
Overview of Palliative Medicine and Hospice

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What is Palliative Medicine?

Specialized
INTERDISCIPLINARY
TEAM

No particular
“guidelines”

In addition to curative
treatment

Discuss GOALS OF
CARE

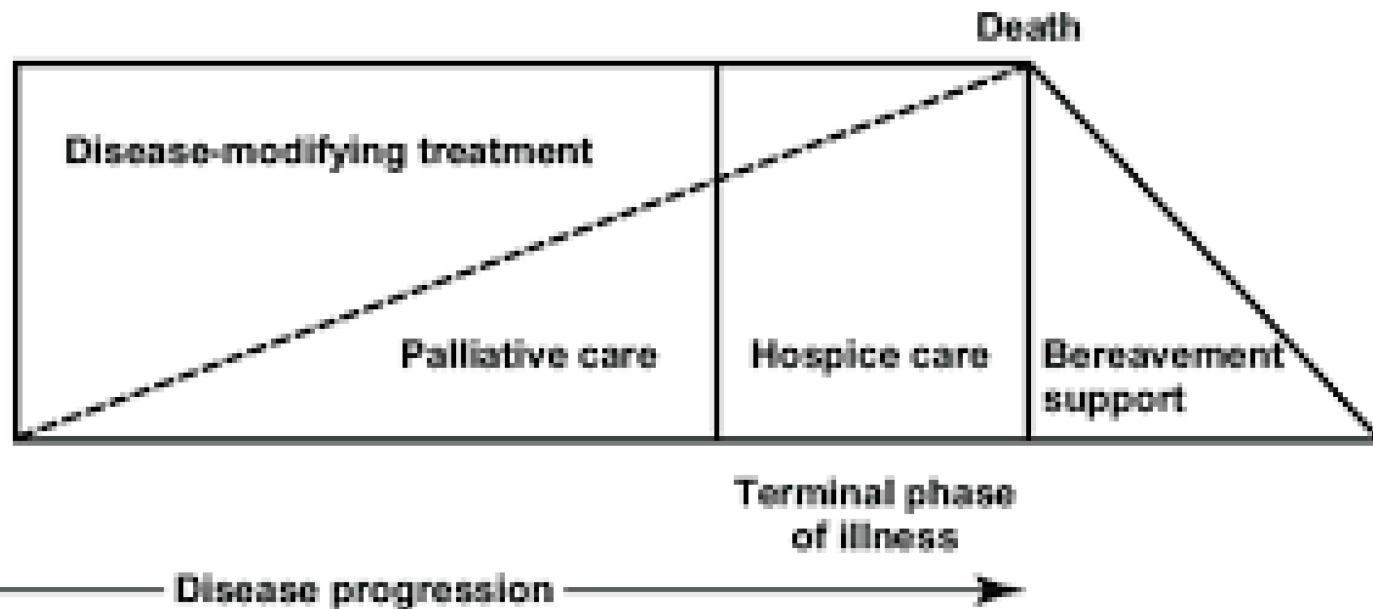
Advance care planning
Prognostication

Symptom Management

Disease specific
interventions

Symptom Specific
intervention

Diagnosis of life-threatening or debilitating illness or injury



What is Hospice?

- END OF LIFE care - EOL defined as 6 MONTHS or less
- Specific care model with interdisciplinary requirements
- Focuses on SYMPTOMS and QUALITY OF LIFE
- Comes to the patient- home, nursing facility

HOSPICE IS NOT:

- Hastening of death
 - Giving up

Palliative Care

Hospice Care

- Used at any point after diagnosis
- Is paired with treatment of your condition

- Focuses on improving quality of life
- Alleviates symptoms like pain

- Used once your condition is considered terminal
- You usually must have six months or less to live

