



The Role of Hospice in Chronic Disease Management

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HOSPICE AND COMMUNITY CARE



Hospice and Community Care

- ▶ Offices located in Lancaster and York Counties
- ▶ 24 bed inpatient center located in Lancaster County
- ▶ Serve patients in Lancaster, York, Adams, Dauphin, Lebanon, Berks and Chester Counties
- ▶ Average Daily Census: 430 with about 25% served in facilities



Objectives

1. Describe hospice eligibility criteria for COPD, CHF, Failure to thrive and Dementia
2. Discuss common hospice interventions in support of high quality end of life care
3. Describe how hospice can support residents with chronic diseases, their families and facility staff

What is Hospice Care?

- ▶ Focuses on improving the quality of life for patients and their families faced with a life limiting illness
- ▶ Neither prolong nor hasten the dying process
- ▶ The primary goals are to provide comfort; relieve physical, emotional and spiritual suffering; and promote the dignity of terminally ill patients

What is Hospice Care

- ▶ Hospice treats the whole person, not just the disease
- ▶ Focuses on the needs of both the patient and family
- ▶ Care is provided by an interdisciplinary team including the patient and family, primary physician, hospice physician, nurse, chaplain, social worker, nursing assistant, bereavement counselor and volunteers
 - ▶ Therapy and dietician services are provided based on the patient's needs



Hospice/Facility Partnership

- ▶ Hospice and SNF/ICF must have a written agreement in place for hospice to provide care
- ▶ No written agreement is required for hospice to provide care in Personal Care/Independent Living

Hospice/Facility Partnership

- ▶ The nursing facility staff become part of the interdisciplinary team when a facility resident elects hospice care
- ▶ Important for each provider to recognize each other's knowledge and remain open to two way learning
 - ▶ Nursing facility staff are skilled in meeting the clinical, psychosocial and spiritual needs of their residents
 - ▶ Hospice staff are skilled at meeting the special clinical, psychosocial and spiritual needs at end of life



Hospice/Facility Partnership

- ▶ **Combined expertise allows the nursing facility and hospice to deliver the most comprehensive care for the patient and family**

Hospice/Facility Partnership

- ▶ **Successful partnerships between a hospice provider and nursing facility include:**
 - ▶ Acknowledgement and respect for each other's regulations
 - ▶ Developing an excellent communication process
 - ▶ Consistent coordination of care by the hospice and nursing facility
 - ▶ Development of a consistent plan of care
- ▶ **Consistent communication, coordination and documentation are key to success**

Hospice/Facility Partnership

- ▶ Facility patients continue to receive the same supportive care they were receiving prior to hospice's involvement
- ▶ Hospice provides supplemental support and care for the terminal condition

Hospice Location of Care

NHPCO National Data Set 2014

▶ Private Residence	45%
▶ Nursing Home	13%
▶ Assisted Living	10%
▶ Acute Care Hospital	11.2%
▶ Inpatient Hospice Facility	18%



Hospital Readmission Rate

Less than 5%

Payers

Patients served by payer source

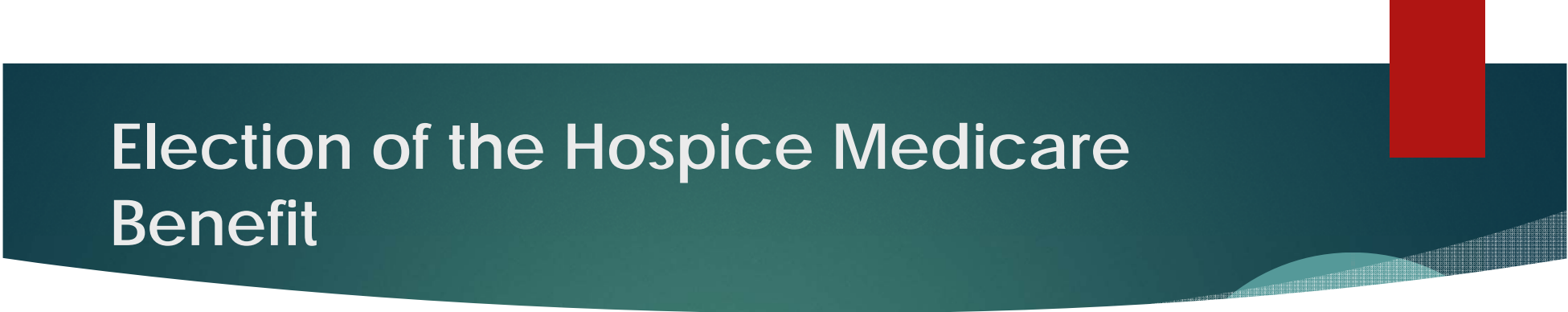
- ▶ Medicare 86%
- ▶ Private Insurance 7%
- ▶ Medicaid 5%
- ▶ Charity Care 1%

