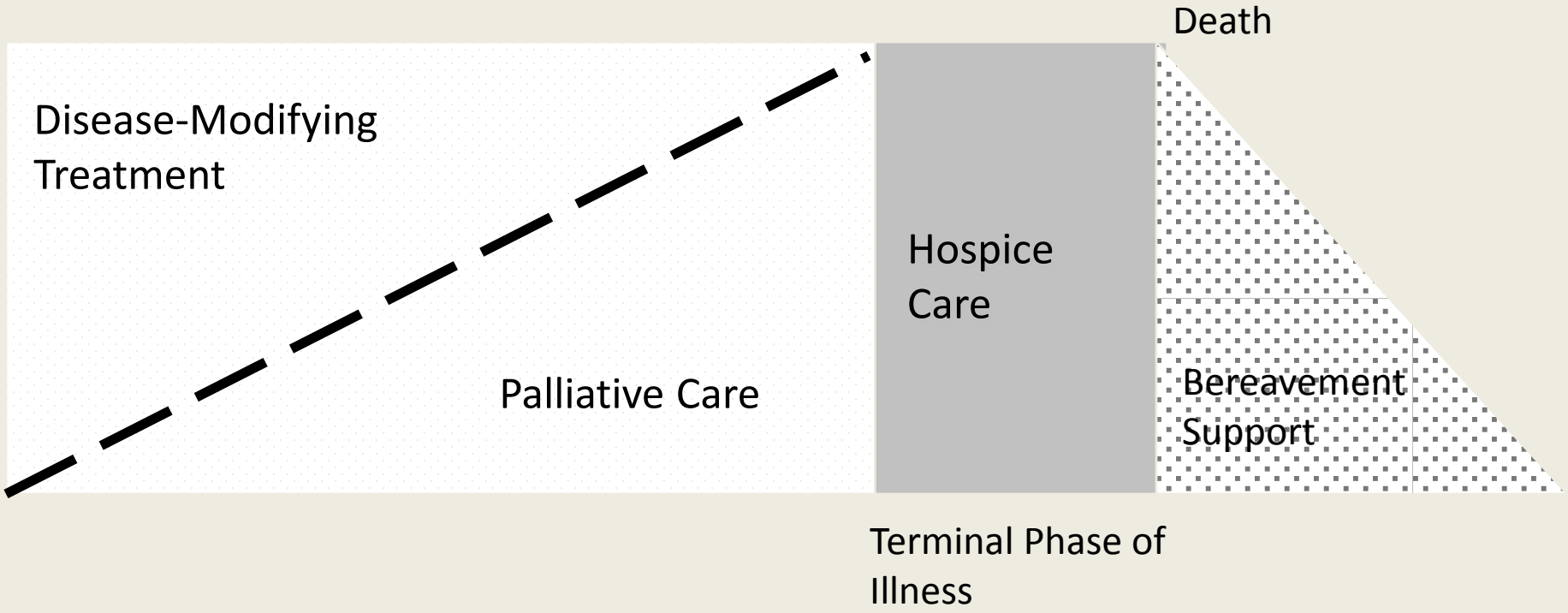

social
physical
spiritual
psychological

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



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

Simply

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

<u>Slam Dunk:</u>

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)

<u>Slam Dunk:</u>

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 …

<u>Slam Dunk:</u>

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 < or equal to 88% on room air or pCO2 > 50

Additional factors to support eligibility …

<u>Slam Dunk:</u>

Dyspnea at rest, progression,

hypoxia or hypercapnea

Renal Disease

Discontinuing dialysis (or not starting)