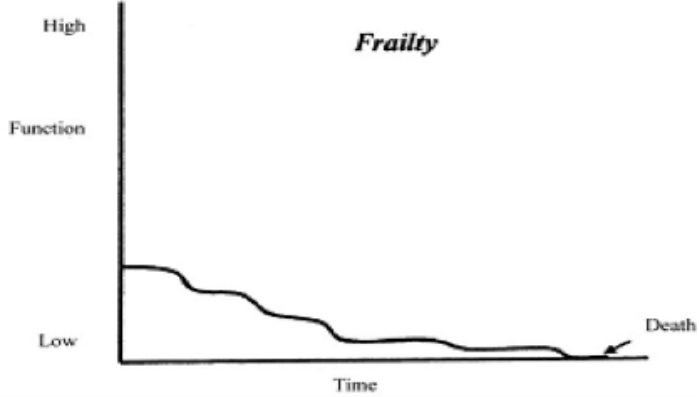
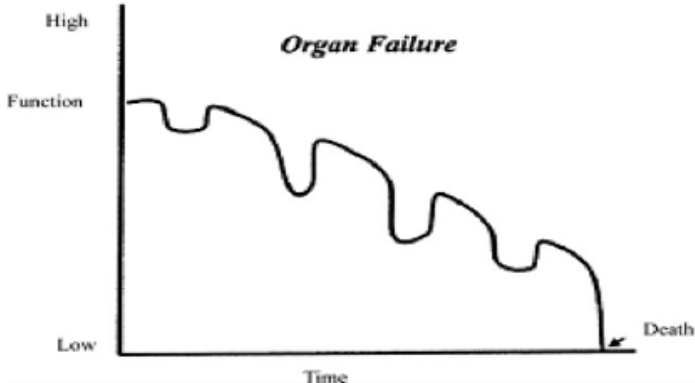
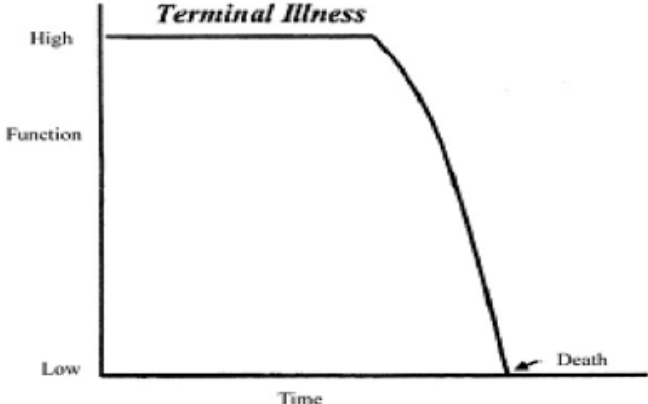
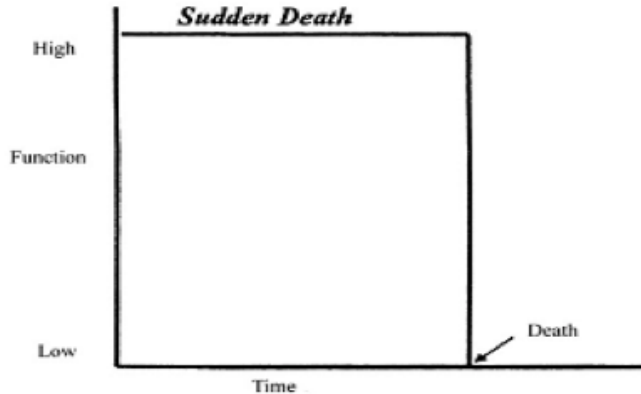


So, What Does Palliative Medicine DO?

- Shared decision making/advanced-care planning
- Prognostication
- Symptom management
- Added layer of support throughout health care delivery

Trajectories of Dying

Proposed Trajectories of Dying



Goals and Decisions

Where you are on the trajectory informs your GOALS, which inform your DECISIONS

- Who are the decision makers
- If time is short, what is important
- Surprise question “would you be surprised if this patient died in the next 12 months?”

Symptom Management

Disease Directed Treatments - CHEMO, XRT, Dialysis, LVAD, other disease directed treatments