Hospice Admissions by Diagnosis

- ▶ Cancer 37%
- ▶ Heart Disease 15%
- ▶ Dementia 15%
- ▶ Lung Disease 10%
- ▶ Stroke/Coma 6%
- ▶ Kidney Disease 3%
- ▶ Liver Disease 2%

Medicare/Medicaid Hospice Eligibility

- ▶ **Prognosis of six months or less if the primary disease and related conditions run their normal course**
 - ▶ Certified as terminally ill by the patient's hospice attending physician and the hospice medical director
- ▶ **Eligible for Medicare Part A**



Election of the Hospice Medicare Benefit

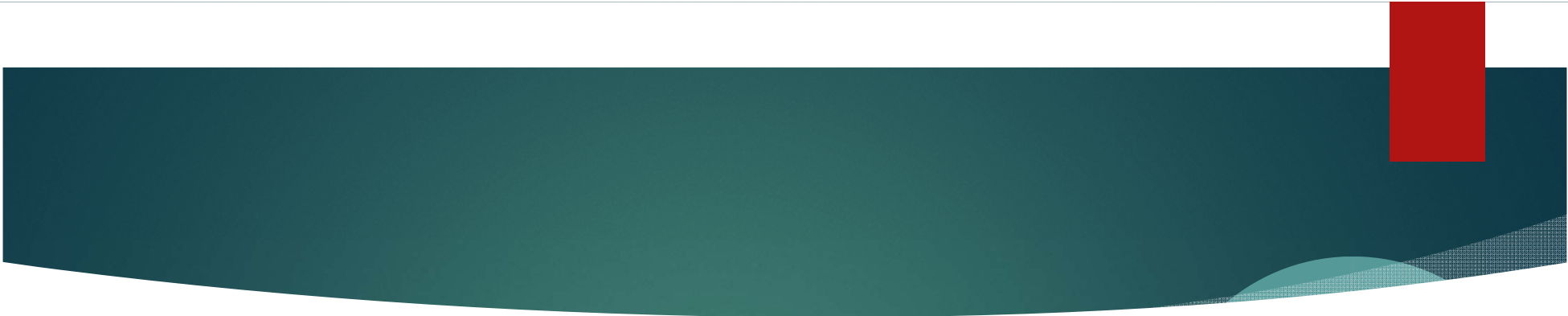
- ▶ The patient understands the palliative rather than curative nature of hospice care
- ▶ The patient waives rights to Medicare payments for all treatment related to the terminal prognosis with the exception of attending physician services

Hospice per diem reimbursement

- ▶ Interdisciplinary Team Support: RN, LPN, CNA, SW, chaplain, hospice physician, volunteers, bereavement counselors
- ▶ Medications, medical supplies, DME, hospital admissions and ER visits related to the terminal prognosis

Determining Medical Eligibility

- ▶ Evaluating prognosis is extremely difficult and generally inaccurate
- ▶ Numerous studies document that physicians are inaccurate when determining prognosis and frequently overestimate survival
 - ▶ In one study, cancer survival was over estimated by 4 weeks and correct to within 1 week in just 25% of cases



**Would you be surprised if
this patient died in the next
six months to a year?**

What to look for to determine Eligibility

- ▶ Recurrent or intractable infections
- ▶ Weight loss
- ▶ Decreasing serum albumin
- ▶ Dysphagia leading to recurrent aspiration or decreased intake
- ▶ SOB with increasing respiratory rate
- ▶ Intractable cough
- ▶ Nausea/vomiting
- ▶ Intractable diarrhea
- ▶ Pain
- ▶ Change in level of consciousness

What to look for to determine Eligibility

- ▶ Systolic B/P less than 90 or progressive postural hypotension
- ▶ Ascites
- ▶ Edema
- ▶ Pleural/pericardial effusion
- ▶ Weakness
- ▶ Change in level of consciousness
- ▶ Decreasing oxygen saturation
- ▶ Increasing creatinine or liver function studies

What to look for to determine Eligibility

- ▶ Declining functional status
- ▶ Increasing emergency room visits, hospitalizations
- ▶ Increased dependence on assistance for ADL's
- ▶ Progressive stage 3-4 pressure ulcers
- ▶ Multiple co-morbidities

