Level Up Your Hospice Skills: Hospice for the Non-Hospice Provider

Holly Pilewski, PA-C
Veterans Affairs

No disclosures

I have no relevant relationships with ineligible companies to disclose within the past 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.)

Objectives

1. Differentiate between Palliative Medicine and Hospice Care
2. Examine the guidelines for hospice eligibility including a basic recognition of CMS rules and regulations
3. Recognize hospice appropriateness through specific cases
4. Learn how to refer patients to hospice

“All hospice is palliative care, but not all palliative care is hospice.”

Palliative Care

"Palliative care is **specialized medical care** for people living with **serious illness**. This type of care is focused on **providing relief** from the symptoms and stress of a serious illness. The goal is to improve **quality of life for both the patient and family**.

Palliative care is provided by a specialty trained **interdisciplinary team** who work together with a patient's other doctors to provide an **extra layer of support**. It is appropriate at **any age and at any stage** in a serious illness, and it can be provided along with curative treatment."

Center to Advance Palliative Care

Palliative Care

- Symptom management
- Disease education
- Assessment of patient's goals/preferences/values AND how to best achieve those goals
- Uses goals to create advance care plans and assist with medical decision making/deciding on treatment options
- Holistic support in setting of chronic and serious illness: physical, psychosocial, mental, and spiritual aspects of serious illness
- Focuses on what is most important to patient
- **Appropriate at any age, any stage of disease***

Primary vs Specialty Palliative Care

- Palliative Care principles can be delivered by any clinician caring for patients with serious and chronic illness and in any setting
- All clinicians encouraged to acquire core skills and knowledge regarding palliative care
- Equivalent to management of severe lung disease by primary care clinicians whom turn to pulmonologists for consultation of complex cases
- Specialist level palliative care is delivered through an interdisciplinary team with specialty training and certifications

Specialty Palliative Care

- Interdisciplinary team
- Physician order required
- Services can be provided at same time as life prolonging/curative care
- Provided at home, nursing home, assisted living facilities, palliative care outpatient clinics, and in the hospital

Specialty Palliative Care

- Visits are usually monthly, and provider is on call for questions
- Billed to Medicare Part B, Medicaid, or other private insurance
- Collaborates with referring provider and/or primary care provider
- Overall goal is improved quality of life

