Identifying the Pulmonary Hospice Patient

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Hospice for the Patient with End-Stage Lung Disease

Goals:
- Increase the ability of the patient to cope with illness.
- Increase family caregiver understanding and care of the symptoms associated with reduced pulmonary function.
- Reduce hospital days and ER visits.

FACTS
- Although COPD is the Third leading cause of death in America, a study conducted by Medicare showed that only 8.2% of the hospice patients in their study had a diagnosis of Lung Disease.

WHY HOSPICE?
- Hospice for pulmonary patients gives back control and quality of life-and that is extremely important.
- Hospice for pulmonary patients helps to improve the quality of life for the patient and significant others.
- Hospice cares for a lot of terminal patients but hospice care is also for a patient with terminal pulmonary disease.

FACTS
- In 2009, NHPCO estimated 41.6% of deaths in America were under the care of hospice.
- 50% of the 41.6% that do receive hospice, are on for 21 days or less.
- 34.4% of hospice patients pass within 7 days of admission.

FACTS
- Studies show that patients on hospice live on average 29 days longer than patients with similar diagnosis who did not choose hospice.
- Hospice patients receive an average of 23 visits a month from a team of specialist which include a physician, a nurse, a chaplain, a social worker, and CNA’s.
- Meds, supplies, and O2 related to the terminal diagnosis are covered under the hospice benefit at 100%, while 30% of O2 and nebulized medications, and 100% of supply costs are the financial responsibility of the patient when receiving their care from a DME company.
- The number one response on our Family Evaluation of Hospice Care survey is "we wish we would have known about this earlier."
FACTS

- Based on evidence gathered from multiple DME companies in our service area, 5-10% of continuous O2, CHF and COPD patients pass away every month on their service.
- Patients being cared for by traditional DME companies and billing under part B are not receiving the hospice benefit.
- DME companies typically see their patients twice a month with their drivers who check equipment and deliver tanks.

Improving End of Life Care for patients

Aim .......
“To improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice with a hospice team that works with the patients doctor.”

Nationally, the preferred location of death for all patient cohorts:

- Is in the home (56%)
- The alternative locations of hospital (11%), Hospice Houses (24%), Care Homes (4%)
- The actual place of death is predominantly:
  - The hospital (56%)
  - Followed by Care Homes (20%), The Home (20%) (reference sources).

Potential benefits

- A redesigned service shall enable the individual to die in their preferred setting and thus reduce unnecessary admissions for patients at their EOL.
- The identification of the number of patients who are ‘identified’ will be improved (and it is likely that the number also increased)
- More patients will die or be prepared to die in their place of choice
- Professionals satisfaction with EOL management will be increased.
- Ultimately, in the long-term this should bring about a reduction in the number of emergency admissions.

End-stage lung disease

The final stages of lung disease, when the lung can no longer keep the blood supplied with oxygen.

Chronic Lung Disease is the 3rd leading cause of death in America – 43 deaths per 100,000 people per year.
Prognosis of End-Stage Lung Disease is Difficult.

- The forced expiratory volume in one second (FEV₁) has traditionally been used to assess COPD severity.
- A FEV₁ of less than 35% of the predicted value represents severe disease; 25% of these patients will die within two years and 55% by four years.

MEDICARE LUNG DISEASE PROGNOSIS PREDICTORS:

- Severe chronic lung disease as documented:
  - Disabling dyspnea at rest
  - Little to no response to bronchodilators
  - Bed to chair existence with fatigue
- FEV₁ after bronchodilation < 30% predicted
- Decrease in FEV₁ > 40mL/year
- Progression as evidenced by increasing visits to the emergency room or hospitalizations
- Hypoxemia at rest with pO₂ ≤ 55 mmHg or
  - Oxygen saturation < 88%
- Hypercapnia with pCO₂ > 50 mmHg
- Cor pulmonale and right heart failure secondary to pulmonary disease
- Unintentional weight loss of > 10%
- Resting Tachycardia > 100 bpm

ASSESSING YOUR PATIENT

- Feeling short of breath with activity or even at rest
- Fatigue
- Loss of weight due to inability to eat and breath at the same time.
- Increased constipation
- A dry cough and chest discomfort
- Pleuritic pain

Karnofsky Score Performance Status

The Karnofsky Score may be requested under certain diagnoses.

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
70 – Cares for self, unable to carry on normal activity or to do work
60 – Requires occasional assistance from others but able to care for most needs
50 – Requires considerable assistance from others; frequent medical care
40 – Disabled, requires special care and assistance
30 – Severely disabled, hospitalization indicated; death not imminent
20 – Very sick, hospitalization necessary, active supportive treatment necessary
10 – Moribund

Benefits of Hospice for the O₂ patient

- DME companies typically send a driver once or twice a month to the patients home
  - Hospice will send an RN, Hospice Aide, Social Worker, Chaplains and Physician to the home. Hospices typically average 23 visits a month per patient.⁴
  - If the patient is on home health they will receive approximately 7 visits a month.
  - While on hospice the hospice benefit will pay for the patients meds/DME/and supplies related to their terminal diagnosis and will be covered at 100%.