or

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

<u>Slam Dunk:</u>

Severe disease and No Dialysis

or stopping Dialysis

Liver Disease

INR >1.5 and Albumin <2.5

and

>1 of additional syndromes …

<u>Slam Dunk:</u>

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 …

<u>Slam Dunk:</u>

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

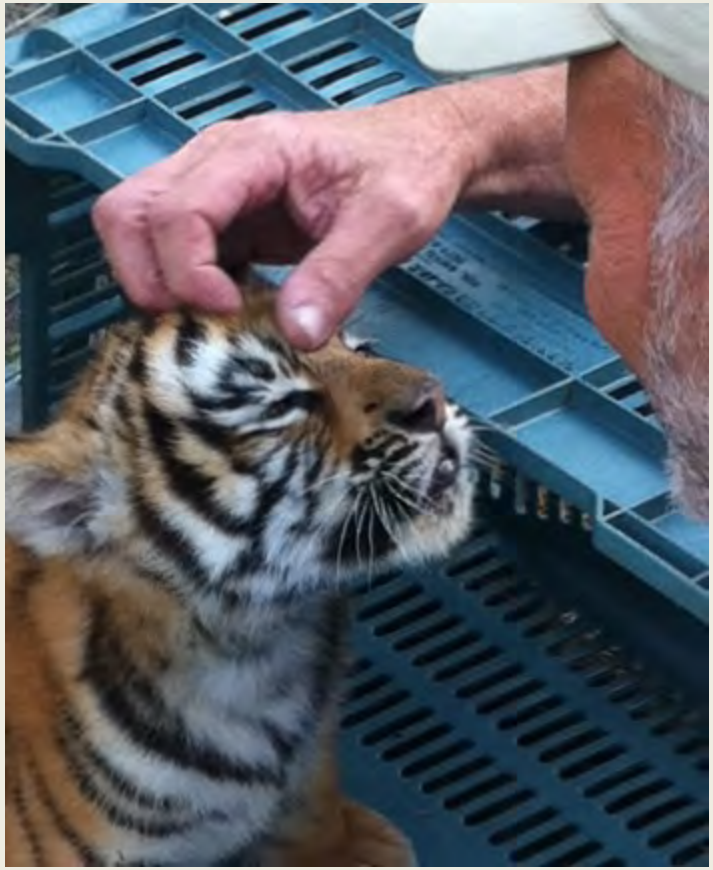
Functional Decline

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

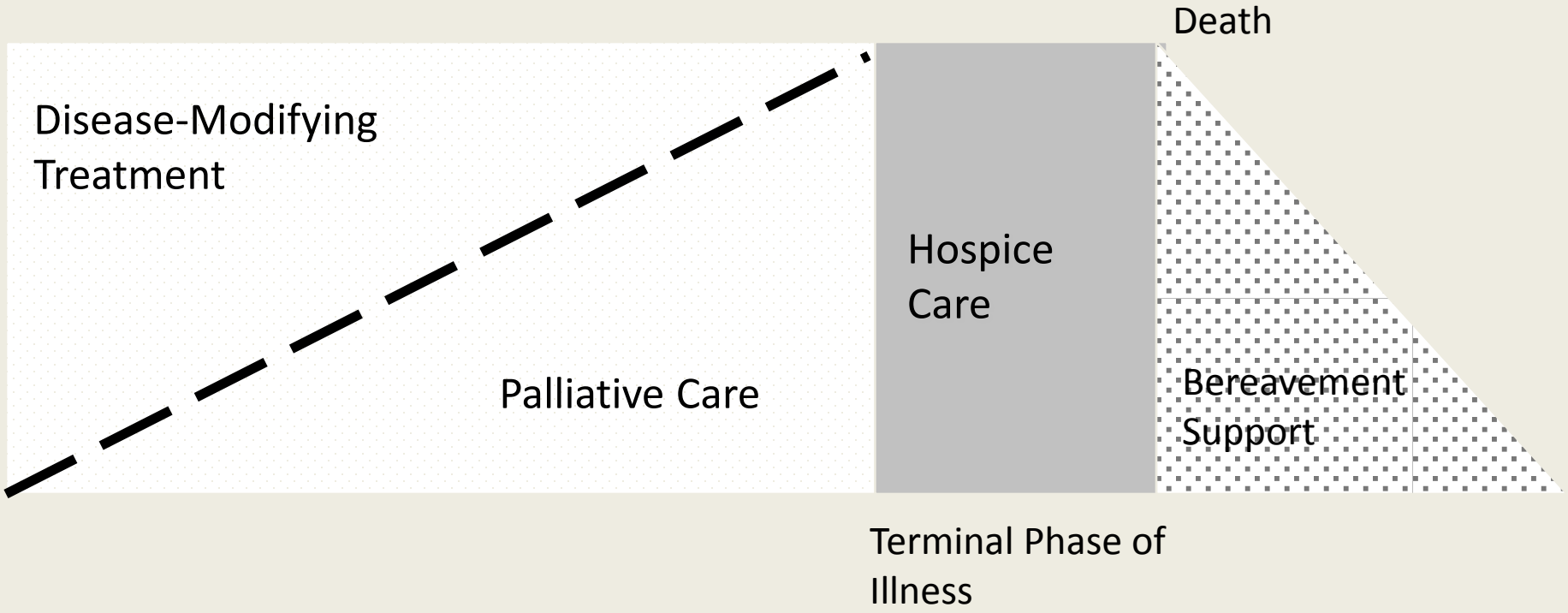
HOMELESS

Song et al, 2007

Psychiatric Co-morbidity

Foti,2003

Continuum of Care



