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Primary Care Clinicians May Actively Direct Hospice Care **CME/CE**

News Author: Laurie Barclay, MD**CME Author: Hien T. Nghiem, MD**[Disclosures](#)**Release Date: March 21, 2008; Valid for credit through March 21, 2009****Credits Available****Physicians** - maximum of 0.25 *AMA PRA Category 1 Credit(s)*™ for physicians;**Family Physicians** - up to 0.25 AAFP Prescribed credit(s) for physicians;**Nurses** - 0.25 nursing contact hours (None of these credits is in the area of pharmacology)

March 21, 2008 — A review article in the March 15 issue of the *American Family Physician* describes the role of the primary care clinician in the referral and treatment of hospice patients. Hospice care should be available to any patient with a terminal illness who chooses a palliative care approach.

"Family physicians can play an invaluable role in caring for patients at the end of life," writes Michelle T. Weckmann, MD, MS, from the University of Iowa Hospitals and Clinics in Iowa City. "Continuity of care and multigenerational relationships allow a family physician to guide a patient and family through the hospice referral process with a unique knowledge of the patient's values, family issues, and communication style. . . . Because of the close relationship that primary care physicians often have with their patients, they are in a unique position to provide end-of-life care, which includes recognizing the need for and recommending hospice care when appropriate."

The hospice philosophy centers on the physical, psychological, social, and spiritual aspects of the dying patient. Hospice care can be offered in patients' homes, nursing homes, hospitals, and other settings, and it is typically provided by an interdisciplinary team with access to a wide range of services to support the primary caregiver, who is responsible for most of the patient's care.

Eligibility criteria for hospice care include diagnosis of a terminal illness with estimated prognosis of less than 6 months. Guidelines from the National Hospice and Palliative Care Organization can help

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Learning Objectives

Upon completion of this activity, participants will be able to:

1. Describe patients with any medical diagnoses that should be considered for hospice.
2. Describe patients who are eligible for the Medicare Hospice Benefit.

Authors and Disclosures**Laurie Barclay, MD**

Disclosure: Laurie Barclay, MD, has disclosed no relevant financial relationships.

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Disclosure: Hien T. Nghiem, MD, has disclosed no relevant financial relationships.

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the clinician determine whether a hospice referral would be helpful.

Suitable diagnoses include New York Heart Association (NYHA) class IV heart failure, severe dementia, activity-limiting lung disease, or metastatic cancer. At present, noncancer diagnoses, including congestive heart failure, chronic obstructive pulmonary disease, failure to thrive, and dementia, account for 56% of all hospice admissions.

Medication, nursing care, equipment, and other expenses related to the terminal illness are covered by the hospice benefit. Because of the cost involved in starting services and the time required to form a therapeutic relationship, timely referrals are recommended. Once hospice is involved, the family clinician typically continues to be the patient's primary attending clinician, remaining in charge of the patient's care, writing orders, seeing the patient for office visits, and completing and signing the death certificate.

"The majority of caregivers and families of patients who have received hospice care report that they would have welcomed more information about hospice from their primary care physician at the time the diagnosis was labeled terminal," Dr. Weckmann writes. "Research has shown that hospice can be a way to offer more support and improved care to patients during their terminal phase of illness, and patient care is enhanced when the primary care physician maintains control of the patient's care until his or her death. . . . Hospice, in turn, is a valuable physician resource when it comes to medication dosages, symptom management, and communication with patients and their families."

Specific clinical recommendations, and their accompanying rating for level of evidence, are as follows:

- Patients with cancer and noncancer diagnoses can benefit from hospice services, and they should be referred when their prognosis is still longer than 2 months (level of evidence, B). Although the most effective length of stay with hospice is debated, most estimates are at least 2 to 3 months. Very short stays have been linked to increased caregiver morbidity and depression.
- Discussions with patients and families about referral to hospice care should occur as early as possible and should be approached in the context of the broader goals of care (level of evidence, C). Late referrals are linked to lower levels of family satisfaction with services and increased caregiver morbidity. Of families surveyed, 11% to 18% feel that they were referred to hospice too late.
- Hospice referral is appropriate for patients with NYHA class IV heart failure who are symptomatic despite optimal management of medications (level of evidence, C).
- Hospice referral is appropriate for patients with dementia who are dependent in all activities of daily living and who can no longer communicate (level of evidence, C)

Common misconceptions regarding hospice care, and their clarifications, are as follows:

- *Patients will be discharged from hospice if they do not die within 6 months.* This regulation was revised, and there is no longer any penalty for an incorrect prognosis if the disease runs its normal course.
- *Patients in hospice must have a do-not-resuscitate (DNR) order.* Medicare does not require a DNR order, but it does require palliative, not curative, treatment. Some hospice organizations may require a DNR order before enrollment.
- *Patients in hospice must have a primary caregiver.* This may be required by some hospice organizations but not by Medicare.
- *The primary clinician must transfer control of his or her patients to hospice.* Most hospice organizations encourage primary clinician involvement.
- *Only patients with cancer are appropriate for hospice.* Any patient with a life expectancy of less than 6 months who has chosen palliative care is appropriate.
- *Only Medicare-eligible patients may enroll in hospice.* Most commercial insurance companies cover hospice.
- *Patients in nursing homes are ineligible for hospice.* Medicare now covers patients in nursing homes.

