FOUR·SEASONS

Compassion for Life

Hospice • Palliative Care • Research • Elizabeth House

Palliative Care and Hospice Care 101 for Cardiopulmonary conditions

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Objectives

- What is the difference between Palliative Care and Hospice?
- What makes my patient eligible for Hospice?
- How can Palliative Care help my patient live with an advanced cardiac or pulmonary condition?

Palliative Care

- A medical specialty for people with serious illnesses that focuses on quality of life
- Is appropriate from the time of diagnosis of a serious illness
- Can be provided simultaneously with curative treatments
- Cardiologists' and Pulmonologist's treatments/care and Palliative Care are mutually enhancing, not mutually exclusive
- Provided at a hospital, nursing home, assisted living facility, or home.
- Covered by insurance like other medical specialties
- Goal of palliative care is to improve quality of life through relieving symptom burden (i.e. pain, dyspnea, constipation), assisting in making medical decisions, goal setting, coordination of care with all members of medical team, and psychological and spiritual support of the patient and their family
- Overall, palliative care can help patients live with a serious illness and better understand their choices for medical care

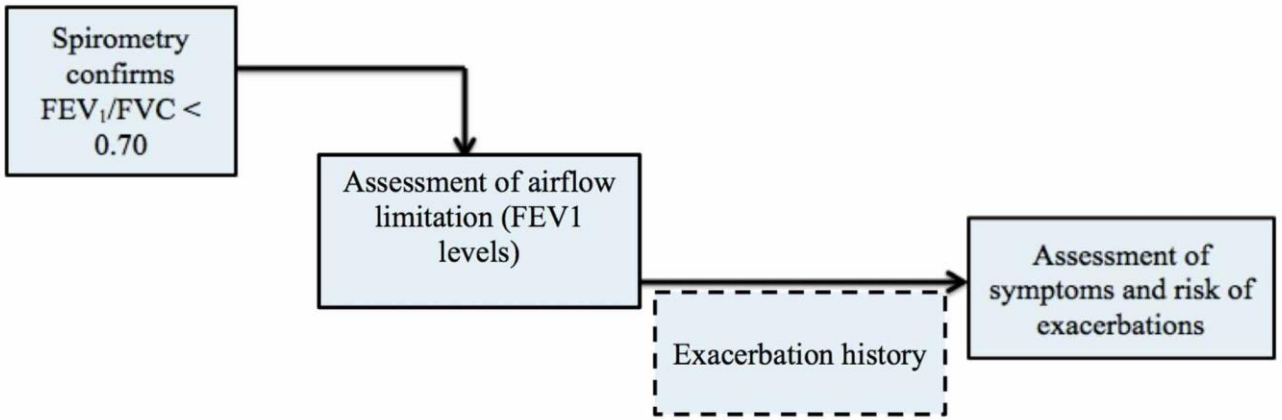
Triggers for Palliative Care Consult

- Frequent admissions – more than 3 in the last 6 months
- Difficult to control physical, psychological, or spiritual symptoms
- ICU length of stay greater than 7 days
- Medical decision making including PEG tube, RRT, LVAD, AICD placement, code status
- No advanced care planning
- Lack of understanding of illness, prognosis, and treatment options
- Concern or uncertainty regarding patient's care post discharge

COPD

- A progressive disease that affects >15million people in the United States.
- People in lower socioeconomic groups have increased prevalence and higher morbidity and mortality
- The prevalence, burden of morbidity and attributable mortality continue to rise.
- Affects both men and women,
  - 10.4% of women will be diagnosed by age 65-74yrs
  - 11.2% of men will be diagnosed by age 75-84yrs

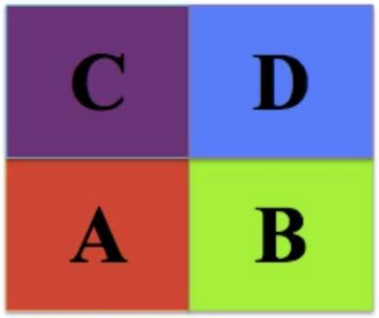
Staging….