Symptom Directed Treatments - IN ADDITION TO the above

symptom burden of chronic diseases > symptom burden with cancer

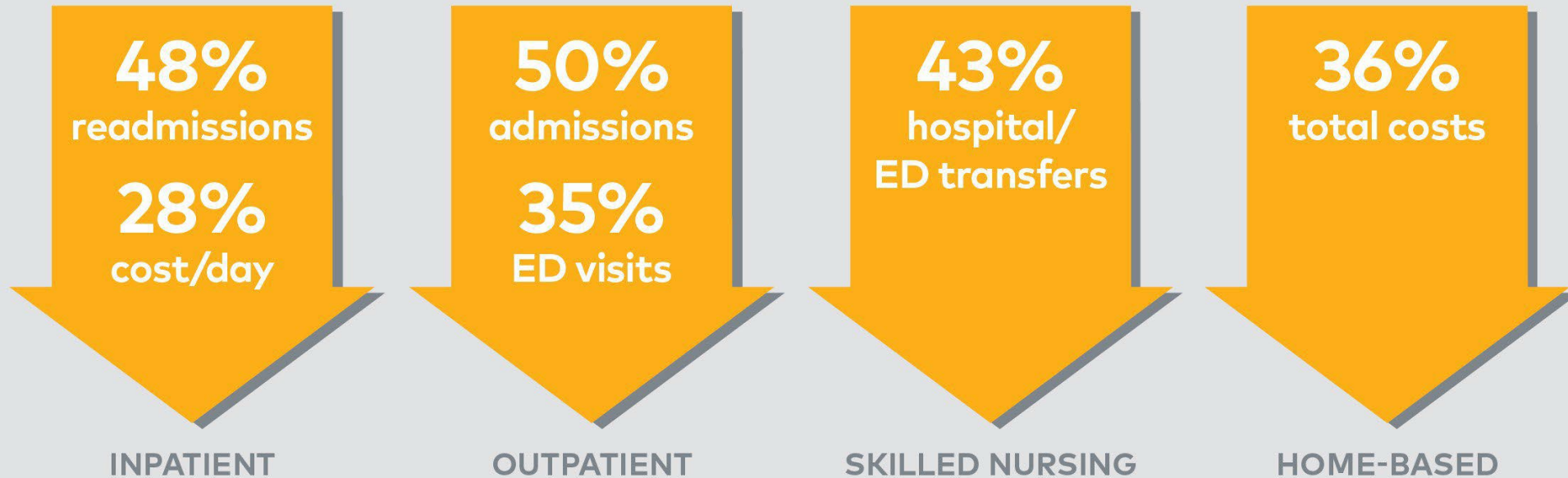
Common Symptoms - pain, dyspnea, constipation, nausea, agitation, anxiety/depression, WORRY

Added Layer of Support

- Time for difficult discussions
- Looks at the WHOLE picture - not organ specific
- Interdisciplinary team - whole pain, suffering, community support
- MD can discuss with other teams
- Cost implications
- Life expectancy

Spending and Utilization

PALLIATIVE CARE REDUCES AVOIDABLE SPENDING AND UTILIZATION IN ALL SETTINGS



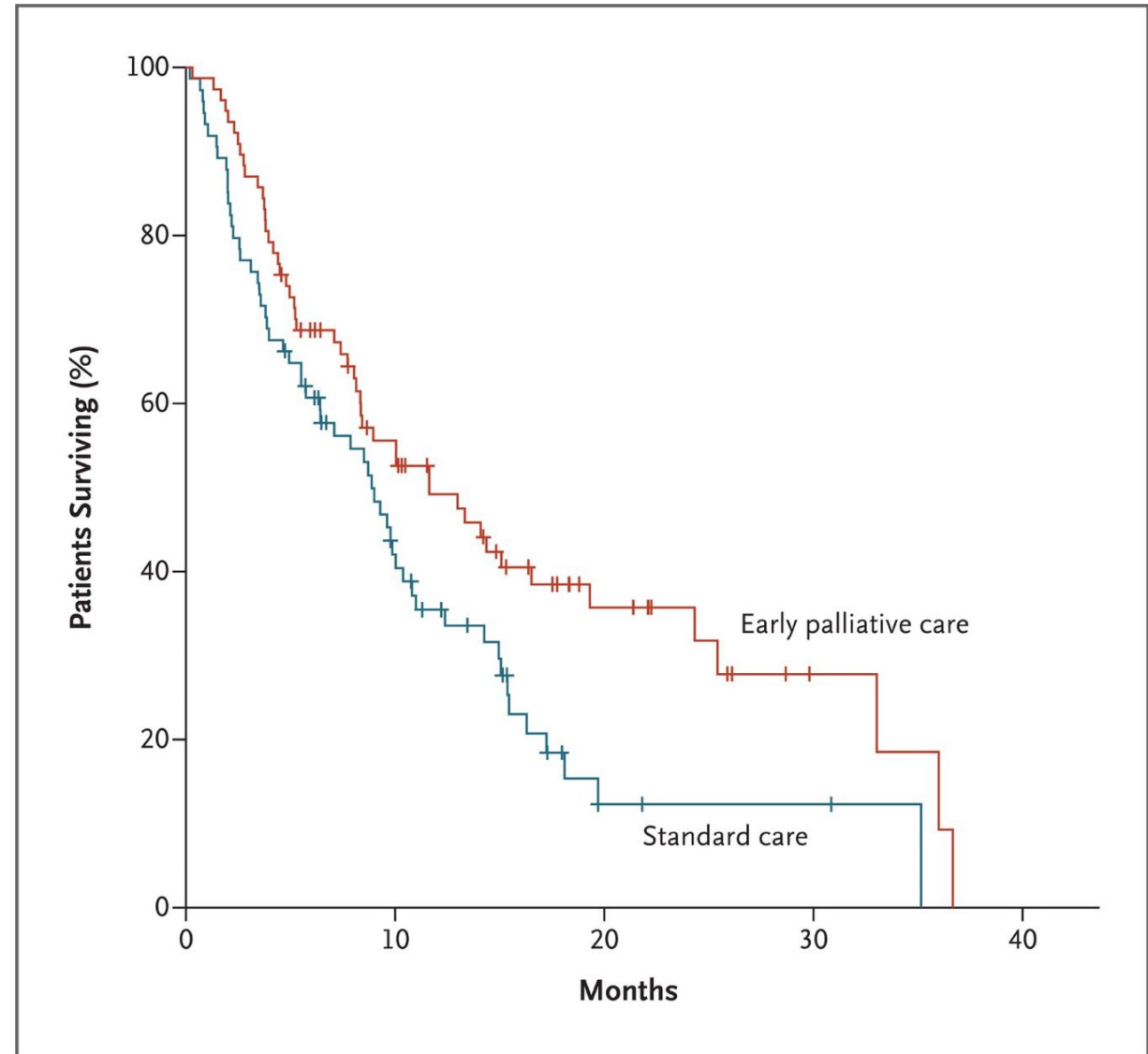
Source: Center to Advance Palliative Care