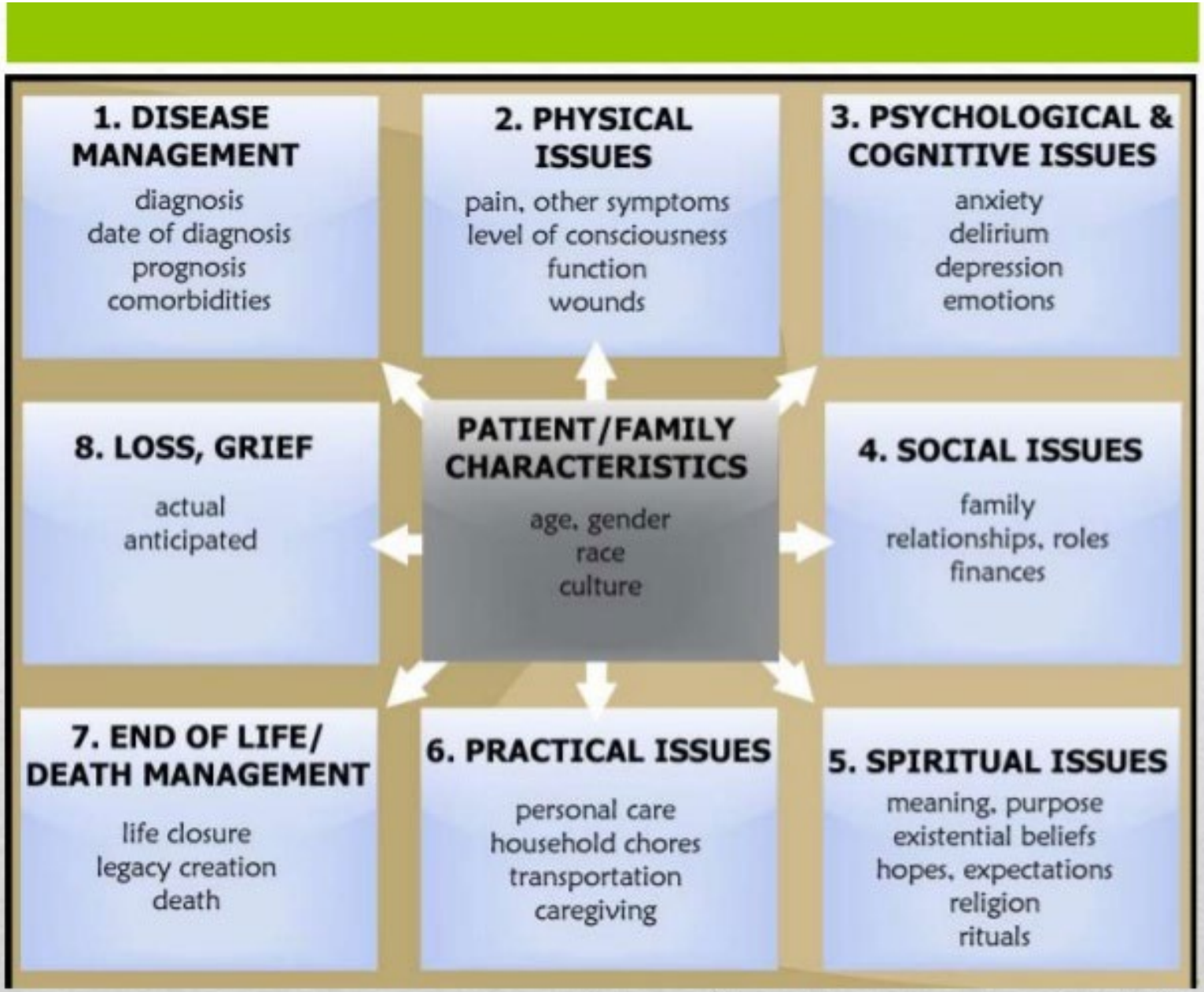
Case #1

Nancy is a 56 y/o female with CKD stage V likely secondary to poor management of diabetes mellitus. Nancy started dialysis three months ago. She lives alone but has a son who lives nearby and helps her get groceries and takes her to medical appointments as she no longer drives secondary to peripheral neuropathy. She is a full code and has no advance directives in place.

Other PMH: PVD, hypertension, tobacco dependence, s/p hysterectomy

Nancy presents to you today for her three-month primary care check up. She reports poorly controlled leg pain, nausea, fatigue, and generally feeling poorly. She reports depressed mood. She is not ready to "give up" but admits that dialysis has been more difficult than she anticipates.

Would you consider a Palliative Care consult for Nancy?

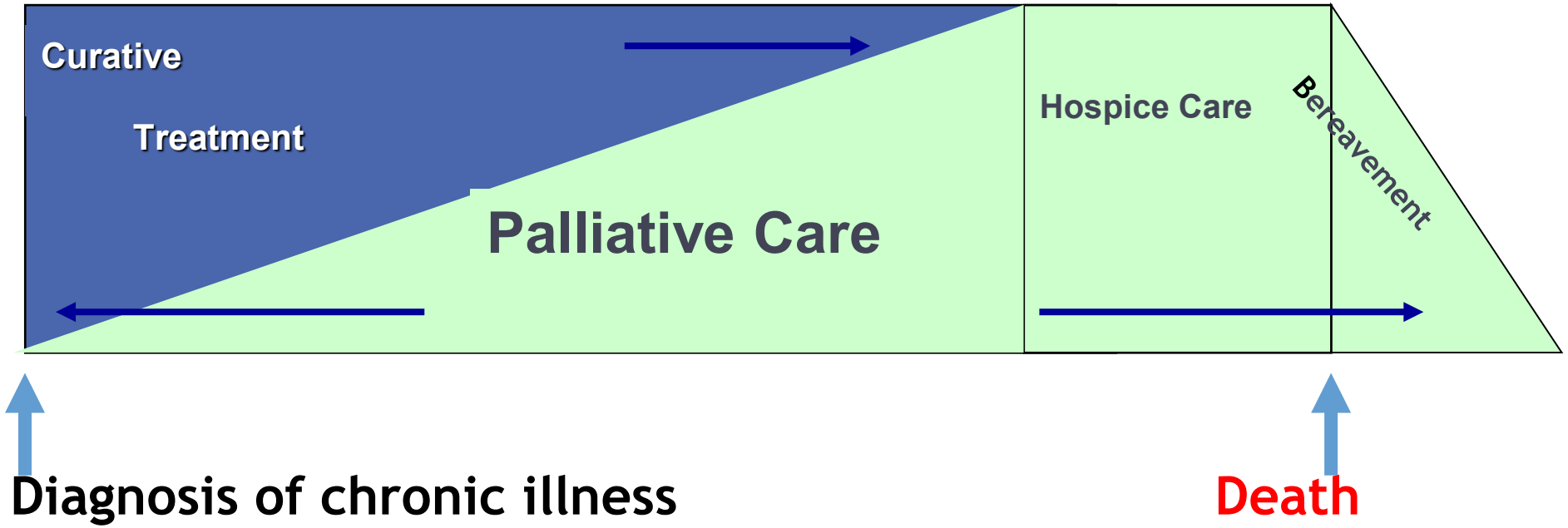


Adapted from Frank Ferris – EPEC-O

Benefits of Palliative Care

- Improved patient and family satisfaction
- Reduced symptom distress especially pain and depression
- Increased spiritual support
- Decreased emotional suffering
- Reduced use of the hospital, ED, and fewer ICU visits
- Reduced length of hospital stay
- Fewer hospital deaths
- Decreased caregiver distress
- Increased use of hospice and earlier referral to hospice
- **Improved quality of life**

Palliative Care



Hospice

- A place
- An organization or program
- An approach to or philosophy of care
- A system of reimbursement

Hospice

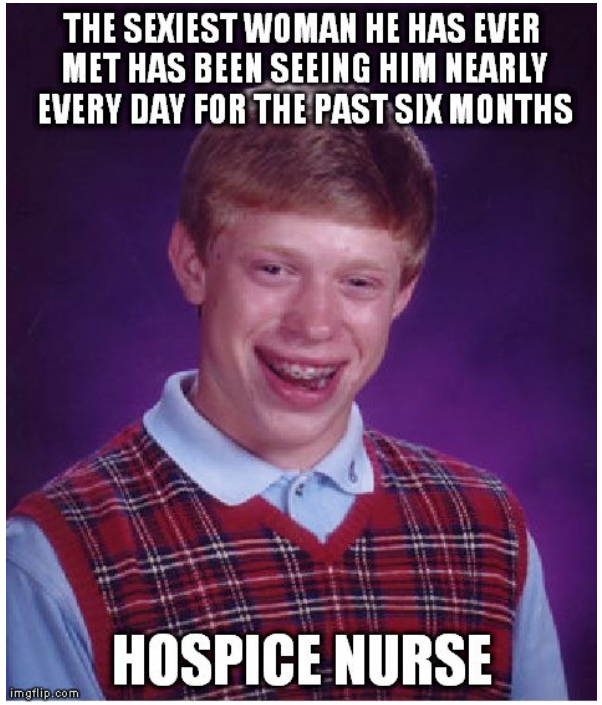
- Provides expert medical care, symptom management, emotional and spiritual support tailored to the patients needs and wishes
- Provides support to both the patient and family in the natural dying process
- Focuses on caring and comfort, not curing