All Patients with Confirmed Spirometry $FEV_1/FVC < 0.70$ (FEV_1 Values after being given bronchodilator)	
GOLD 1	$FEV_1 \geq 80\%$
GOLD 2	$50\% \leq FEV_1 < 80\%$
GOLD 3	$30\% \leq FEV_1 < 50\%$
GOLD 4	$FEV_1 < 30\%$

HIGH RISK: ≥ 2 exacerbations or ≥ 1 resulting in hospital admission in the last 12 months

LOW RISK: ≤ 1 exacerbation not resulting in hospital admission in the previous 12 months



Predictors of Increased Mortality in COPD

Increased Risk of Dying within 12 months	6 month mortality of 30%-40%	2 year Mortality of 30%-40%	Comorbidities associated with Increased risk of Death
1. Best FEV1 <30% predicted	Using SUPPORT criteria: 2 of the following for hospitalized patients	Highest quartile on the BODE index (score of 7-10)	Oncologic.. Lung, pancreatic, esophageal, breast.
2. Increasing dependence on caregivers	1. Baseline PaCO2 >45mmHg	B >21 0 <21 1	Pulmonary Pulmonary fibrosis
3. Activity limited to a few steps without need to rest	2. Presence of Cor Pulmonale	O FEV1 36 -49% 2 FEV1 <35% 3	Cardiac Atrial fibrillation, CHF, CAD.
4. Depression	3. FEV1 <0.75L	D mMRC score 3 2 mMRC score 4 3	GI Peptic ulcers, Liver Cirrhosis
5.No Spouse	4. Previous episode of respiratory failure within past 12 months	E walks 150-249m in 6mins 2 Walks <149m in 6 mins 3	Endocrine Diabetes with neuropathy
6. Recurrent hospitalizations in past year			Psychiatric Anxiety
7. Associated chronic illness			

Pulmonary Rehab

- People living with advancing COPD often decrease their activity as a response to increasing symptoms
- The cycle of resultant deconditioning and increased symptoms can be ‘never ending’
- Pulmonary Rehab can help with this, especially when combined with palliative care.

Symptom management

- Dyspnea
- Fatigue
- Cough
- Anxiety
- Depression
- Anorexia
- Irritability

How Palliative Care can help

- Symptom management
- Prescribing
- Evaluation of psychosocial issues
- Referrals to other organizations or services
- Goals of Care discussions
- Advance Care Planning