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- *Patients are ineligible for hospice once they revoke the hospice benefits.* Patients who want to resume hospice care can do so provided they are still eligible.
- *Only clinicians can refer patients to hospice.* Any clinician or lay person (eg, nurse, social worker, family member, friend) may refer the patient to hospice.
- *Hospice care precludes patients from receiving chemotherapy, blood transfusions, or radiation.* Medicare requires hospice to cover all care related to the terminal illness, provided it is palliative.
- *Patients who have elected the hospice benefit can no longer access other health insurance benefits.* Each insurer has rules defining eligibility for covered services.
- *Patients in hospice cannot be admitted to the hospital.* Most insurance companies will still cover hospital admissions for unrelated illnesses, management of symptoms related to the terminal illness, and respite care.
- *Hospice care ends when a patient dies.* All hospice programs must provide families with bereavement support for up to 1 year.

"Because hospice is funded on a per diem basis with a fixed sum of money from which all medical care must be paid, there can be the perception, both real and imagined, that hospice is trying to reduce or prevent patient access to the acute medical care system to cut costs," Dr. Weckmann concludes. "This can lead to conflict between the attending physician and the hospice with regard to specific tests or evaluations necessary to care for the terminally ill patient. . . . It is important to remember that, despite the potential conflicts of interest, excellent patient care is at the heart of all hospice organizations, and the hospice staff can be a valuable resource for physicians who are uncomfortable or unfamiliar with certain medications or dosages to manage end-of-life symptoms."

Dr. Weckmann has disclosed no relevant financial relationships.

Am Fam Physician. 2008;77:807-812, 817-818.

Clinical Context

During 2006, approximately 1.3 million patients received hospice, and one third of all deaths occurred under hospice care. The philosophy of hospice is that the dying patient has physical, psychological, social, and spiritual needs. Hospice should be considered when a patient has NYHA class IV heart failure, severe dementia, activity-limiting lung disease, or metastatic cancer. Family clinicians can play an invaluable role in caring for patients at the end of life. To help determine whether a hospice referral would be helpful, guidelines from the National Hospice and Palliative Care Organization are available to assist in this decision.

The aim of this review article was to report the role of the family clinician in the referral and management of hospice patients.

Study Highlights

- Hospice includes an interdisciplinary team that consists of multiple members providing a wide range of services to support the primary caregiver.
- The responsibility for hospice referral in a noncancer diagnosis is to the primary care clinician, who facilitates continuity of care for the patient in his or her final days and months.
- Hospice benefits cover all expenses related to the terminal illness, including medication, nursing care, and equipment.
- To be eligible for hospice, a patient must have a terminal illness and estimated prognosis of less than 6 months.
- Tools for determining the prognosis in terminally ill patients include the Karnofsky Performance Scale, the National Hospice Organization Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diagnosis, the Palliative Performance Scale, and the Palliative Prognosis Score.
- Patients who are eligible for Medicare are also eligible for hospice benefits. Medicare

covers hospice care for patients who are older than 65 years or have been disabled for more than 2 years.

- To be eligible for the Medicare Hospice Benefit, 4 criteria must be met:
 - The patient must be eligible for Medicare Part A (hospital insurance).
 - The patient must be enrolled in a Medicare-approved hospice.
 - The patient has signed a statement choosing hospice.
 - Both the patient's clinician and the hospice medical director must certify that the patient has a terminal illness with an estimated life expectancy of less than 6 months.
- The clinician may bill directly through Medicare Part B, as long as the attending clinician is not an employee of hospice.
- It is possible to bill for non–face-to-face services with use of the care oversight code. To use this code, the clinician must be the same provider who signed the certification for hospice, needs to see the patient at least once every 6 months, and must provide a cumulative service of 30 minutes each calendar month.
- The attending clinician is expected to be the primary clinician on record, be available by telephone or has coverage arranged, write admission orders, provide medication refills, and handle routine decisions for patient care.

Pearls for Practice

- Hospice should be considered when a patient has NYHA class IV heart failure, severe dementia, activity-limiting lung disease, or metastatic cancer.
- To be eligible for the Medicare Hospice Benefit, the patient must be eligible for Medicare Part A, must be enrolled in a Medicare-approved hospice, and has signed a statement choosing hospice. Also, both the patient's clinician and the hospice medical director must certify that the patient has a terminal illness with an estimated life expectancy of less than 6 months.

CME/CE Test

Questions answered incorrectly will be highlighted.

Which of the following patients should *not* be considered for hospice?

- A 50-year-old man with NYHA class II heart failure
- A 45-year-old woman with breast cancer and carcinomatous meningitis
- A 60-year-old man with chronic obstructive pulmonary disease who is dyspneic at rest
- A 65-year-old woman with severe dementia and dependent in all activities of daily living

According to this review article by Weckmann, eligibility for the Medicare Hospice Benefit requires all of the following criteria *except*:

- The patient must be eligible for Medicare Part A (hospital insurance)
- The patient must be enrolled in a Medicare-approved hospice
- The patient has signed a statement choosing hospice
- Both the patient's clinician and the hospice medical director must certify that the patient has a terminal illness with an estimated life expectancy of less than 12 months

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