Palliative and Hospice Care

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January,2023

Objectives

- Define palliative care
- Define hospice care
- Identify barriers to palliative and hospice care
- Discuss benefits of palliative and hospice care
- Review examples of patients appropriate for palliative and hospice care
- Identify similarities & differences between palliative and hospice care
- Review the palliative/hospice care referral process

Important Facts

- More than 90 million Americans are living with a serious illness, this will more than double over the next 20 years as the baby boomers age
- 68% of Medicare costs are for those with 4 or more chronic conditions
- More than 90% of people say it is important to discuss their wishes, only 32% have had such a conversation
- Palliative care saves more than $3,000 per patient per 3 day hospital stay
- Reduces re-hospitalization

"To care for those who once cared for us is one of the highest honors in life."
-Tia Walker

Spears, P., & Walker, T. (2013). The inspired caregiver: Finding joy while caring for those you love.

What is Palliative Care?

- Specialized team care for people living with a serious illness
- Focuses on providing relief from symptoms and stress of a serious illness
- Goal is to improve quality of life for the patient and family
- Interdisciplinary collaborative approach to care
- Provides an extra layer of support
- Appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment

Who is appropriate?

- Frailty
- Falls/Recurrent falls
- Dementia
- Parkinson's Disease
- COPD
- Liver disease
- Renal disease
- ALS
- Recurrent infections
- CHF
- Cancer

- Pain
- Fatigue
- Dysphagia
- Anorexia
- Nausea/Vomiting
- Wounds
- Depression/Anxiety

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work 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 Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

What is Hospice Care?

- Patient must have qualifying terminal diagnosis with prognosis of 6 months or less if disease progression takes natural course
- Hospice care includes visits from nursing, CNA, chaplain, social worker, volunteers
- 3 levels of care
  - Routine
  - General Inpatient (GIP)
  - Respite

Palliative Care v Hospice Care

- All hospice is palliative care, but not all palliative care is hospice.

PALLIATIVE CARE	HOSPICE
Treatment: Patients with life-limiting, chronic disease who may or may not still be seeking aggressive treatment(s)	**Treatment:** Patients with a prognosis of 6 months or less
Focus: Relief of symptoms, support of the family, improving quality of life	**Focus:** Relief of symptoms, support of the family, maintaining quality of life, dignified death
Services: The Palliative Care team utilizes and interdisciplinary approach in collaboration with the primary care physician to provide: • Time to discuss needs, concerns, and goals of care • Expert management of pain and other symptoms • Guidance with difficult and complex medical treatment options • Emotional support for patients and families to cope with the stress and burden of serious illness • Services are flexible and based on patient needs	**Services:** The Hospice team in collaboration with the primary care physician provides: • A registered nurse (RN) and certified nursing assistant (CNA) to care for the patients and provide ongoing support and education of the dying process • Hospice related medications that treat pain and control symptoms • Durable medical equipment and supplies needed in daily care of the patient • Emotional/spiritual support of social services and the chaplain • Bereavement counseling
Payment: Most insurance plans cover all or part of the palliative treatment. Medicare B and Medicaid also cover as well.	**Payment:** Hospice is a Medicare A benefit. It is also covered by Medicaid and private insurance.

Barriers to Palliative and Hospice Care

- Lack of training/education
- Cultural/Social/Religious beliefs
- Common misconceptions/misunderstandings
  - Only for those who are dying
  - Only for cancer patients
  - Palliative care is stepping stone to hospice
  - Fear of addiction with opioid use

Overcoming barriers…

- Collaborate
  - Include the patient and family
  - MD/NP
- Educate

- Consistency/Continuity

Palliative and Hospice Care Referral Process

- Talk to patient and family
- Obtain MD order
- Fax referral
  - Face sheet
  - MD order
  - Recent progress notes/reason for PC or Hospice
  - Medication list
- Once fax received, information will be reviewed, insurance verified, then, social worker/APN will contact patient/family for consents

Case Study

91 y/o female who sustained a fall at her ALF prompting hospitalization and then rehab at a skilled nursing facility. PMH includes but is not limited to hypercalcemia, hyperparathyroidism, HTN, CAD, GERD, remote hx of breast CA. She is a DNR, no artificial nutrition or dialysis. Following rehab course, 24 hour care was recommended et patient transitioned to LTC at the facility. Over 3-4 weeks time, patient had decreased appetite, ongoing weakness and fatigue. She was seen by the dietician et supplements were initiated however po intake remained poor. Further testing would reveal a parathyroid adenoma et patient was deemed to be a poor surgical candidate. She opted to continue conservative treatment with medications. Over the next several weeks her calcium levels would reach critical levels requiring IVF for the next 10 days at which point her calcium levels would normalize. Despite improvement in calcium levels, she develops new onset of cough and congestion along with low grade fever for which she was given diuretics and antibiotics, however she continued to decline.

Case Study

92 year old female who has a PMH of HTN, Dementia, DM, A-fib, OA, CVA, Depression, Dysphagia, Recurrent falls, Recurrent UTIs who was hospitalized most recently 2/2 UTI. She has now returned to her private home following a brief stay in a rehab facility. She lives with her spouse and daughter who serve as her primary caregivers. She requires assistance w/ ADLs, is able to ambulate short distances with her walker but does spend the majority of time in a chair. Family reports they have noticed a decrease in appetite but report that patient is still eating adequately, but "not like she used to." She has a history of falls, most recently over the weekend in which she sustained a skin tear to the left arm. Husband reports that the hospital trips are taking a toll on his wife. Home health care is following since recent return home for skilled nursing, PT/OT.

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