Palliative Care to Hospice: Forging an Effective Partnership

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The “Old Days”

• Home Care or Hospice
  – There was a clear choice
  – Physicians needed to take a stand
    • Have the Hospice conversation or not
  – Patients needed to make a choice
Nowadays

• Many programs exist allowing patients and families to “pick and choose.”
• Physicians can delay “The Conversation”
• Palliative Care Programs offer choice of aggressive or comfort care
  – People can now seek Palliative expertise without giving up on life extending options
    • Hospital
    • Chemotherapy/Radiation
    • Infusions
    • Dialysis
What is Palliative Care?

• Palliative care is specialized medical care for people with serious illness focused on providing relief from the symptoms, pain and stress of the illness (Center to Advance Palliative Care)

• Palliative Care addresses:
  – Physical
  – Emotional
  – Psychosocial
  – Spiritual
Patient Directed Care

• Predicated on fact that only informed patients can give consent

• Advance Care Planning to direct own care
  – Discussion of Hospice vs PCP vs traditional care
  – Issues like DNR, hospitalization, intubation

• Documentation of wishes appropriately
  – POLST, other Advance Directives
Why Palliative Care?

- On average, palliative care and hospice patients may live longer than similarly ill patients who do not receive such care (Institute of Medicine report on Dying in America, 2014)
- Improves Quality of Life
  - Proactive in having patients direct care
- Improves Continuity of Care
  - Limits Fragmentation in patient care
- Provides alternative to aggressive, curative mode for patients not ready for Hospice
- Saves $$$
  - Avoiding even one ICU stay can be large savings
Fragmented Care

- Inadequate care coordination
- Poor provider communication
- Inadequate symptom management
- Inadequate medication management
Misdirected Expenditures

• Aggressive treatment near end of life
  – Often unwanted

• Multiple hospitalizations and ED visits
  – Inadequate preparation for discharge
  – Poor coordination of care
  – Poor post-acute follow up
  – Patients are particularly vulnerable at time of transition in care

• High utilization of services does not correlate with good health outcomes
Total Medicare Spending

- 28% in Last Year of Life
- 8% in Last Month of Life

US Dept. of Health & Human Services 2003

Dartmouth Atlas 2008
Where is Palliative Care Provided?

• Wherever you want it to be:
  – Hospitals
  – Outpatient Clinics
  – Home
  – RCFE’s
  – Often not available in SNF

• Lots of room for growth of Palliative Care in SNF’s
What Does Home Based Palliative Care Include?

• Assessment of symptoms
• Patient directed goals of care
• Medication monitoring
• Coordination of Care
• Community resource planning
• Advance Care Planning
  – Counseling re: EOL care
Sometimes Things Don’t Go According to Plan

“Sorry I’m late, but they had me on a life-support system for two months.”
What Does Hospice Include

• Hospice is End of Life Care
  – 6 month prognosis
• Hospice avoids life extending treatments
• Hospice generally able to offer more comprehensive end of life care
  – Chaplains
  – Volunteers
  – 24 hour on-call and time of death visits
  – Easier access to DME
What is the Right Referral?

• It Depends:
  – Patient and family goals of care
  – How advanced is the illness
  – Viability of various treatment options
  – Emotional adjustment to mortality
    • For patient and loved ones
The Conversation

• Every EOL conversation is unique
• Some are straightforward, some very long and difficult
• “The Conversation” is actually a process
  – Might take months
• Depends on many factors
  – Severity of illness
  – How recent and unexpected is diagnosis
  – Age
  – Cultural issues
Niagara Falls Death

[Image of Niagara Falls with sunrise and snow-covered branches]
“Niagara Falls Death”

• Maintaining Quality of Life as long and as well as possible

• When decline and death are inevitable it is rapid, limiting suffering

• Both Hospice and PCP’s can help with this
When is Hospice Appropriate?

• Short Prognosis

• Preference for home death

• Does not want hospitalization

• Is not pursuing active, life prolonging treatment
When is Palliative Care Appropriate?

• Wants aggressive treatment
  – PCP’s are not limited to comfort care
  – Patients can be on chemo, dialysis, transfusions, other procedures

• Does not want home death

• Not accepting of mortality

• Prognosis >6mos
Are Hospice and Palliative Care Compatible?

• Working with many of the same patients
  – In AIM 36% of our patients are Hospice eligible

• Hospice-eligible patients often land in PCP temporarily
  – Working through issues
  – Exploring treatment options
Be Careful What you Ask for

JUST SO YOU KNOW...

I NEVER WANT TO LIVE IN A VEGETATIVE STATE, DEPENDENT ON SOME MACHINE.

IF THAT EVER HAPPENS, JUST UNPLUG ME, OK?

OK.

Hey!
Do PCP Patients Eventually Transfer to Hospice

- Sutter AIM Program discharges 57% of patients to hospice
  - 18% die in AIM
- Prior to AIM only 25% of these patients went to Hospice
- Some patients never enroll in hospice
  - Emotionally not ready to accept hospice
    - Denial
  - Treatment wishes not compatible with hospice
    - Wanting to fight until the end
    - Wanting hospital death
Building Trust Between PCP’s and Hospice

• Territoriality issues

• Overlap in patients we serve can create:
  – Competition
  – Tension

• Patient wishes needs to be primary determinant
  – Assuming informed consent
Trust

• We need to know and understand each other
• Hospice and PCP both best for same patient but at different times
• We need to discern when each is best
• We need to “Hand Off” at the appropriate time
• In the big picture we are a tremendous asset to each other
Professional Education

• PCP’s and Hospice need to know, understand, and respect what the other has to offer
  – In AIM training we spend a lot of time educating staff re: what hospice can do that we can’t

• We need to avoid “Educational silos that impede the development of interprofessional teams.” (Institute of Medicine, 2014)
Same Agency Vs Outside Referral

• If PCP and Hospice are same company handoffs are easier
  – Choice is offered (of course)
  – Communication is easier, more effective
  – Trust more likely to be present

• Greater challenge is when referral goes to outside agency
  – Importance of building relationships is critical

• Financial motive needs to be avoided
Electronic Health Record

• Extraordinary opportunity for improvement in care coordination

• Can assure POLST and other Advance Directives are present for all providers to see
  – This alone can have profound impact

• To date large healthcare systems are mostly unwilling to interact with “competitors” in EHR
Pitfalls

• When PCP is hesitant to let go of their patients
  – “I just love my nurse”
  – And we just love to be loved

• PCP and Hospice staff need to be educated and embrace each other’s value
  – Appropriate care is generally one or the other
  – Determined by patient:
    • Goals of care
    • Treatment choices
    • Emotional adjustment
Building a Complementary Partnership

• PCP can avoid inappropriate Hospice referrals

• PCP can facilitate timely referrals to Hospice
Conclusion

• Hospice and PCP programs are perfect complement to each other

• The better educated staff and patients are the more optimally they can interact

• Cooperating together these programs can:
  – Improve Patient Care
  – Allow patient control and self-determination
  – Save money
What Questions do you Have?

I have time