Hospice

- Interdisciplinary team
  - MD/NP/PA, social worker, RN, CNA, chaplain, psychologist, music therapists, bereavement support, volunteers
- Usually* not provided at same time of curative, life prolonging care
- Physician order + prognosis of less than six months + comfort-oriented goals of care
- Medicare Part A Hospice Benefit
  - Covered by other insurances as well, benefits sometimes vary

Hospice

- Equipment and prescriptions provided
- Visits are weekly, often more than once a week with various disciplines
- On-call RN available by phone or to visit 24/7
- Home, nursing home*, assisted living facilities, acute care, inpatient hospice house
- Bereavement support before and after death
- Overall goal is improved quality of life, dignity, and a peaceful death



Hospice Attending

- May be the primary care or specialist MD/PA/NP OR the hospice provider
- Maintains primary responsibility for the patient
- Writes basic admission orders
- Works in collaboration with the hospice team to manage symptoms
- Provides prescriptions and medication refills as needed
- Continues to certify that a patient remains eligible for hospice (PAs excluded)
- Completes and signs death certificate

Hospice Myths

- “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, 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, you will be re-evaluated at intervals
- “primary provider must transfer control of his or her patients to hospice”. . .hospice encourages ongoing involvement of primary care provider as part of the team and contributing to hospice plan of care
- “patients on hospice can’t go to the hospital”. . .most insurances will still cover hospital admissions unrelated to hospice diagnosis or management of symptoms related to terminal diagnosis. patient can also revoke services for care, then re-enroll in hospice

Hospice *Appropriateness*

Goals of care are comfort, quality of life, and to forego curative, life prolonging treatments

Hospice *Eligibility*

Terminal illness, prognosis felt to be six months or less

The Surprise Question

Palliative Care

Would you be surprised if this patient died in the next one to two years?

No? Palliative Care referral

Hospice

Would you be surprised if your patient died in the next six months?

No? Start hospice discussions and at the least, consider Palliative care referral

Case #2

Jerry is a 68 y/o with hepatocellular carcinoma with widespread tumors in the liver.

PMH: CHF, mild COPD, hyperlipidemia, hypertension, depression, anxiety, and tinnitus.

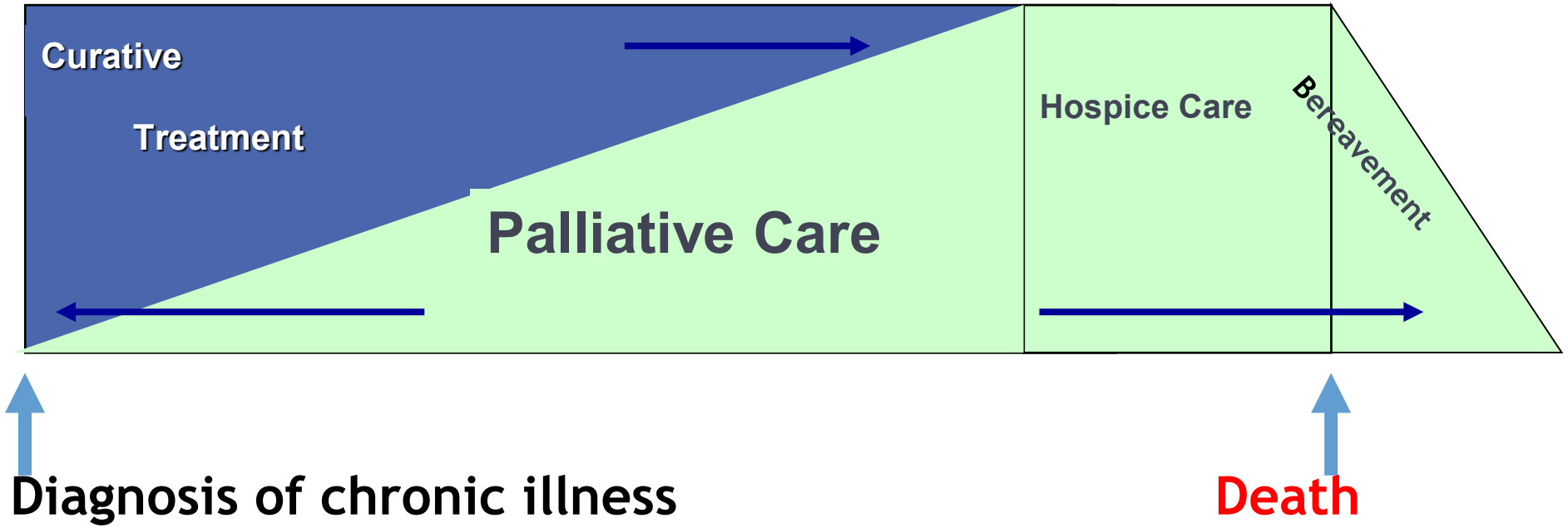
He had progression on systemic therapy with sorafenib and chemo, trialed one round of immunotherapy.

