Partnering with Hospice - Setting Expectations: *How to avoid the ‘over-promise’*

Unity Grand Rounds
Tuesday, September 13, 2022
TODAY’S DISCUSSION

• Brief review of the relationship between Palliative care and Hospice

• How to Engage Patients and Families when making a Hospice referral

• Define Hospice services

• What attending for hospice means

• Explain Hospice Level of care (LOC) determination

• Understand how the Hildebrandt serves our community
Disclosure: COI

Adam Herman, MD – Executive Medical Director Palliative Medicine and Hospice Care Service Line, RRH
None

Erin Klinkman, MD – Hospice Medical Director, RRH Hospice
None

Michael DiSalle, MD – Interim Chief, Division of Palliative Medicine, Unity Hospital
None
Case: Should I refer to Hospice?

• 86y with Dementia, ‘moderate to severe’, DM2, HTN, dysphagia with PEG tube in place on artificial nutrition. Frequent hospitalizations for Failure to Thrive (FTT), UTIs with dehydration, responds to ABX and Hydration. Current weight is 128 lb. - 6 months ago was 130lbs. Her current MOLST is DNR/DNI. Able to hold some conversation, intermittent nausea, dyspnea, sun downing . Living at home with her son.

• Family just ‘wants her to be comfortable’

• Q: Should I refer to Palliative Medicine? Hospice?

• Q: Is this patient eligible for Hospice enrollment?
What does comfort mean?

- Family/Patient defined
  - Artificial nutrition?
  - BiPAP?
  - Hospitalization?
Criteria for Dementia -

Prognosis in Dementia is difficult.

• Advanced dementia PLUS

• Another qualifying condition such as
  • Non healing decubitus wounds stage III or IV
  • Weight loss >10% in 6 months, or albumin < 2.5
  • Upper UTI or other sepsis
  • Fever persistent on IV antibiotics
  • Dysphagia and aspiration
  • Other comorbid illness such as COPD, CHF, ESRD or liver disease
Case: Should I refer to Hospice?

Case: This patient has moderate to severe dementia, she is not able to take enough nutrition in orally, she has frequent UTIs...

• The family wants a medical plan focused on comfort, for the this includes PEG nutrition - Relatively stable weight, no skin breakdown. They are not sure about re-hospitalization.

• The patient at this time does NOT qualify for hospice enrollment based on health status and family wishes
Palliative Medicine is a team-based medical subspecialty focused on providing relief from the symptoms, pain and stress of serious illness.
What is Palliative Medicine?

Palliative Medicine is appropriate at any age and any stage in a serious illness, and it can be provided along with curative treatment.

Because palliative care services are based on patient and family need, not prognosis, palliative care teams respond to the episodic, complex, and long-term nature of serious illness.

Key Aspects:

1. Maximize quality of life and treat symptoms (pain, dyspnea etc.) to alleviate suffering
2. Patient and family centered
3. Uses multidisciplinary approach
4. At any stage of illness (you can pursue curative therapies)
5. Setting goals of care and enabling informed decisions and proactive care planning
6. Moves toward alignment of expectation and prognostication
Paradigms for Palliative Medicine

Diagnosis of serious illness

TC = Terminal Care
Case

• Patient goes home with home care services (and referral to outpatient palliative care)

• 3 months later patient has increased bloating and emesis on their tube feeds. Hospitalized and work up for reversible causes shows none. Weight is now 115lbs. Artificial nutrition is decreased further – despite this patient is not able to supplemental nutrition.

• Family want to ‘make sure she is comfortable’ They are not sure they can manage care at home.

• Q: is this patient eligible for hospice enrollment?
Case

• You don’t have to be sure if the patient is eligible or not

• Let the Hospice evaluators help you figure that out

• Be prepared that they may say they are
  • Appropriate
  • Not appropriate
  • Suggest palliative care follow
  • Recommend Complex illness home care ‘enriched care’
The Continuum of Care

Palliative Medicine

- Hospice Care
- End of Life Care
## Palliative or Hospice?

