PALLIATIVE CARE VS HOSPICE

While the objective of both hospice and palliative care is pain and symptom relief, the prognosis and goals of care tend to be different.

HOSPICE IS.....

Comfort care with out curative intent, the patient no longer has curative options or has chosen not to pursue treatments because the side effects outweigh the benefits.

PALLIATIVE CARE IS....

Comfort care with or without the curative intent.

Hospice care is similar to palliative care, but there are important differences. Because more than 90% of hospice care is paid for throughout the Medicare hospice benefit, hospice patients must meet Medicare's eligibility requirements; palliative care patient do not have to meet the same requirements.

HOSPICE VS PALLIATIVE CARE DEFINITIONS.....

The definition of hospice care is compassionate comfort care (as opposed to curative care) for people facing a terminal illness with a prognosis of 6 months or less, based on their physicians estimate if the disease runs it course as expected.

The definition of palliative care is compassionate comfort care that provides relief from the symptoms and physical and mental stress of a serious or life limiting illness. "Upstream from hospice care. Palliative care can be pursued at diagnosis, during curative treatments and follow up, and at the end of life. It does not cure.

HOSPICE VS PALLIATIVE CARE ELIGIBILITY.....

Hospice eligibility requires two physicians to certify that the patient has less than six months to live if the disease follows it usual course.

Palliative care is begun at the discretion of the primary care physician and the patient at any time, at any stage of the illness, terminal or not. Focus is improved quality of life, and reduced inpatient and ED visits.

HOSPICE AND PALLIATIVE CARE TEAMS...

Interdisciplinary teams deliver both hospice and palliative care. They address physical, emotional, and spiritual pain, including such common worries as loss of independence, the well being of the family and feeling like a burden.

PAYING FOR HOSPICE VS PALLIATIVE CARE...

Hospice care costs are pain at 100% by Medicare. Medicaid and private insurance; hospice is the only Medicare benefit that includes pharmaceuticals, medical equipment, 24/7 access to care for emergencies, nursing social services, chaplain visits, grief support following a death and other services deemed appropriate by the hospice team.

By comparison, palliative care costs from office visits can vary. Many insurance companies are reimbursing the agency for palliative care services.

WHERE DO I RECEIVE HOSPICE OR PALLIATIVE CARE?

Hospice care is delivered where ever the patient calls home. Nursing homes, VA facilities, Assisted Living facilities. Target populations are Perinatal/Neonatal, pediatric, adult care and geriatrics.

WHAT KIND OF PATIENTS CHOOSE PALLIATIVE CARE?

Serious illness such as COPD, CHF, cancer, dementia, and Parkinson's disease.

CHARACTERISTICS OF A PATIENT WHO SHOULD RECEIVE PALLIATIVE CARE BUT NOT CURATIVE TREATMENT.

- The patient has limited ability to care for himself.
- The patient has received curative treatment and is no longer benefiting from it.
- The patient does not qualify for an appropriate clinical trial.
- There is no evidence that further treatments would be effective.

TALK TO YOUR FAMILY AND DOCTOR ABOUT YOUR GOALS OF CARE AND WHETHER PALLIATIVE CARE AND/OR HOSPICE MIGHT IMPROVE YOUR QUALITY OF LIFE!

Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sitting	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	—	—	—	—

Functional Assessment Scale (FAST)

1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.*
6	Occasionally or more frequently over the past weeks. * for the following A) Improperly putting on clothes without assistance or cueing . B) Unable to bathe properly (not able to choose proper water temp) C) Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) D) Urinary incontinence E) Fecal incontinence
7	A) Ability to speak limited to approximately ≤ 5 intelligible different words in the course of an average day or in the course of an intensive interview. B) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview C) Ambulatory ability is lost (cannot walk without personal assistance.) D) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) E) Loss of ability to smile. F) Loss of ability to hold up head independently.

*Scored primarily on information obtained from a knowledgeable informant.
Psychopharmacology Bulletin, 1988 24:653-659.

Hospice Eligibility Criteria

Patient has a terminal illness with a life expectancy of 6 months or less

CANCER

Pt meets ALL of the following:
1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing sx, worsening lab values and/or evidence of metastatic disease
2. PPS <70%
3. Refuses further life-prolonging therapy
OR
Continues to decline in spite of definitive therapy

Supporting documentation includes:
Hypercalcemia >12
Cachexia or weight loss > 5% in past 3 months
Recurrent disease after surgery/radiation/chemo
Signs/sxs of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

RENAL FAILURE

Pt refuses dialysis or renal transplant (or requests to discontinue dialysis)
AND
Creatinine clearance is <10 (<15 for diabetics)
AND
Serum creatinine >8 (> 6 for diabetics)