Patients with Alzheimer's Dementia

- ▶ Stage 7 or beyond on the Functional Assessment Staging Scale (FAST)
 - ▶ 7a
 - ▶ Needs help with dressing, bathing
 - ▶ Incontinent of bowel and bladder
 - ▶ Speaks 5-6 words per day
 - ▶ 7b
 - ▶ Speaks only 1 word clearly
 - ▶ 7c
 - ▶ Can no longer walk

Patients with Alzheimer's Dementia

- ▶ **Functional Assessment Staging Scale (FAST)**

- ▶ 7d

- ▶ Can no longer sit up

- ▶ 7e

- ▶ Can no longer smile

- ▶ 7f

- ▶ Can no longer hold head up

Patients with Alzheimer's Dementia

- ▶ Unable to ambulate without assistance
- ▶ No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer words
- ▶ Have had one of the following in the last 12 months
 - ▶ Aspiration pneumonia
 - ▶ Pyelonephritis
 - ▶ Septicemia
 - ▶ Multiple stage 3 or 4 decubitus ulcers
 - ▶ Recurrent fever after antibiotics
 - ▶ 10% weight loss in the last six months



Patients with Alzheimer's Dementia

- ▶ Decreased appetite/inability to eat
- ▶ Increased periods of sleep
- ▶ Staying in bed for longer periods of time
- ▶ Frequent aspiration
- ▶ Decreased serum albumin

Patients with heart disease

- ▶ Hard to accept as a fatal disease because so often come to the brink of death only to recover
- ▶ Can put off decision making due to the nature of the disease
- ▶ No clear period when seen as dying-slowly decline with episodes of being relatively functional and stable punctuated by periods of life threatening illness that may well be appropriately treated with hospitalization



Patients with heart disease

For many heart failure patients, the day they die they will probably appear no more ill than any other day, in sharp contrast to patients who die from cancer, who will most likely be the most ill they have ever been on the day they die

Patients with Heart Disease

- ▶ **Classified as New York Heart Association Class IV**
 - ▶ Patient shows symptoms at rest and any physical activity increases discomfort
- ▶ Ejection fraction of <20%
- ▶ Symptomatic arrhythmias
- ▶ History of cardiac arrest
- ▶ History of unexplained syncope
- ▶ Brain embolism of cardiac origin

Patients with Heart Disease

- ▶ Use oxygen majority of the time
- ▶ Leaning forward propping hands on chair
- ▶ So SOB, they use a walker, wheelchair or scooter
- ▶ Decreased endurance
- ▶ Frequent ER or urgent visits
- ▶ Frequent episodes of bronchitis or pneumonia
- ▶ Decreasing ability to perform ADL's
- ▶ Unintentional weight loss (Patients are often too short of breath to eat enough)



Patients with heart disease

- ▶ Two or more heart failure hospitalizations in six months
- ▶ Increasing need for diuretics
- ▶ Serum sodium <136 mmol/L
- ▶ BUN >40 or creatinine > 1.8 mg/dL
- ▶ Hematocrit <35%

Patients with lung disease

- ▶ Disabling dyspnea at rest
- ▶ Decreasing response to bronchodilators
- ▶ Cough
- ▶ Fatigue
- ▶ Decrease ability to perform ADL's
- ▶ Bed to chair existence
- ▶ Unintentional progressive weight loss



Patients with lung disease

- ▶ Shortness of breath at rest or with minimal exertion
- ▶ Use of continuous oxygen
- ▶ Frequent use of ER
- ▶ Frequent hospitalizations
- ▶ Resting tachycardia $>100/\text{min}$
- ▶ Oxygen saturation $<88\%$ on room air



How hospice can help

- ▶ Discussion of prognosis
- ▶ Goals of care discussion
- ▶ Advance Care Planning
 - ▶ Having advance discussions about what might happen
 - ▶ Prevent crisis mode decisions
 - ▶ Discuss predictable events and plan for how to respond
 - ▶ Discuss ER visits and hospitalizations



How hospice can help

- ▶ Emotional support for patient, family and facility staff
- ▶ Spiritual support for patient, family and facility staff
- ▶ Extra level of care and presence for the patient
- ▶ Bereavement support for survivors
- ▶ Symptom management

Symptom Management

- ▶ Move from treating the disease to treating the patient
- ▶ Common end of life symptoms
 - ▶ Pain
 - ▶ Shortness of breath
 - ▶ Nausea/vomiting
 - ▶ Anorexia/cachexia
 - ▶ Delirium