**The right service at the right time for seriously ill individuals**

Source: National Hospice and Palliative Care Organization

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<th>Question</th>
<th>Palliative Medicine Medical Subspecialty</th>
<th>Hospice Home Health Insurance Benefit</th>
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| **What is the focus?**          | • Palliative care is not hospice care; it doesn’t replace the patient’s primary treatment; palliative care works together with the primary treatment being received.  
• Focuses on pain, symptoms, and stress of service illness most often as an adjunct to curative care modalities.  
• It is not time limited. | • Hospice care focuses on pain, symptoms, and stress of serious illness during the terminal phase.  
• Terminal phase is defined by Medicare as an individual with a life expectancy of 6-months or less if the disease runs its natural course. |
| **Who can receive this type of care?** | • Any individual with a serious illness, regardless of life expectancy or prognosis. | • Any individual with a serious illness measured in months not years. (likely <6 months)  
• Hospice enrollment requires the individual has a terminal progress. |
| **Can patients continue to receive curative treatments?** | • Yes, individuals receiving palliative care are often still pursuing curative treatment modalities.  
• Palliative care is not limited to the hospice benefit. | • The goal of hospice is to provide comfort through pain and symptom management, psychosocial and spiritual support because curative treatment modalities are no longer beneficial. |
History of Palliative Medicine and Hospice Care at RRH

2008
- Unity launches Palliative Care Program
- Unity launches Outpatient Program

January 2011
- Launched Palliative Care Consult Services at RGH

July 2011
- RGH Hired 1st APP

2010
- Unity launches Palliative Care Program

2012
- Unity expands Physician FTEs
- RGH Hired 2nd APP

2013
- Unity receives Joint Commission Certification
- RGH Hired 3rd APP

2014
- Unity adds FT SW and FT PA
- RGH Hires 2nd MD SW FTE Added

2015
- Unity expands FT Providers
- RGH Hires 2nd O/P Session

2016
- Unity adds 2nd O/P Session
- RGH Hires 3rd MD

2017
- RGH Hires 3rd MD

2018
- RGH Infrastructure Growth
- LVAD Program Support

2019
- More Extensive Outpatient Program

Oct 2019
- HPM Fellowship Started

April 2021
- Medical Direction at RRH Hospice

July 2022
- Medical Direction at RRH Hospice

Today

ROCHESTER REGIONAL HEALTH
RRH Palliative, Hospice and Home Care Footprint

Lakeville (Livingston County); Newark (Ontario, Seneca & Wayne Counties)
Auburn (Cayuga County); Dundee (Schuyler & Yates Counties)
So you want a hospice evaluation...

- How we communicate this recommendation to the patient and family?
  - How do we avoid the ‘over-promise’
  - Our patients and family already have ideas... that may not be accurate... and they hang on every word we say
Frequent Hospice Misconceptions

• Hospice is a place to go
• Home hospice provides 24 hour care
• Comfort care is the same as hospice
• Hospice will “speed up” end of life.
• Electing hospice will allow patient to stay indefinitely in the hospital.
• Referring to hospice equals going to the Hildebrandt
Inpatient Hospice Evaluations

• Comfort care vs hospice vs end of life

• Who Is Hospice Right For?
  • Patients who have an expected prognosis of 6 months or less based on the usual disease course
  • Patients who want care in place (wherever they may live) and do not want to return to the hospital (except for symptoms that cannot be managed elsewhere)
  • Patients who want to focus on aggressive management of their symptoms
RRH Hospice Liaisons

• The hospice liaisons are based in the hospitals
• They meet with patients and families after referral to explain the hospice philosophy and services and assist with disposition.
• Liaisons follow hospice eligible patients while they are waiting for placement for possible change in status and/or prepare them for home discharge.
• When patients are highly acute with significant care needs, the Hildebrandt Inpatient Unit is the optimal destination. The liaisons coordinate with the hospice team and Hildebrandt teams to get eligible patients there.
Unity Hospice Liaisons
(Referrals can be made through Secure Chat)

Andrea Carroll
585-402-4385

Sarah Banker
585-683-5236
Rochester General Liaisons
Referrals: 585-642-1309 / Secure Chat
8:30am – 4:00pm

Mark Broussard   Tatum Mondo
Mary Verhulst

ROCHESTER REGIONAL HEALTH
Rochester General Liaisons

Molly Kundin

Annie Kummer
(weekend liaison)
How You Can Help The Hospice Team

• Provide a succinct but detailed rationale for why the patient is seeking a hospice plan
• Contact them as soon as you know you need a consult
• Don’t make promises about where patients will be cared for
• Let them meet (without you) with the patient and family and explain what a hospice plan for that patient will look like
• If you don’t know, ask!
LOC (Level Of Care) Determination

• Routine home care
  • Most common level of care in hospice. Patient is generally stable and the patient's symptoms, like pain or nausea and vomiting, are adequately controlled.
  • Usually provided in the home.

• General inpatient care
  • Crisis-like level of care for short-term management of out of control patient pain and/or symptoms
  • Usually provided outside the home, in an inpatient setting at a medical facility like a hospital or skilled nursing facility.

