Palliative Care vs. Hospice Care

What's the Difference?

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  - **Nursing Home Administrators:** This program has been approved for Continuing Education for **1.0 total participant hours** by NAB/NCERS.

Learning Outcomes

- After this course, the learner will:
  - Describe the purpose of both palliative and hospice care
  - Differentiate the services provided under palliative and hospice care
  - Identify different settings that are appropriate for palliative and hospice care
  - State two (2) barriers of referrals to palliative or hospice care

Definitions

- **Serious Illness:** A health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life **OR** excessively strains their caregivers. *(Amy Kelley/Clinical practice Guidelines for Quality Palliative Care 4th ed.)*

Definitions

- **Palliative Care:**
  - High risk of mortality, but not necessarily terminally ill, with deceased function and increased need for social support. *(Coalition to Transform Advanced Care C-TAC)*
  - Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice. *(National Hospice and Palliative Care Organization)*
- **Hospice Care:** Hospice focuses on caring, not curing, and in most cases, care is provided in the patient's home. *(National Hospice and Palliative Care Organization)*


Door A or B?


Door C!

Palliative Care

- A board-certified medical specialty since 2006 in the US
- Models of care vary
  - Primary clinic
  - Home-based
  - Hospital consults
- Visit structure
  - Visits based on need
  - Medical delivery model – physician/FNP

Who qualifies for palliative care?

Individuals diagnosed with a life-threatening illness, including but not limited to:

- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer
- End-Stage Kidney Disease (ESRD)
- End-Stage Liver Failure (ESLF)
- Dementia
- Cerebrovascular Accident (CVA)
- Amyotrophic Lateral Sclerosis (ALS)
- Multiple Sclerosis

Why palliative care?

- Treats the whole person
- Promotes quality of life
- Supports the family
- Is an “extra layer of support” for all

Goals of Palliative Care

- Improve quality of life for both the patient and the family
- Ensure patients, families and caregivers understand all aspects of the patient's illness and guide them to make informed, well-educated choices
- Address spiritual and emotional needs and provide support when needed
- Coordinate care with other members of the health care team
- Treat physical, psychosocial and spiritual symptoms that patients experience

When should palliative care be considered?

- When there is difficulty managing symptoms like pain, shortness of breath, fatigue, anxiety, nausea, vomiting, constipation, loss of appetite, difficulty sleeping or side effects of treatment
- A patient has repeat ER visits or hospital admissions
- A patient needs help establishing goals, making health care decisions, clarifying treatment options, and/or planning for the future, including code status and advanced directives

Primary Criteria*

- The “surprise” question: You would not be surprised if the patient died within 12 months
- Frequent admissions (e.g., more than one admission for same condition within several months)
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)

**Primary Criteria are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.*

Secondary Criteria*

- Admission from long-term care facility or medical foster home
- Elderly patient, cognitively impaired
- Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document or in need of goal clarification

**Secondary Criteria are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.*

Source: Weismann & Meier, 2011

Benefits of Palliative Care

- Interdisciplinary Team Approach
  - Physician
  - Nurse
  - Social Work
  - Chaplain
- Reduced Cost
- Improved Patient Outcomes
  - Social Determinants of Health (non-medical needs)
  - Nutrition
  - Transportation
  - Social/Caregiver Support
  - Housing
- Gives the Patient a Voice
  - Goal clarification
  - Giving the patient the care they want
  - Palliative care or hospice consult necessary when patient's wishes do not align with family's wishes

Why is palliative care important to facilities?

- 30 Day Readmission Rates
- COPD
- Heart Failure
- Stroke
- Pneumonia

www.medicare.gov/care-compare/

I've consulted palliative care. Now what?