Pain

- ▶ Pain under diagnosed and under treated in the elderly
- ▶ Reluctance to report
- ▶ Belief pain is normal in old age
- ▶ Fear of addiction and side effects

Pain

- ▶ Acute or chronic
- ▶ Location, onset, description, and possible etiologies
- ▶ Severity
- ▶ Aggravating and relieving factors
- ▶ Current medications
- ▶ Ability to take meds by mouth
- ▶ Desired degree of alertness

Pain

- ▶ **Nonpharmacological interventions**
 - ▶ Distraction
 - ▶ Imagery
 - ▶ Relaxation techniques
 - ▶ Breathing techniques
 - ▶ Meditation
 - ▶ Repositioning
 - ▶ Massage therapy
 - ▶ Music therapy

Pain

- ▶ **Mild Pain (1-3/10)**
 - ▶ Acetaminophen, Aspirin, NSAIDs

- ▶ **Moderate pain (4-6/10) or Severe pain (7-10/10)**
 - ▶ Mild pain med plus an opioid

Pain

- ▶ Consider routine dosing
- ▶ Start low and go slow
- ▶ Patients on opioids become resistant to respiratory depression within 48-72 hours
- ▶ Hypersomnolence precedes respiratory depression after initiation or increase of opioids
 - ▶ Narcotic agonists rarely necessary
 - ▶ Close observation until the effect diminishes is sufficient

Shortness of Breath

- ▶ Up to 75% of dying patients experience shortness of breath
- ▶ Assessment
 - ▶ Rate
 - ▶ Characteristics
 - ▶ Aggravating and relieving factors
 - ▶ Possible etiology
 - ▶ Current medication regimen
 - ▶ Pulse oximetry and/or CXR if clinically indicated

Shortness of Breath

- ▶ **Nonpharmacological interventions**
 - ▶ Provide cool environment
 - ▶ Cool cloth to the face
 - ▶ Fan
 - ▶ Elevate head of bed
 - ▶ Relaxation techniques
 - ▶ Provide emotional support and reassurance
 - ▶ Eliminate allergens and smoke
 - ▶ Position change
 - ▶ Pursed lip breathing

Shortness of Breath

- ▶ PRN dosing of previously ordered inhaled therapies
 - ▶ Evaluate use of inhalers vs. nebulized medications
- ▶ Morphine
- ▶ Lorazepam
- ▶ Diuretics for pulmonary edema
- ▶ Vasodilators for CHF
- ▶ Corticosteroids
- ▶ Bronchodilators

Infections

- ▶ Common in terminally ill patients
- ▶ UTI and respiratory most common
- ▶ Treated empirically based on clinical signs and symptoms

Infections

- ▶ **Goals of care**
 - ▶ Are you trying to eradicate the infection or control symptoms?
- ▶ **Can hepatic and renal function support antibiotic administration?**
- ▶ **Does the potential to prolong dying exist?**
- ▶ **What is the benefit/burden to the patient?**

Infections

- ▶ Use oral therapy whenever possible
- ▶ Particularly vulnerable to adverse clinical events
 - ▶ Allergic reactions
 - ▶ Drug interactions
 - ▶ Nausea/vomiting
 - ▶ C. difficile
 - ▶ Infusion related complications if IV therapy utilized



Nutritional Support Considerations

- ▶ **Goals of Care**
 - ▶ What would change for the patient if nutritional support started?
- ▶ **Benefit vs. Burden**
- ▶ **Life expectancy**
- ▶ **Quality of Life**

Dehydration Considerations

- ▶ No evidence to support administration of fluids at end of life
- ▶ Benefit vs. Burden
- ▶ Has an analgesic effect at end of life
- ▶ Need to ensure meticulous mouth care

Consider Discontinuing

- ▶ Physical, Occupational and Speech Therapy
- ▶ Turning schedules
- ▶ Weights
- ▶ Full meals
- ▶ Out of bed schedules
- ▶ Toileting Schedules

Consider Discontinuing

- ▶ Anticoagulants
- ▶ Antihypertensives
- ▶ Dementia medications
- ▶ Bisphosphonates
- ▶ Appetite Stimulants
- ▶ Vitamins
- ▶ Supplements
- ▶ Statins

Antipsychotics

- ▶ Use extremely challenging in the LTC environment
- ▶ May be very helpful in managing symptoms at end of life
- ▶ National Hospice and Palliative Care Organization working with CMS



Questions?



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