• Continuous home care
  • Crisis-like level of care for short-term management of out of control patient pain and/or symptoms
  • Usually provided in the home.

• Respite care
  • A level of temporary care provided in nursing home, hospice inpatient facility, or hospital so that a family member or friend who's the patient's caregiver can take some time off.
  • This level of care is tied to caregiver needs, not patient symptoms.
Reducing GIP in the Hospitals

- Ideally patients should receive hospice care in another location (most people do not see themselves dying in the hospital)
- When patients receive GIP care, they are occupying bed that could be used by patients who are acutely ill and/or curative measures over comfort measures
- If patients truly need this level of care, we can best serve most patients at the Hildebrandt Inpatient Unit
When A Patient Enrolls With Hospice in the Hospital

• In the hospital, their acute stay ends and they are readmitted for General Inpatient Care (GIP)

• Care focuses on symptom management, maximizing satisfaction, and optimizing administrative issues such as LOS and payment for care delivery

• Billing providers need to use the GV modifier
What Does Being the Hospice Attending Entail?

• Signing opening paperwork (the Certificate of Terminal Illness)
• Working with the patient’s case manager to manage symptoms
• Refilling medications/signing orders
• You can bill for visits using the GV modifier
History of Inpatient Hospice Care at RRH

1989
GRHC (Genesee Region Home Care) Inpatient Hospice Unit St Mary’s Hospital

2001
St. Mary’s Hospice Inpatient Unit expands from 6 to 10 beds

2007
Lifetime Care (fmr GRHC) opens Hildebrandt Hospice Care Center (11 beds)

2018
RRH acquires Lifetime Care Hospice

2022
Hildebrandt Continues the 34 year tradition of excellence in inpatient Hospice Care

Today
The Hildebrandt (HIPU)

- Hildebrandt Hospice Center – 11 Bed
  - Free-standing hospice facility
  - The only one in Monroe County
  - https://youtu.be/T1R0hf56y3E
3 basic types of patients at Hildebrandt

- GIP (acute); sx cannot be managed in another setting (acute hospice or hospital inpatient)
  - Parenteral meds (not just a CADD pump)
  - Complex nursing care (wounds and secretions)

- Respite (5 days stay); relieve caregiver stress

- Resident/SNF level care: cost to family, Medicaid, or private LTC insurance
Discussing comfort care and Hospice referral

• Setting up the hospice team for success

• Step 1: Is Patient/family ready for comfort focused care?
Step 2

• *Don’t skip step 1 !!*
Ready for hospice?

• “focus our efforts on comfort” rather than cure / longevity
• No longer ordering diagnostics, etc
• No return to hospital
• Life prolonging meds are discontinued
• No IVFs, tube feedings, etc.
• no SpO2 monitors, blood pressures

• If not ready, that’s ok!
The real step 2

• Where will hospice take place?

• This step you can (and should) skip!
Where should hospice take place?

• Resist having an agenda!
• Avoid the over promise (of inpatient care)
• Leave the details to the Hospice Liaisons
Acute hospice appropriate?

- 91 yo female, found down at home by dtr (who is HCP). Has massive hemorrhagic stroke. Completely Unresponsive, dense left hemiplegia. HCP elects comfort care. Pt is comfortable. No oral intake.
- Exam: Extremities are cool and mottled, no pulses.
- Very shallow resps, no distress, 15-20 sec apnea
- Requiring no medications for dyspnea nor pain.
• 71 yo male with h/o prostate ca and bladder ca in the past, was more recently dx’d with metastatic cholangiocarcinoma and malignant ascites. Admitted to Unity with refractory ascites, abd pain. Transitioned to comfort care with the support of the Palliative team.

• Pt and wife would prefer to be on home hospice. Over the next 24-48 hours, unable to transition from parenteral meds due to worsening sx.

• Hydromophone and antiemetics dose increased due to worsening abd pain and nausea.
What Hildebrandt provides

- Atmosphere, atmosphere, atmosphere

- High staffing ratios
  - Nursing
  - Nursing aides
  - Social work
  - Pastoral Care
  - Music therapy
Medical care

- Intravenous (PICC lines, triple lumen cath, mediports)
- Subcutaneous
- Around the clock and prn injections (IV or SQ)
- Infusions (CADD pumps SQ or IV)
- Complex wound care (except wound Vac)
- Tenckhoff, Aspira, Pleurex drains for chest and abdominal fluid
- Oxygen (prefer 6 litres at most)
- Wall suction
Questions?
thank you!