- New consults to palliative care are seen within one to two weeks of receipt.
- The patient will remain under the care of a PCP and specialists.
- Visit Frequency: Risk Stratification
  - NP: once to twice monthly - more often if needed
  - RN: extension of NP for follow up and education
  - SW: as needed (some patients seen as often as once weekly for counseling services)

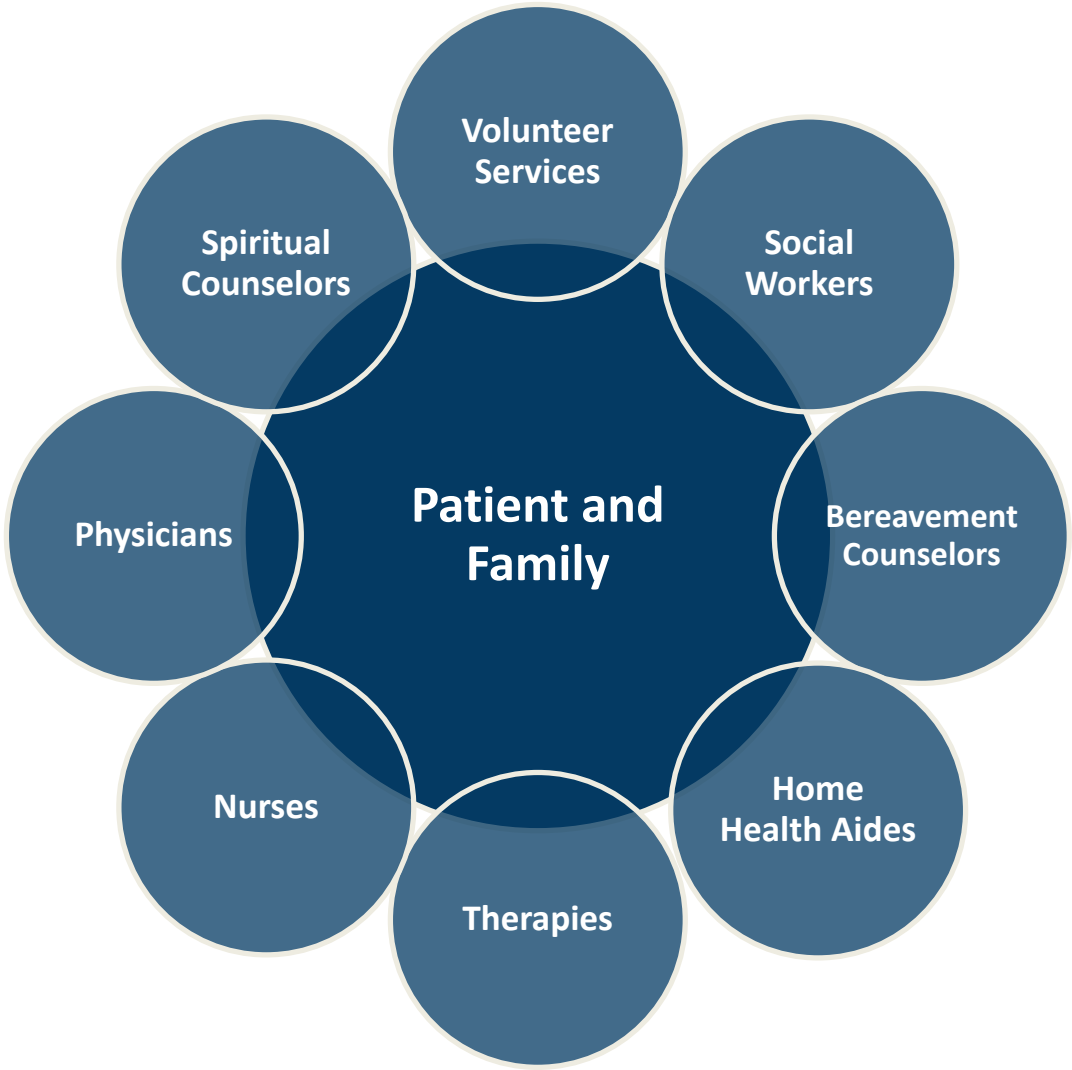
I've consulted palliative care. Now what?

