Comparing & Contrasting Palliative Medicine and Hospice Care

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Disclosure

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Agenda/Objectives

- Define Palliative Care
- Discuss History of Palliative Care and Hospice
- Describe Palliative Care Criteria
- List Hospice Levels of Care
- Compare Palliative Medicine vs. Hospice
Palliation

- From the Latin root word *Pallium*
- Which referred to an outer garment that covered or cloaked a person or object
- Suggests that palliative care can effectively “cloak” the symptoms of serious illness
- Although it has its roots in the hospice movement, the focus of Palliative Care goes beyond end-of-life care
What is Palliative Care?

- Prevention and relief of symptoms of a serious illness at any age and at any stage of serious illness (Cancer, COPD, CHF, kidney failure, Alzheimer’s, ALS, and many more...)
- Patients will continue with the life-prolonging therapies
- Attention to emotional and spiritual needs
- Care for the patient and family as a unit
- Sensitive communication, goal setting and advance care planning
- Interdisciplinary care
Personhood

- Societal attachments
- Relationships
- Cultural attachments
- Secret life
- Perceived future
- Political being
- Body
- Unconscious mind
- Person's history
Suffering

Cassell’s concept of suffering: he defined suffering as the state of severe distress associated with challenges that threaten the intactness of the person.

- Physical
- Emotional
- Social
- Spiritual

Medicine’s traditional mind-body dichotomy, will cause physicians misunderstand the meaning of suffering.
Physical Suffering
The Palliative Response

- Pain and multiple non-pain symptoms
  - Treat pain; it is frequently under-treated
  - Assess/treat other sources of physical distress (Fatigue, Nausea, Vomiting and etc.)

- Symptom Prevention—Foster compliance with treatment plan
Emotional Suffering
The Palliative Response

- Depression
- Anxiety
- Delirium
- Loneliness
Social Suffering
The Palliative Response

- Limited Income
- Lack of Insurance—Insurance often does not cover prescription medicines and home health services
- Inadequate Housing
- Social Isolation
- Caregiver Fatigue
Spiritual Suffering
The Palliative Response

- Loss of hope
- Inability to sustain relations with faith community
- Search for meaning
Traditional Healthcare Model

- Diagnosis of serious illness
- Prognosis of less than 6 months
- Hospice
- Death
- Bereavement

Life-Prolonging Therapy
The Palliative Care Continuum
Palliative Medicine

• Treats complex pain syndromes and other symptoms
• Handles intensive patient/family communication
• Clarifies goals of care
• Supports the referring physician within an identified plan of care to maximize comfort at all stages of illness
Palliative Medicine

- Supports the referring physician by assuming coordination of care for the patient
- Beneficial to patients while they receive ongoing disease-modifying treatment
- Facilitate transition of patients to hospice for end-of-life care when appropriate
Palliative Consult Triggers

- Frequent admissions for same condition within several months
- Complex, difficult symptoms or psychological need
- Functional dependence for complex home support needed
- Decline in functional status, weight, or ability to care for self
- No history of advance care planning
- Limited social support
- The "surprise question": You would not be surprised if the patient died within 12 months
Early Palliative Care Consult in Cancer

- New England Journal of Medicine (NEJM) published a RCT study in 2010 that showed the benefit of early palliative care consult in cancer patients.
- Early Palliative consult in metastatic non-small-cell lung cancer
  - Pt had a better quality of life
  - Fewer depressive symptoms
  - Median survival was longer (11.6 months vs. 8.9 months)
The word “hospice” derives from the Latin word hospes, which means both “guest” and “host.”

Since the 11th century, the concept of hospice was adopted by the Roman Catholic tradition.

Dame Cicely Saunders introduced the modern hospice – St. Christopher’s Hospice in London 1960s.

U.S. 1970

Medicare Benefit 1982-enacted in 1986
Hospice is palliative care with some rules.

- It’s a concept, not a place
- Generally there is a terminal diagnosis with six months prognosis
- Patient is not pursuing a curative approach to care.
- Any Medicare beneficiary is entitled
- Recognizes dying as part of the normal process of living
- Affirms life and neither hastens nor postpones death.
Facts

25% of deaths occur at home - more than 80% of Americans would prefer to die at home.
Hospice

- Allow patients to remain in their ‘home’ (House, ALF, nursing home, street...)
Patient Choice

- Patient has to indicate they know they have a life limiting disease
  - Disease is beyond therapy
  - Patient/family refuse therapy
- Patient or surrogate sign an informed consent to get enrolled into hospice
Levels of care

• Routine home care
  – Patient lives “at home”
    • House
    • Apartment
    • ALF
    • LTC
    • Street
  – Hospice developed to allow patients to remain in their ‘home’
Levels of care

- Inpatient care
  - Care given in facility not the patient’s residence for symptoms that cannot be managed under routine care at home
    - Pain
    - SOB
    - N/V
    - Delirium
    - Psycho-social crises
  - Either in dedicated hospice units or ‘contracted beds’
Levels of care

- Continuous care
  - For situations where symptoms are out of control and patient should be at inpatient care
  - Patient or family refuses to leave residence
  - Skilled nurses remain at bedside for care
Levels of care

• Respite care
  – Caregiver is exhausted and needs break
  – Caregiver needs to go out of town for family event or emergency and patient needs to be kept safe
  – “Baby-sitting” for patient whose needs have not changed
Who Pays?

- Any Medicare beneficiary is entitled
- Medicare, Medicaid, HMOs, private insurances, private pay, or combination of these
- Covers all equipment, medication and professional care related to the terminal illness.
- Patients can revoke at any time.
Interdisciplinary care for patients with serious life-threatening illnesses
- Prognosis estimated at < 6 months if disease runs its expected course (life-limiting illness)
- Emphasizes pain and symptom management and psychosocial/spiritual support
  - Primary goals relate to quality of life goals and symptom control
- Is tailored to the needs and wishes of patients and their families, as is hospice
- Part B fee-for-service physician consultation practice vs Part A Medicare entitlement with per diem reimbursement and defined levels of care
References

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- [https://www.nhpco.org](https://www.nhpco.org)
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