He returns to your office today complaining of increased symptom burden including ascites, moderate to severe abdominal pain, vomiting, fatigue, no appetite, and new onset edema in lower extremities.

Would you be surprised if Jerry died in the next six months?

Is Jerry appropriate for hospice?

Hospice Care



Levels of Hospice Care

- Routine Hospice Care
  - Most common; hospice care at the patient's residence
- Continuous Home Care
  - 8-24 hours/day to manage pain or other acute symptoms; must be predominately nursing care supplemented with caregiver and hospice aide; intended to maintain patient at home during symptom crisis
- Inpatient Respite Care
  - Temporary inpatient stay to provide relief to caregiver; provided in hospital, hospice facility, or long-term care facility that has 24hr nursing staff available
- General Inpatient Care
  - Provided for pain or other acute symptom management that cannot be provided in another setting; usually in hospice facility but can be done in nursing home or hospital

VA Hospice Benefit

- Veterans' Health Care Eligibility Reform Act of 1996 (Title 38 Code of Federal Regulations § 17.36 and 17.38) mandates that VHA offer to provide hospice and palliative care services to eligible enrolled Veterans who need these services or purchase them from the community
- Payor source for hospice may be through the VA if veteran is enrolled in VA
- Follows Medicare guidelines for hospice eligibility, though VA is more supportive of concurrent care
- VA physician may be the attending
- Veterans can receive both VA and community services concurrently
- VA has their own inpatient hospice units for which veterans can be referred
- Community hospice providers can help Veterans who may be eligible to enroll in VA for health care services by contacting the enrollment office
- www.va.gov/healthbenefits.

Medicare Hospice Benefit

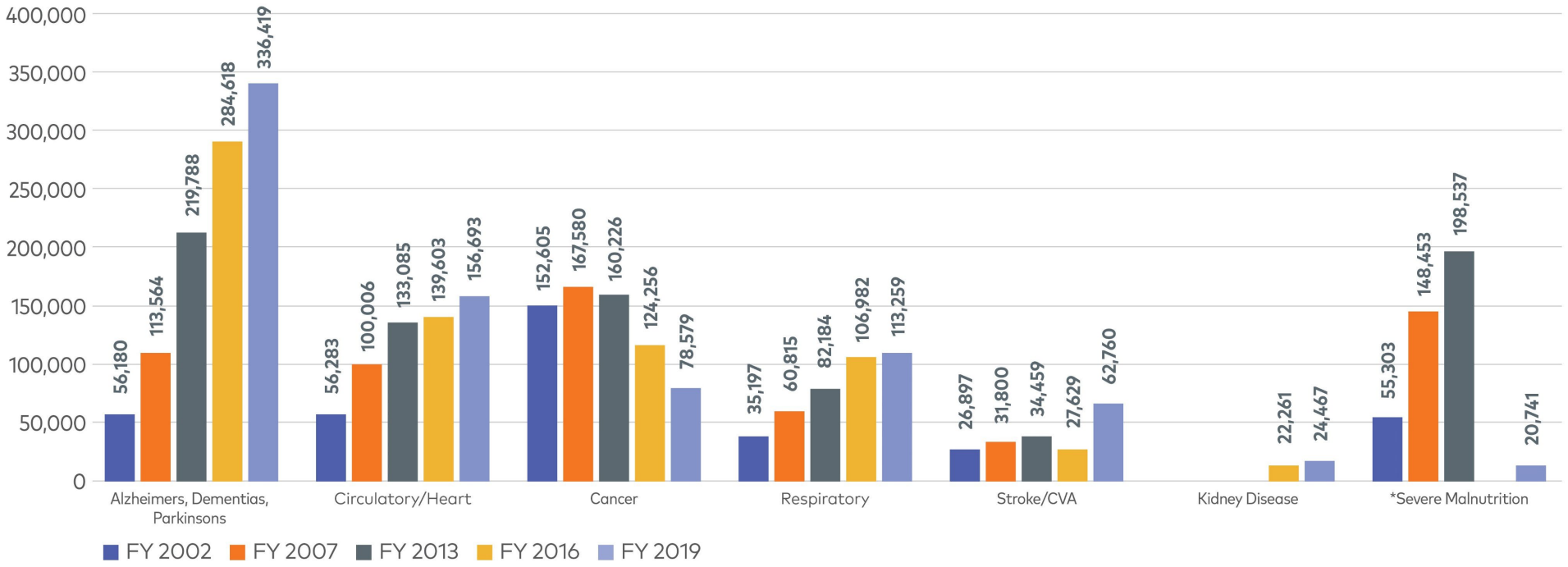
- Covers 100% of hospice services including equipment and medications
- Hospice benefits are divided into benefit periods:
  - First 90-day benefit period
  - Second 90-day benefit period
  - Then, unlimited number of 60-day benefit periods
- After each benefit period, the patient must be recertified to ensure they continue to meet qualifications for hospice care
- Recertification can only be done by hospice medical director after a face-to-face assessment by MD or NP (more on this later)

Who is receiving hospice care?

- 20.9% Alzheimers, dementia, parkinsons
- 7.1% respiratory
- 6.4% circulatory/heart
- 5.4% stroke/cva
- 4.9% cancer
- 1.6% kidney disease
- 1.3% severe malnutrition
- Average length of stay was 92.6 days

Based on Medicare Decedents Utilizing Hospice Care in 2019. NHPCO Facts and Figures 2021

Figure 9: Number of Medicare Decedents Using Hospice by Top 15 Diagnoses



** In 2002, 2007 and 2013, severe malnutrition includes debility unspecified and adult failure to thrive. Those diagnoses were disallowed and no longer used in later years.*

Source: CMS-1675-P, FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements and CMS-1754-P Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

CMS Guidelines for Hospice Eligibility

"To be eligible to elect the Medicare hospice benefit, beneficiaries must be certified by their attending physician (if any) and by the hospice physician as being terminally ill with a prognosis of 6 months or less to live, should the illness run its normal course."