Heart Failure

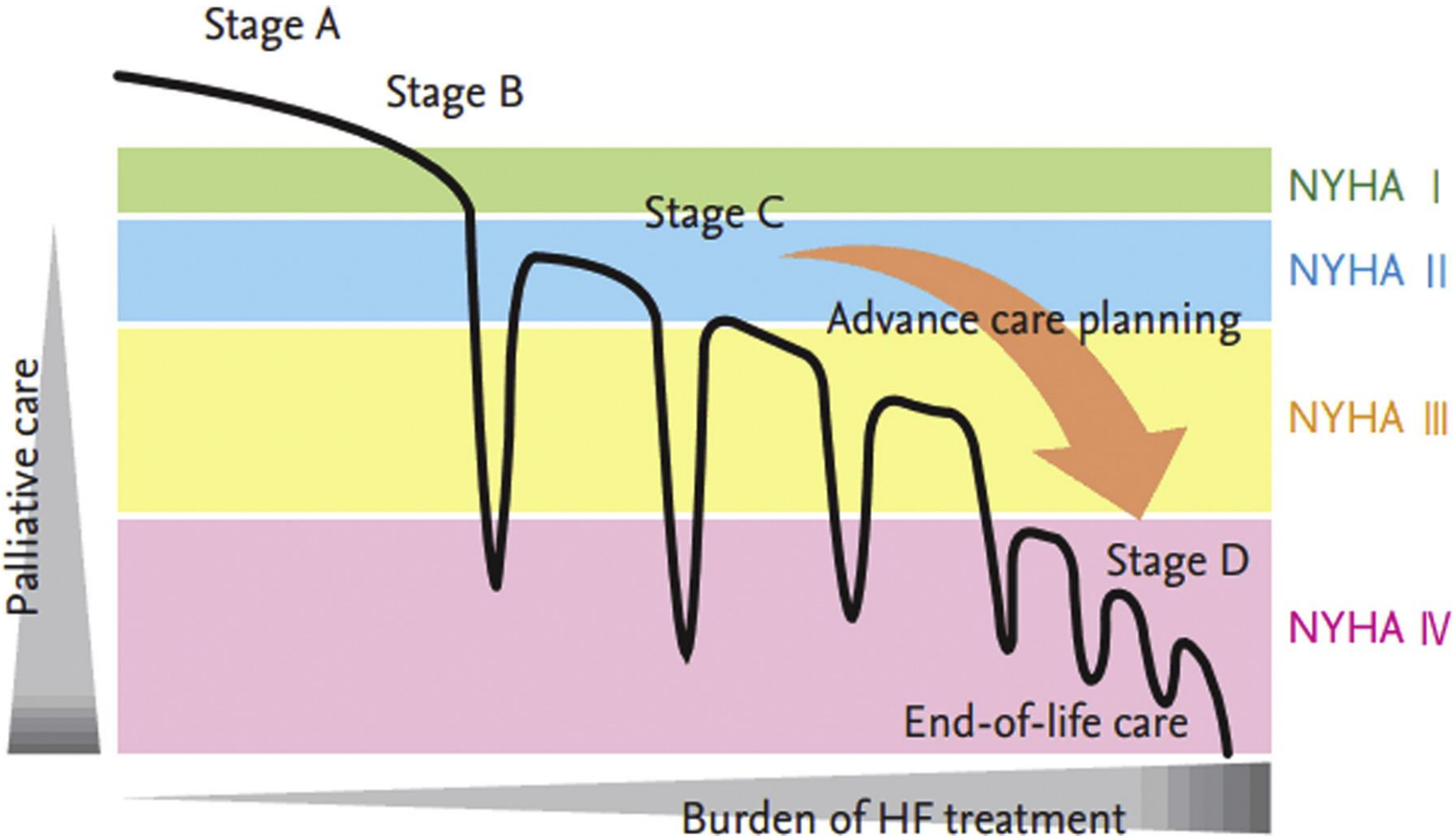
- Cardiac Disease is a leading cause of death
- Significant portion is due to Heart Failure

Classification of Heart Failure

- A At risk for HF, but no S/S or structural changes
- B Structural heart disease, but no S/S of HF
- C Structural heart disease with prior or current symptoms of HF
- D Refractory HF req specialized interventions.

- I No limitations to activity
- II Slight limitation of physical activity, Comfortable at rest, Sx with exertion
- III Marked limitations of physical activity. Comfortable at rest,
- IV Unable to carry on any physical activity without symptoms of HF, or has symptoms at rest.

Prognosis and trajectory



HF Survival score

- Seattle Heart Failure Model… predicts mean 1, 2 and 5 yr survival.
- Heart Failure Survival Score.. Helps stratify patients awaiting heart transplant

Both validated models to help identify survival rates for people with advanced heart failure.

Increased risk factors contributing to poorer prognosis:

Ischemic etiology for HF, Low EF, Low SBP, Low serum Na, More severe NHYA classification.

Palliative Care in Heart Failure

- Symptom management for symptoms common in HF
- Better to be involved earlier in disease trajectory for relationship building .. Recommend Class I or II stage B or C at latest
- Shared decision making, patient autonomy with medication algorithms.

What might the future hold? End Stage Issues

- Increased symptom burden
- Potential withdrawal of life prolonging therapies .. Even if for adjunct or co morbid conditions
- Increased need for Family support
- Caregiver burden/stress and even burnout.
- Existential issues

Crucial Conversations

- Benefits vs Burdens of interventions
- Where does care take place?
- Who makes decisions?
- Timing?
- Family meetings
- Goal concordant care
- Decreasing hospitalizations