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:

43 year old Korean man with abdominal pain. History of Hepatitis C, vertical transmission. Diagnosed with liver cancer, married with a 6 year old.

Palliative care

Unable to tolerate chemotherapy, not a transplant candidate

Hospice care

Case Study 3:

89 year old man with Alzheimer's Disease -

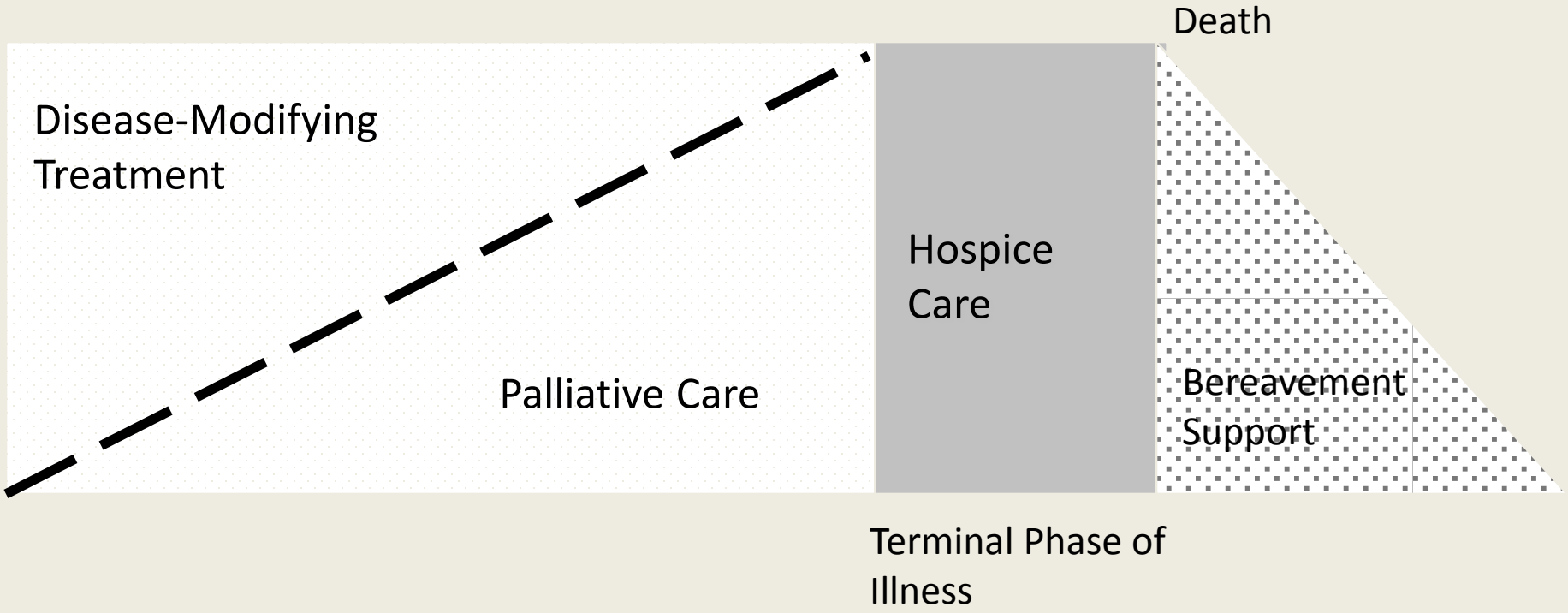
FAST 6, escalating aggressive behavior

Palliative care

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

Hospice care

Continuum of Care



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