CMS Guidelines for Hospice

Part I. Decline in clinical status guidelines

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are listed in order of their likelihood to predict poor survival, the most predictive first and the least predictive last.

1. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results*
2. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
3. Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis
4. Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST)
5. Progression to dependence on assistance with additional activities of daily living
6. Progressive stage 3-4 pressure ulcers in spite of optimal care

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538

CMS Guidelines for Hospice

Part 1, Number 1 Progression of disease as documented by worsening . . .

1. Clinical Status
    1. Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.
    2. Progressive inanition as documented by:
        1. Weight loss not due to reversible causes such as depression or use of diuretics
        2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
        3. Decreasing serum albumin or cholesterol
    3. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538

CMS Guidelines for Hospice

Part 1, Number 1 Progression of disease as documented by worsening . . .

2. Signs
    1. Decline in systolic blood pressure to below 90 or progressive postural hypotension
    2. Ascites
    3. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
    4. Edema
    5. Pleural / pericardial effusion
    6. Weakness
    7. Change in level of consciousness
3. Laboratory (When available. Lab testing is not required to establish hospice eligibility.)
    1. Increasing pCO2 or decreasing pO2 or decreasing SaO2
    2. Increasing calcium, creatinine or liver function studies
    3. Increasing tumor markers (e.g. CEA, PSA)
    4. Progressively decreasing or increasing serum sodium or increasing serum potassium

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538

CMS Guidelines for Hospice

Part II. Non-disease specific baseline guidelines (both of these should be met)

1. Physiologic impairment of functional status as demonstrated by:
   Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%.
2. Dependence on assistance for two or more activities of daily living (ADLs):
   1. Feeding
   2. Ambulation
   3. Continence
   4. Transfer
   5. Bathing
   6. Dressing

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538

CMS Guidelines for Hospice

Part III. Co-morbidities: Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

1. Chronic obstructive pulmonary disease
2. Congestive heart failure
3. Ischemic heart disease
4. Diabetes mellitus
5. Neurologic disease (CVA, ALS, MS, Parkinson's)
6. Renal failure
7. Liver Disease
8. Neoplasia
9. Acquired immune deficiency syndrome
10. Dementia

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538

Tools for Determining Prognosis

- Karnofsky Performance Scale
- Palliative Performance Scale
- Palliative Prognostic Score
- Palliative Prognostic Index
- ePrognosis
- Seattle Heart Failure Model
- Cardiovascular Medicine Heart Failure Index
- Functional Assessment Staging for Dementia
- Advanced Dementia Prognostic Tool (ADEPT)
- BODE index for COPD

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Palliative Performance Scale

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	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

Wilner LS, Arnold R. Fast Facts and Concepts #125. The Palliative Performance Scale (PPS). July 2015. Available at: https://www.mypcnow.org

Disease Specific Guidelines: Cancer

- Pt meets ALL of the following:
  1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing symptoms, worsening lab values and/or evidence of metastatic disease
  2. PPS <70%
  3. Refuses further life-prolonging therapy OR Continues to decline despite definitive therapy
- Supporting documentation includes:
  - Hypercalcemia >12
  - Cachexia or weight loss > 5% in past 3 months
  - Recurrent disease after surgery/radiation/chemo
  - Signs/symptoms of advanced disease such as nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.
- In some cases, palliative chemo or radiation may be continued

Disease Specific Guidelines: Dementia

Patients with dementia should show all the following characteristics:

- Stage seven or beyond according to the Functional Assessment Staging Scale
- Unable to ambulate without assistance;
- Unable to dress without assistance;
- Unable to bathe without assistance;
- Urinary and fecal incontinence, intermittent or constant;
- No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

Patients should have had one of the following within the past 12 months:

- Aspiration pneumonia;
- Pyelonephritis or other upper urinary tract infection;
- Septicemia;
- Decubitus ulcers, multiple, stage 3-4;
- Fever, recurrent after antibiotics;
- Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl.

Disease Specific Guidelines: Heart Disease

1 and 2 should be present. Factors from 3 will add supporting documentation:

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease or is not a candidate for a surgical procedure or has declined a procedure. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)

2. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of ≤20%,but is not required if not already available.

Disease Specific Guidelines: Heart Disease

3. Other factors:
    1. Treatment resistant symptomatic supraventricular or ventricular arrhythmias;
    2. History of cardiac arrest or resuscitation;
    3. History of unexplained syncope;
    4. Brain embolism of cardiac origin;
    5. Concomitant HIV disease.

Disease Specific Guidelines: Pulmonary Disease

1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation:

1. Severe chronic lung disease as documented by both a and b:
   a) Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough: (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
   b) Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)
2. Hypoxemia at rest on room air, as evidenced by pO2 ≤55 mmHg; or oxygen saturation ≤88%, determined either by arterial blood gases or oxygen saturation monitors; (These values may be obtained from recent hospital records.) OR Hypercapnia, as evidenced by pCO2 ≥50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)

Disease Specific Guidelines: Pulmonary Disease

3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).