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The Final Chapter

Moving from serious illness to end of life

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

Definition	An interdisciplinary consult service which focuses on providing care for patients with serious illness. Services can be provided at the same time as curative/life-prolonging care if desired.	An interdisciplinary approach to providing care for patients at the end of life that focuses on pain and symptom management. Comfort is the primary goal.
Eligibility	• Physician order • Diagnosis of a serious illness at any stage of a disease, ideally early in the course of an illness	• Physician order • Diagnosis of a terminal illness • Certification by a physician of prognosis likely to be 6 months or less.
Goals of Care	• Disease education and assistance with deciding on treatment options • Pain and other symptom management • Assistance to cope with the stressors of living with an illness	• Pain and other symptom management • Improved quality of life • Support the natural process of dying
Scope of Services	The interdisciplinary team includes a doctor, nurse practioner, social worker, and chaplain. The nurse practitioner (an advanced nurse who functions similarly to a doctor) makes visits an average of once each month. On-call services are not available. A social worker and chaplain are available on a limited basis if needed. All care is coordinated with the patient's regular doctor.	Interdisciplinary team including doctor, nurse, nurse aide, social worker, chaplain, and volunteers. The patient's regular doctor can continue as the hospice doctor. The nurse makes visits at least weekly. There is the availability of an on-call nurse 24 hours a day for crisis. Bereavement support available to family for 13 months after the death.
Location Services Provided	• Home • Skilled Nursing Facility • Assisted Living Facility • Hospital	• Home • Skilled Nursing Facility • Assisted Living Facility • If patient requires inpatient level of hospice care, needs to be in the Elizabeth House or a contracted facility with 24-hour registered nurse coverage. • Hospital
Payor Source	As with any consult service, insurance will be billed for the physician's services. Medicare part B will pay 80% of these charges; the remainder is billed to either a secondary insurance or to the patient. ***We are committed to providing services regardless of insurance coverage or ability to pay.***	Patients elect their hospice Medicare benefit; the majority of hospice services are paid at 100%, including medical equipment and some medications. There may be out of pocket expenses for room and board charges at a facility. Most private insurances also have a hospice benefit
Restrictions	No restrictions, patients may continue to receive curative/life-prolonging treatment.	• May not receive curative/life-prolonging treatment at the same time as hospice care. • May be unable to use Medicare skilled days for payment of long term care

Hospice Care

- A type of palliative care for people with a serious or terminal illness who are no longer pursuing aggressive treatments.
- Generally, hospice is for people with a prognosis of less than 6 months.
- Provided at home, a nursing home, or in an inpatient hospital facility.
- Goal of hospice is also to improve quality of life by providing physical, spiritual, and emotional comfort. However, hospice care can not be given with curative or aggressive treatment.
- Paid for in full by the Hospice Medicare benefit. Most insurances will also cover hospice services in full or with minimal co-payments
- Patients have to meet certain criteria for in patient level hospice care; uncontrolled symptoms, imminent death, sudden loss of caregiver

- To determine if someone is eligible for hospice care, ask yourself, would you be surprised if this person dies within six months?
- To determine if someone is appropriate for hospice, ask whether the goals are to stop aggressive, curative treatments and focus on symptoms, comfort, and Quality of Life

Hospice Myths

- "you can't have hospice if you are still driving"....Yes you can, many patients travel whilst under hospice care.
- "you have to have someone at home"... No, you may live alone, the team will help work on a plan for safety or emergency situations.
- "you have to be a DNR"...No, you can request resuscitation attempts, the team will work with you
- "if you don't die in 6 months they will kick you out" ... You can not be discharged from hospice unless you no longer meet criteria, a doctor or Nurse Practitioner must see you every 60 days to re-evaluate your condition.

What does Hospice look like?

- Can be delivered wherever the patient lives
- A team of clinicians works together to determine an individualized plan of care
- Nursing visits at least every 2 weeks, most often at least weekly… depending on need… 24hr on call capability
- Medical providers to see the pt where they reside
- CNA assistance with personal care needs 2 -3 times weekly
- Social Work help with resources and counseling
- Chaplaincy opportunities for spiritual counseling/ support
- Music Therapy for help with symptoms
- Grief Support services for 13 months following the death of the patient.

What else does Hospice provide?

- Covers medications to provide comfort and help manage the disease
- Covers equipment needs such as a hospital bed, wheelchair or bedside commode.
- Covers some supplies, bed pads, wound care, diapers etc
- Covers oxygen and other equipment like a nebulizer or respiratory support device

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