¹NHPCO
⁴Allscripts. Discipline visit analysis report. AllVoyager company data May 2010 thru April 2011.
### Benefits of Hospice for the O2 patient

- Hospice will support families by providing everything from psycho-social support for grieving family members, to pre and post bereavement services:
  - Help with advanced directives
  - Allow loved ones to focus on being loved ones rather than caregivers
  - Psycho social services
  - Treat anxiety related to COPD with meds, lifestyle training (energy conservation pursed lip breathing), psycho social support, and 24 hr on call nurses

### Independence training for surviving family members

- 24 hr on call staff

- Continuous care and General Inpatient services are available for acute symptom management

- Respite care available

### The hospice team will provide the following services to individuals in the home, wherever they consider home to be:

- On-call services 24 hours a day / 7 days a week
- Manage pain and other symptoms
- Offer support with the emotional and spiritual aspects of dying
- Pay for medications, medical supplies and equipment related to patients diagnosis
- Teach family members skills to help them provide care
- Deliver special services like speech and physical therapy if needed
- Make short term inpatient care available when pain or other symptoms become too difficult to manage at home
- Provide support and counseling to family members and loved ones

### Symptom management

- Supplemental oxygen
- administer morphine for pain relief and to manage anxiety
- fatigue is a common symptom - plan your interventions so that the patient doesn't need to expend much energy
- eat frequent, small meals of high-calorie foods that are easy to swallow

### End-of-life Care

- Position the patient for maximal lung expansion by sitting them up in bed
- Teach patient pursed lip breathing
- pace themselves so they don't become short of breath
- Run a fan

“The only failure in therapy for terminally ill patients is the failure to refer hospice as the next step in health care.”

By Michael Gloth, III, M.D.
Health care that can follow a person from birth to death is good medicine, good clinical management, not just pain care. It's pain and symptom management along with emotional and spiritual aspects of care for the patient.

How to begin talking to patients and families about End-Of-Life Care

- Choose appropriate private environment (neither hall nor curtain provide privacy)
- Have tissue available
- Allot enough time (20-30 minutes minimum with documentation)
- Determine who should be present
- Turn beeper to vibrate (avoids interruptions, demonstrates full attention)
- Shake hands with the patient first
- Introduce yourself to everyone in the room
- Always sit at eye level with patient at a distance of 50-75 cm
- Ask permission before sitting on edge of bed
- Arrange seating for everyone present if possible (helps put patient at ease, prevents patient from hurrying)

Starting the Conversation

- Ask: How do pt./family understand what is happening? What have others told them?
- Wait: 15-30 seconds to give opportunity to respond
- Listen: Response may vary from "I think I am dying" to "I don't understand what is happening."
- How much does patient want to know?
- Ask patient if he/she wants to know prognosis
- Patient may decline conversation and designate a spokesperson

Source: Bailey, A. The Palliative Response (modified for BCBSRI/Brown University project)

When Family Wants to “Protect” Patient

- Honor patient’s autonomy
- Meet legal obligation for consent
- Promote family alliance and support for the patient
- Ask what family is afraid will happen
- Offer to have family present when you speak to the patient (so they can hear patient’s wishes about knowing status/prognosis)

Response to Emotions of Patient, Family, and Staff

- Be prepared for a range of emotions
- Allow time for response
- Communicate nonverbally as well as verbally (usually acceptable to touch arm)

Suggest a Brief Plan

- Medical plan (e.g. control dyspnea, home assistance to help deal with weakness)
- Ancillary support (e.g. social work visits, pastoral care visits)
- Introduce advance care planning (“Sometimes when people die, doctors try to bring them back to life… Have you considered whether you would want this or not?”)
- Discuss timeline
Offer Follow-up Meeting

- When? Usually within 24 hours
- Who? For current and additional family members
- Why? To repeat portions of news
- How? Offer to contact absent family members. Get permission to share news if necessary
- Next meeting, upcoming decisions, suggest flexible timeline

Ending the Meeting

- Ask: “Do you have any questions?”
- Wait
- Answer
- Stand - An effective way to end the conversation

Summary

- Countless O2 patients pass away without ever receiving the benefits of hospice.
- Less than 40% of the deaths that occur in America receive hospice services.1
- Hospice patients live longer, live more comfortably, and save money when compared to patients with similar diagnosis who do not choose hospice.

Summary

- Physicians may follow and bill for patient office visits without having to field the frequent phone calls that end stage COPD and CHF patients often require.
- Studies show that by utilizing the hospice benefit early Medicare’s overall healthcare cost are significantly reduced.7

Benefits to Physician

- Physician may experience decreased after hours phone calls. Hospice will encourage patients to call our 24/7 staff.
- We will manage patient anxiety both with counseling and medication, which may reduce the need for calls to Physician’s office.
- Re-hospitalizations will generally be reduced.

Illness, death, and grief touch everyone. Hospice can help patients and their families, but many people don’t understand what hospice services are or how to get them.
By identifying our hospice appropriate patients 4-6 months prior to passing, we can help improve their overall quality of life, while saving both the patient and the government money.

We owe it to our seniors to do all that we can to ensure that they receive all of the care that they are entitled in their final journey.

Cited References