4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

5. Resting tachycardia >100/min.

Disease Specific Guidelines: Renal Failure

Acute renal failure: 1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis;
2. Creatinine clearance GFR <15 ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics);
4. Comorbid conditions:
    1. Mechanical ventilation;
    2. Malignancy (other organ system);
    3. Chronic lung disease;
    4. Advanced cardiac disease;
    5. Advanced liver disease;
    6. Sepsis;
    7. Immunosuppression/AIDS;
    8. Albumin
    9. Cachexia;
    10. Platelet count <25,000;
    11. Disseminated intravascular coagulation;
    12. Gastrointestinal bleeding.

Disease Specific Guidelines: Renal Failure

Chronic renal failure: 1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis;
2. Creatinine clearance GFR <15ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics);
4. Signs and symptoms of renal failure:
    1. Uremia;
    2. Oliguria
    3. Intractable hyperkalemia (>7.0) not responsive to treatment;
    4. Uremic pericarditis;
    5. Hepatorenal syndrome;
    6. Intractable fluid overload, not responsive to treatment.

Disease Specific Guidelines: Stroke

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of 40% or less

2. Inability to maintain hydration and caloric intake with one of the following:
    1. Weight loss >10% in the last 6 months or >7.5% in the last 3 months;
    2. Serum albumin <2.5 gm/dl
    3. Current history of pulmonary aspiration not responsive to speech language pathology intervention;
    4. Sequential calorie counts documenting inadequate caloric/fluid intake
    5. Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, in a patient who declines or does not receive artificial nutrition and hydration.

Disease Specific Guidelines: Liver

1 and 2 should be present; factors from 3 will lend supporting documentation:

1. The patient should show both a and b:
   a) Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) >1.5;
   b) Serum albumin <2.5 gm/dl

2. End stage liver disease is present and the patient shows at least one of the following:
   1. Ascites, refractory to treatment or patient non-compliant;
   2. Spontaneous bacterial peritonitis;
   3. Hepatorenal syndrome (elevated creatinine and BUN with oliguria)
   4. Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
   5. Recurrent variceal bleeding, despite intensive therapy.

Disease Specific Guidelines: Liver

3. Other factors:
    1. Progressive malnutrition;
    2. Muscle wasting with reduced strength and endurance;
    3. Continued active alcoholism (>80 gm ethanol/day);
    4. Hepatocellular carcinoma;
    5. HBsAg (Hepatitis B) positivity;
    6. Hepatitis C refractory to interferon treatment.

- Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare hospice benefit, but if a donor organ is procured, the patient should be discharged from hospice.

Disease Specific Guidelines: HIV

1 and 2 should be present; factors from 3 will add supporting documentation:

1. CD4+ Count 100,000 copies/ml, plus one of the following:
    1. CNS lymphoma;
    2. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass);
    3. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;
    4. Progressive multifocal leukoencephalopathy;
    5. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy;
    6. Visceral Kaposi's sarcoma unresponsive to therapy;
    7. Renal failure in the absence of dialysis;
    8. Cryptosporidium infection;
    9. Toxoplasmosis, unresponsive to therapy.
2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of ≤50%

Disease Specific Guidelines: HIV

3. Other factors:
    1. Chronic persistent diarrhea for one year;
    2. Persistent serum albumin <2.5 gm/dl;
    3. Concomitant, active substance abuse;
    4. Age >50 years;
    5. Absence of, or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
    6. Advanced AIDS dementia complex;
    7. Toxoplasmosis;
    8. Congestive heart failure, symptomatic at rest;
    9. Advanced liver disease.

Case #3

Richard is an 80 y/o with oxygen dependent COPD.

Other PMH: BPH, CAD s/p CABG, hyperlipidemia, osteoarthritis, hypothyroidism, macular degeneration.

Richard has been followed by your office for 6 years with his disease slowly progressing over time. Over the last year, functional status has declined to now requiring a walker to ambulate but must stop and rest after only a few feet due to dyspnea, needs assistance with bathing, but can still get dressed on his own though takes longer due to shortness of breath. He is spending more time sleeping during the day. 20lb weight loss, decreased appetite.

He does not drive. He notes he still enjoys weekly breakfasts with men's group from his church despite decreased appetite but finds himself worn out for the remainder of the day.

He resides at ALF with limited family support, but excellent support from ALF staff and church community.

Richard is maximized on nebulizers and inhalers. He reports increasing his oxygen 5L on ambulation, 3-4L at rest. You have had previous goals of treatment discussions with Richard. He is a DNR, wants to avoid hospitalizations, and prefers to die at his ALF.

Is Richard hospice eligible? Is Richard hospice appropriate?

Case #4

Marsha is an 62 y/o with NYHA Class IV biventricular heart failure whom is now admitted to the hospital for the 4th time this year for uncontrolled heart failure symptoms and new NSTEMI. She has been started on IV Bumex for diuresis. Repeat echocardiogram shows further deterioration of her ejection fraction, decreased from 35 to 25% in the last six months. Cardiology consulted with no further recommendations to changes in her care. She is requesting to be a full code and asking that "everything be done for her". Daughter is concerned about depression. Marsha's major complaint is pain in her legs secondary to severe, lower extremity edema.

Other PMH: CKD stage III, insulin dependent diabetes mellitus type II,

Social: Marsha lives with her daughter in a two-story home. She is no longer able to climb the stairs to her bedroom and daughter set up a bed in their dining area. Marsha just retired two years ago due to worsening medical problems. She has been fiercely independent and spends most her time in a chair watching tv. She refuses assistance with ADLs.

Is Marsha hospice eligible?

How could hospice benefit Marsha?

What is the next best step in her case?