- Care provided:
  - Identify needs and clarify goals
  - Communicate with all providers goals of care/care provided
  - Education and counseling
  - Recommend and/or treat
- Palliative care services continue until one or all of the following:
  - Patient requests discontinuation of services
  - Patient no longer meets palliative care criteria
  - Patient expires
  - Patient transitions to hospice
  - Physician requests patient no longer receive palliative care services

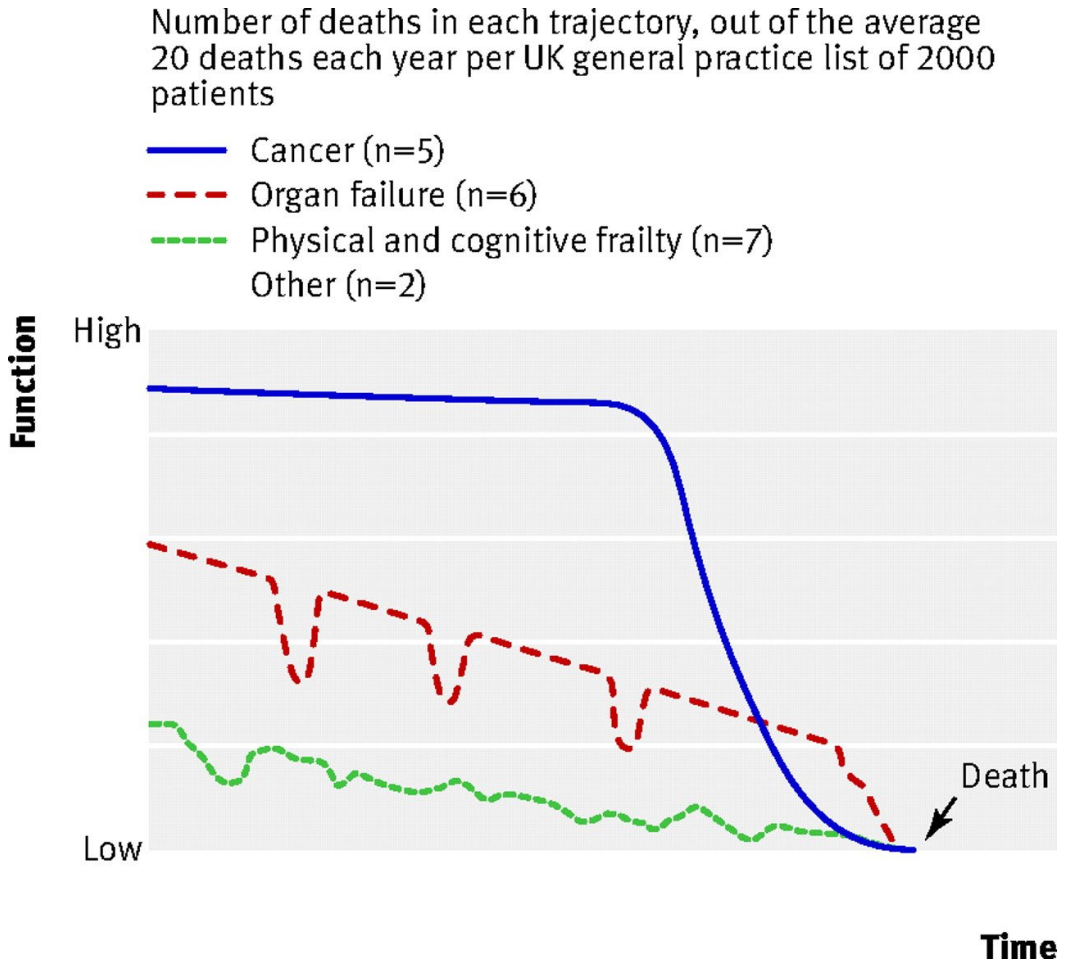
What does hospice offer?