Supporting documentation for CRF:
Uremia, oliguria (urine output <400cc/24hrs), intractable hyperkalemia (>7), uremic pericarditis, hepatorenal syndrome, intractable fluid overload

Supporting documentation for ARF:
Mechanical ventilation, malignancy (other organ system), chronic lung disease, advanced cardiac disease, advanced liver disease

DEMENTIA

Stage 7C or beyond according to FAST Scale
AND
One or more in the 12 months:
Aspiration pneumonia
Pyelonephritis
Septicemia
Multiple pressure ulcers (stage 3-4)
Recurrent Fever
Inability to maintain sufficient fluid and calorie intake in past 6 months (10% weight loss or albumin <2.5)
Other significant condition that suggests limited prognosis

HEART DISEASE

CHF NYHA Class IV --> Significant sxs at rest
AND
Inability to carry out minimal physical activity without dyspnea or angina
AND
Optimally treated: diuretics, vasodilators, ACEI, hydralazine, nitrates
OR
Angina at rest, resistant to standard nitrate tx, and either not a candidate for/or declined invasive procedures

Supporting documentation:
EF ‹20%, treatment resistant symptomatic dysrhythmias
h/o cardiac related syncope, CVA 2/2 cardiac embolism
H/o cardiac resuscitation, concomitant HIV disease

HIV/AIDS

CD4+ <25 **OR** Viral load >100,000
AND
At least 1: CNS lymphoma, untreated or refractory wasting (loss of >33% lean body mass), MAC bacteremia, PML, systemic lymphoma, visceral ICS, RF on no HD, cyptosporidium infection, refractory toxoplasmosis
AND
PPS <50%

LIVER DISEASE

ESLD as demonstrated by:
PT> 5 sec **OR** INR > 1.5
AND
Serum albumin <2.5
AND
One or more of the following:
Refractory ascites, h/o SBP, hepatorenal syndrome, refractory hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documentation:
Progressive malnutrition, muscle wasting with dec. strength, ongoing alcoholism (>80 gm ethanol/day), hepatocellular CA HBsAg positive, Hep. C refractory to treatment

PULMONARY DISEASE

Patient has ALL of the following:
Disabling dyspnea at rest
Little/no response to bronchodilators
Decreased functional capacity --> bed to chair existence, fatigue, cough
AND
Progression of disease --> recent increasing office, home, ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure
AND
Documentation within past 3 months:
RA hypoxemia at rest (p02 <55 by ABG)
or 02 sat <88%
or hypercapnia pC02 >50

Supporting documentation:
Cor pulmonale and right heart failure, unintentional progressive weight loss

NEUROLOGIC DISEASE:

Chronic degenerative conditions such as ALS, Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)
Critically impaired breathing capacity, with all:
Dyspnea at rest, vital capacity <30%, needs O2 at rest, refuses artificial ventilation
OR
Rapid disease progression with progression from:
Independent ambulation to wheelchair or bed-bound status
Normal to barely intelligible or unintelligible speech
Normal to pureed diet
Independence in most ADLs to needing major assistance in all ADLs
AND
Critical nutritional impairment demonstrated by all of the following in the preceding 12 months:
Oral intake of nutrients/fluids insufficient to sustain life
Continuing weight loss
Dehydration or hypovolemia
Absence of artificial feeding methods
OR
Life-threatening complications in the past 12 months › 1:
Recurrent aspiration pneumonia, pyelonephritis, sepsis, recurrent fever, stage 3 or 4 pressure ulcers

STROKE OR COMA

PPS ‹40%
AND
Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ›1 of the following:
›10% weight loss in past 6 months
›7.5% weight loss in past 3 months
Serum albumin <2.5
Current history of pulmonary aspiration without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events

Supporting documentation includes:
Coma (any etiology) with 3 of the following on the 3rd day of coma:
Abnormal brain stem response
Absent verbal responses
Absent withdrawal response to pain
Post anoxic stroke
Serum creatinine > 1.5

***Other Terminal Illness

If pt does not meet any of the above guidelines, pt may still be eligible if documentation strongly supports a prognosis of less than 6 months
ie. Sepsis, Severe limb-threatening ischemia due to PVD

*Adult Failure to Thrive cannot be used as a principal dx

***Inpatient Unit (IPU) - Eligibility

Symptoms that cannot be managed in any other setting (i.e. pt requires IV pain medications/anti-emetics, uncontrolled dyspnea, frequent suctioning, intensive wound care)
Documentation of ongoing IPU eligibility required daily
Intended to be short-term
Imminent death - **only** if skilled nursing needs
Inpatient facilities ABQ, NM - Kindred Hospice and Presbyterian Hospice