Benefits of Hospice

- Decreased hospitalization, non-hospice healthcare utilization
- Decreased high-intensive non-hospice care at end of life
- Decreased cost of care
- Avoided feeding tubes
- Better spiritual support
- Better relationship with physician
- Increased likeliness of dying at home
- Improved patient and family satisfaction
- **Higher quality of life in last weeks of life**
- **Potential to live longer**

Benefits of Hospice

- Analyses of data from 3069 deceased patients more than 50 years of age revealed that hospice enrollment significantly decreased hospitalization, non-hospice healthcare utilization, and cost of care[4]
- Research has shown that caregivers' satisfaction with hospice increases when patients are enrolled for more than 30 days, and that patients who spend at least two months in hospice appear to benefit the most.[17]
- 396 patients with advanced cancer and their caregivers interviewed reported higher quality of life in last weeks of life, worried less, did not die in the hospital and felt a strong therapeutic alliance with their physicians (Coping with Cancer Study[8,9])
- Connor et al found[18] that patients with cancer and congestive heart failure had a mean survival of 29 days longer on hospice care than those not receiving hospice care
  - Specifically, patients with lung cancer, pancreatic cancer, and colon cancer lived longer
  - Patients with congestive heart failure lived on average 81 days longer than those without hospice care

Barriers to Hospice Care

- End of life care is inconsistent, varies from region to region
- Hospice regulations and reimbursement limitations too restrictive
- Misunderstanding and/or negative perceptions of hospice care
- Discomfort with communicating prognosis and need for hospice care
- Inability to prognosticate/overestimation of life expectancy
- Fear of losing control of the patient

Case 5

Marsha is an 62 y/o with NYHA Class IV biventricular heart failure whom is now admitted to the hospital for the 4th time this year for uncontrolled heart failure symptoms and new NSTEMI. She has been started on IV Bumex for diuresis. Repeat echocardiogram shows further deterioration of her ejection fraction, decreased from 35 to 25% in the last six months. Cardiology consulted with no further recommendations to changes in her care. She is requesting to be a full code and asking that "everything be done for her". Daughter is concerned about depression. Marsha's major complaint is pain in her legs secondary to severe, lower extremity edema.

Other PMH: CKD stage III, insulin dependent diabetes mellitus type II,

Social: Marsha lives with her daughter in a two-story home. She is no longer able to climb the stairs to her bedroom and daughter set up a bed in their dining area. Marsha just retired two years ago due to worsening medical problems. She has been fiercely independent and spends most her time in a chair watching tv. She refuses assistance with ADLs.

Is Marsha hospice eligible?

How could hospice benefit Marsha?

What is the next best step in her case?

Case 6

George is a 72 y/o with stage IV metastatic small cell carcinoma of the lung.

PMH: hypertension, diabetes mellitus type II.

George diagnosed by his primary care and was seen by Oncologist where chemo regimen recommended. George refused treatment and returns to your office today with his wife to discuss options.

George tells you his brother had lung cancer and he witnessed him have a precipitous decline with Oncologic treatments and eventually George had to make decision to withdraw ventilatory support on his brother and felt he died a very poor death. George indicates he has lived a long, satisfying life and he wants the remainder of his time to be home with his wife and spending time with his children and grandchildren. He is having some shortness of breath, but otherwise limited symptoms. He asks for your advice on how you can help meet his wishes.

Because you have attended this lecture, you talk with George further about his goals and values, oxygen for symptom management, and why you think hospice care may benefit him. Ultimately, George chooses the path of home hospice. He lived 10 months and died peacefully in his home surrounded by his wife and children.

How to Refer Your Patients

1. Patient's with 6-12 month prognosis or less – dedicate a "hospice information" visit
    1. Assess patient and family understanding of dying process and expectations
    2. Education opportunity
    3. May ease transition for patient and family
    4. Also a good time to complete an AD and determine where patient wants to die
2. Ensure hospice care is understood and referral wanted
3. Identify local hospice agency. Send written order and records pertinent to hospice diagnosis to agency (most EMRs have orders built it)
    1. NHPCO Choosing a Quality Hospice Worksheet
4. Notify hospice if you would like to be considered attending or request the agency medical director to follow
5. Reassure patient of your ongoing support

That's it!

The Good News about PAs and Hospice

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by physician assistants (PAs) to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician.

40.1.3.3 – Physician Assistants as Attending Physicians (Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

The Good News about PAs and Hospice

- PAs are paid 85 percent of the fee schedule amount for their services as designated attending physicians. If a beneficiary does not have an attending physician, a nurse practitioner, or physician assistant who has provided primary care prior to or at the time of the terminal illness, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. The beneficiary must be provided with a choice of a physician or a nurse practitioner.
- **Medicare pays for attending physician services provided by physician assistants to Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This applies to physician assistants without regard to whether they are hospice employees.**
- Attending physician services provided by PAs may be separately billed to Medicare only if:
- ・The PA is the beneficiary's designated attending physician; and
- ・Services are medically reasonable and necessary; and
- ・Services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice; and
- ・Services are not related to the certification of terminal illness.
- If the physician assistant is employed by the hospice, the hospice can bill Part A for physician services meeting the above criteria on a hospice claim. If the physician assistant is not employed by the hospice, the physician assistant can bill Part B for physician services meeting the above criteria.
- PAs are authorized to furnish physician services under their State scope of practice, under the general supervision of a physician; therefore the regulations at 42 CFR 410.150(a)(15) require that payment for PA services may be made to the employer or contractor of a PA. Payment for physician assistant services is made at 85 percent of the physician fee schedule amount. Services that are duplicative of what the hospice nurse would provide are not separately billable.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

And the bad news. . .