Hospice Care:

- A philosophy of care focused on comfort and quality of life.
- Hospice is “comfort care.”
- Hospice is a whole package of care services that is almost always provided at the patient’s home, whether a private residence or a care facility.



When should hospice be considered?



Hospice Referrals

Common sources of admissions:

- Emergency room
- In-patient hospital
- Primary care physicians/RHC/FQHC
- Palliative care
- Clinics
- Specialist (Cardiologist, Pulmonologist, Oncologist, etc.)
- Patient/Family

Physicians can continue to manage the patient with the support of the Hospice Medical Director (HMD) or the HMD can provide full management.

Hospice Appropriateness and Admissions

Home Hospice Admission

Physician verifies terminal disease with approximately six months or less until end of life

- ***Any physician can refer to hospice***
- ***Hospice medical director and RN review all admissions***

In-Patient Hospice Admission

Uncontrolled symptoms

Respite Care Admission

For hospice-enrolled patients

Family/caregiver can bring patient to a hospice house once a month for up to five days per respite period

Palliative Care vs. Hospice Care

Palliative Care vs. Hospice Care

Palliative Care	Hospice Care
Aimed at anyone diagnosed with a life-threatening illness	Aimed at patients diagnosed with a terminal illness
Helps maintain quality of life and reduce illness symptoms; recent findings suggest cancer patients receiving palliative care along with standard treatment can live longer	Provides patients with a dignified, pain-free death; usually meant to be administered inside the patient's home

Source: The Mayo Clinic (mayoclinic.com) and OncologyNurseAdvisor.com

Palliative vs. Hospice

Palliative Care	Hospice Care
Not dependent on age	Not dependent on age
For patients at any stage in a serious/chronic illness	For patients nearing the end of life with a terminal diagnosis
Not dependent on prognosis	Prognosis must be 6 months or less
Can be provided along with curative treatment	Cannot seek aggressive/curative treatment

Palliative vs. Hospice

Palliative Care

- Supportive Care
- Symptom Management
- Education
- Patient/Family Centered Care
- Advanced Care Planning
- Psychological and Spiritual Care
- Enhances Quality of Life
- Applicable ***early*** in course of illness