Life Expectancy

Life Expectancy - Temel NEJM 2010

107 pts with metastatic NCLCA cancer - palliative v std care

- Median survival of PC patients was 11.6 mo v 8.9 mo for those who received usual care
- Higher QOL scores and less depressive symptoms



Who Is Appropriate?

Advanced care planning - serious illness PLUS

- Multiple ED/hospital visits
- Symptom burden
- Family conflict

“Would you be surprised if this patient died in the next 12 months?”

Triggers for PC consults/discussions - harness EMR for improved outcomes

State by State Report Card

<https://reportcard.capc.org/>

KANSAS - rated “C” for access to PC-56.7%

NONPROFIT > FOR PROFIT

Limited access in rural hospitals - 17% of hospitals w 50 or more beds reported pc programs

WHAT IS HOSPICE?

A specially trained team of professionals and caregivers that provide care for the “whole person”, physically, emotionally, socially and spiritually

Program of care and support at END OF LIFE

EOL = prognosis less than 6 months

Focuses on improving quality of life AND controlling symptoms

Focuses on comfort therapies with patients often desiring no intensive therapies

Usually in patients' home (you do not usually GO TO HOSPICE)

Coverage of meds, equipment, “extras” dependent on insurance

Hospice vs. Palliative Care

| HOSPICE | PALLIATIVE CARE |
|--|---|
| Focus on QOL and symptom mgmt. | Focus on QOL and symptom mgmt |
| Prognosis less than 6 month | Any point in serious illness |
| Focuses on COMFORT therapies | Patients usually receiving concurrent curative therapies and desire hospitalization |
| Home support includes home nurses, social workers, chaplains, home aids, physicians/NP | Home support varies |
| Medications/equipment typically covered by hospice (no copay) | Medications/equipment with copays |

Does My Patient Qualify?

Disease Specific Criteria - cancer, ALS, heart disease, pulmonary disease, dementia, HIV, liver failure, renal failure, stroke, coma

Non-Disease Specific Criteria - irreversible decline, clinical decline-functional, nutritional status, ED/hospital visits, labs, pressure ulcers, infections

Team Members

Physician

RN

HHA

Social Work

Chaplain

Bereavement

Volunteer Coordinator

IDG meeting

“Extras” -
physical/speech/occupational
therapy, massage, music, PET,
legacy therapy

Four Levels of Hospice Care

Routine Home Care - care performed in patient's home, not 24h care by hospice and dependent on family/outside caregiver support

Continuous Home Care - continuous care in patient's home to manage ACUTE symptoms in home setting. At least 8 hours of care in a 24h period and 50% of that time needs to be by RN

General Inpatient Care - "GIP" intensive hospice care

Respite Care - 5 days of care outside of patient's home for caregiver relief

Resources

- Essential Practices in Hospice and Palliative Medicine, 5th Ed, Medical Care of People with Serious Illness, Thomson, Patel, Lally
- Concurrent/integrative model of palliative care. A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report. Chapter 1. Framework. National Quality Forum. Washington, DC, 2006, p. 3.
- Temel NEJM 2010 Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, List of authors, Jennifer S. Temel, M.D., et al, Aug 19, 2010; 363: 733-742
- CMS.gov - Hospice Regulations and Notices
- CAPC.org
- mypcnow.org

Questions?

Please feel free to submit through chat or unmute yourself and ask!