- **Since PAs are not physicians, as defined in 1861(r)(1) of the Act, they may not act as medical directors or physicians of the hospice or certify the beneficiary's terminal illness and hospices may not contract with a PA for their attending physician services** as described in section 1861(dd)(2)(B)(i)(III) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the agency or organization. All of these provisions apply to PAs without regard to whether they are hospice employees.
- **Physician assistants cannot certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.**
- **The hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner. PAs may not perform the face-to-face encounter.**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

So what does all that mean?

- PAs can act as attending including ordering medications*, equipment and establishing and reviewing a hospice patient's plan of care and have these services reimbursed by Medicare
- The caveat? PAs still cannot be employed by hospice directly in this role
- PAs cannot take the position of a physician as one of the required members of the hospice interdisciplinary team (nor can NPs)
- PAs cannot certify terminal illness or admit a patient to hospice (nor can NPs)
- PAs cannot provide the face-to-face exam needed to recertify someone for hospice services (NPs can!)
- Some state laws still exist that do not reflect CMS changes and prevent PAs from being hospice attending
- https://pahpm.org/advocacy

Resources

- AAPA PAs in Hospice and Palliative Medicine Handout
- Physician Assistant Clinics: Hospice and Palliative Medicine
- Oxford Press Palliative and Serious Illness Patient Management for Physician Assistants textbook
- CSU Shiley Haynes Institute for Palliative Care PA Certificate in Palliative and Serious Illness Care
- Role of the Family Physician in the Referral and Management of Hospice Patients
- Physician Assistants in Hospice and Palliative Care

	Palliative Care	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 practitioner, PA, 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

Take Home Points

- All hospice is palliative care, but not all palliative care is hospice
- Palliative Care and Hospice improve quality of life and in some patient populations can increase longevity of life
- Every patient deserves the option of hospice at end of life
- We can be the conduit to end myths about hospice care
- Physician assistants CAN work as hospice or palliative care providers!
  - Still many limitations we need to advocate to eliminate

References

1. Mack JW, Chen K, Boscoe FP, et al. Underuse of hospice care by Medicaid-insured patients with stage IV lung cancer in New York and California. J Clin Oncol 2013; 31: 2569-2579. https://www.ncbi.nlm.nih.gov/pubmed/23733768
2. Bergman, J, Saigal CS, Lorenz KA, et al. Hospice use and high-intensity care in men dying of prostate cancer. Arch Intern Med 2011; 171:204-210. https://www.ncbi.nlm.nih.gov/pubmed/20937914
3. Breitkopf CR, Stephens EK, Jatoi A. Hospice in end of life patients with cancer: Does it lead to changes in nonhospice health care utilization after stopping cancer treatment? Am J Hosp Palliat Care 2013. https://www.ncbi.nlm.nih.gov/pubmed/23666617
4. Kelley AS, Deb P, Du Q, et al. Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. Health Aff (Millwood) 2013; 32:552-561. https://www.ncbi.nlm.nih.gov/pubmed/23459735
5. Enzinger AC, Zhang B, Schrag D, Prigerson HG. Outcomes of prognostic disclosure: Associations with prognostic understanding, distress and relationship with physician among patients with advanced cancer. J Clin Oncol 2015; 33: 3809-3816. https://www.ncbi.nlm.nih.gov/pubmed/26438121
6. Ciechanowski PS, Katon WJ, Russo JE, Walker EA. The patient-provider relationship: attachment theory and adherence to treatment in diabetes. Am J Psychiatry 2001; 158:29-35. https://www.ncbi.nlm.nih.gov/pubmed/26438121
7. Stewart, MA. Effective physician-patient communication and health outcomes: a review. CMAJ 1995; 152:1423-1433. https://www.ncbi.nlm.nih.gov/pubmed/7728691
8. National Comprehensive Cancer Network Guidelines in Oncology Palliative Care Version 2 2017 – June 1, 2017. NCCN.org.
9. National Comprehensive Cancer Network Guidelines in Oncology Palliative Care Version 2 2019 – February 8, 2019. NCCN.org.
10. Medicare Hospice Guidelines Fact Sheet. Center for Medicare Services. https://www.cgsmedicare.com/hhh/education/materials/pdf/medicare_hospice_benefit_facts.pdf
11. Centers for Medicare and Medicaid Services: Hospice Center. https://www.cms.gov/Center/Provider-Type/Hospice-Center.html
12. NHPCO Facts and Figures 2021 edition. National Hospice and Palliative Care Organization. https://www.nhpco.org/hospice-care-overview/hospice-facts-figures/
13. "Introduction to Palliative Care and Hospice." Physician Assistant Clinics. 5 (2020): 277-288.
14. Clinical Practice Guidelines for Quality Palliative Care. 4th edition (2018). National Coalition for Hospice and Palliative Care. Available at: https://www.nationalcoalitionhpc.org/ncp. Accessed July 1, 2021
15. Boucher N.A., Nix H.: The benefits of expanded physician assistant practice in hospice and palliative medicine. JAAPA 2016; 29: pp. 38-43..
16. Buss M.K., Rock L.K., McCarthy E.P.: Understanding palliative care and hospice: a review for primary care providers. Mayo Clin Proc 2017; 92: pp. 280-286.
17. Weckmann, M. The Role of the Family Physician in the Referral and Management of Hospice Patients. Am Fam Physician. 2008 Mar 15;77(6):807-812.
18. Connor,S. et al. Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window. Journal of Pain and Symptom Management. 2007 Mar 1; 33(3):238-246.

Questions?

hpilewsk@gmail.com