- Supportive Care
- Symptom Management
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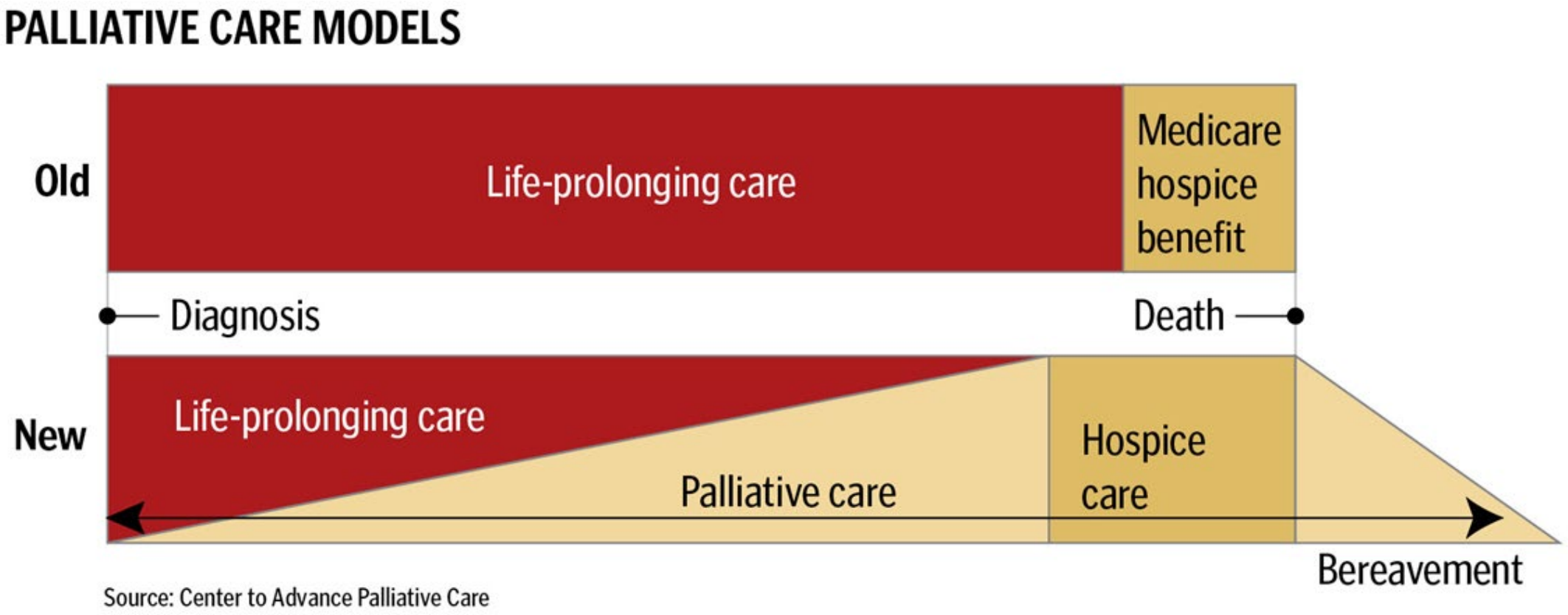
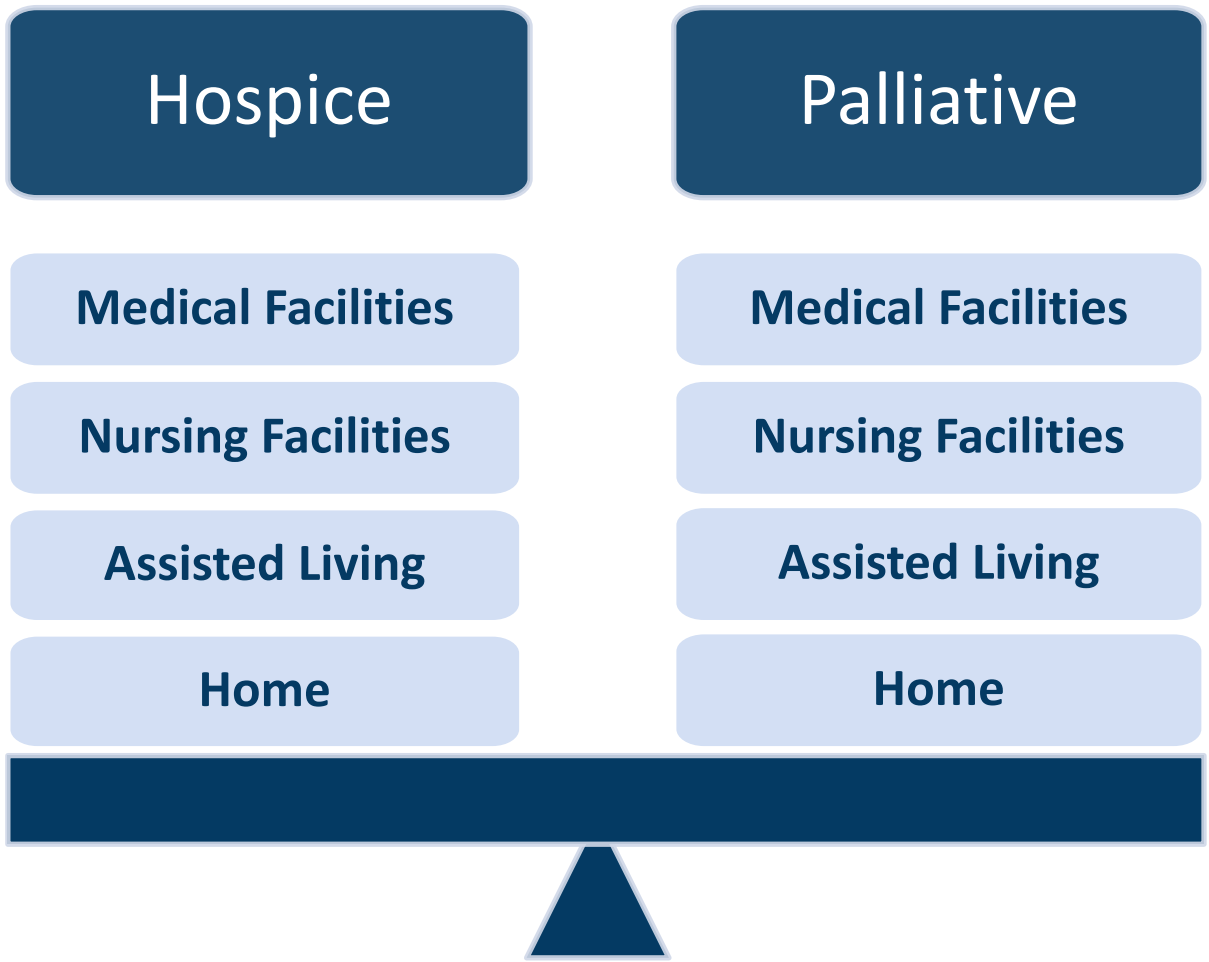
- Patient/Family Centered Care
- Advanced Care Planning
- Psychological and Spiritual Care
- Enhances Quality of Life
- Applicable ***later*** in course of illness

Hospice Care

Palliative Care Model



Where are services available?



Palliative vs. Hospice

Hospice	Palliative
Stage IV metastatic breast cancer with metastatic disease to brain, lungs and bone, awake and oriented, eating and drinking, but not a candidate for chemo/radiation	Stage IV metastatic breast cancer with metastatic disease to brain, lungs, and bone, actively taking chemo/radiation treatment
Alzheimer's disease FAST score of 7a	Alzheimer's disease FAST score of 6a
Congestive heart failure Class IV	Congestive heart failure Class III
Stage IV prostate cancer with metastatic disease to bone and liver receiving PALLIATIVE radiation	Stage IV prostate cancer with metastatic disease to bone and liver and is s/p prostate removal awaiting radiation consult
COPD with disabling dyspnea, oxygen dependent, increased exacerbations and hospitalizations despite therapy	COPD oxygen dependent

Palliative vs. Hospice

Hospice	Palliative
Life limiting disease	Serious illness
Paid for by Medicare Hospice Benefit - no cost to patient	Commercial insurance, Medicare, Medicaid, may have a co-pay
May be managed by physician	Maintains PCP and all specialists
Non curative	May continue curative treatment options
5 days of respite care a month paid for by Medicare	No respite option
24/7 call; weekly to daily follow-up	No after hours call; bi-weekly to monthly follow-up
Rapid response to patient decline	Not a rapid response team
New consults seen in 24-48 hours	New consults seen in one week
Team of physician, nurse, nursing aide, social worker, and bereavement with 24/7 availability	Team of nurse practitioners, nurses and social workers available Mon-Fri, 8-hour days
Symptom management for comfort and end-of-life care	Symptom management in collaboration with curative efforts and patient goals

Referrals

- Delayed
- Absent
- Timely
- Culture
- Knowledge deficit
- Refusal to accept change

“Our job is improving the quality of life, not just delaying death.”

- Patch Adams

Questions?

Evaluation & Post-Knowledge Check

- https://www.surveymonkey.com/r/SMHLBN3

QR Code
Activate the camera on your smart phone and scan this QR code to link to the **evaluation**

Thank you!

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