Hospice Issues Continue to Challenge LTC

Complications include predicting life expectancy and coordinating hospice and nursing services.

BY HEIDI SPLETE

WASHINGTON — Providing hospice care isn't easy. And when such end-of-life services are delivered in a skilled nursing facility, it's more complicated still, according to a panel presenting a broad view of hospice at the annual meeting of the American Geriatrics Society.

A major difficulty in admitting patients to hospice care involves making a prognosis, said Joanne Lynn, MD, who specializes in palliative care issues for the Centers for Medicare and Medicaid Services.

Currently, physicians need to certify that a patient's death is anticipated within 6 months for that person to qualify for hospice. But in skilled nursing facilities, "people are mostly dying from events that are statistically describable, but clinicians can't predict whether the process will take 2 months or 22 months," said Dr. Lynn.

"I am not good at predicting when a patient is going to die," said Patrick Coll, MD, a geriatrician at the University of Connecticut, Farmington, who also serves as the medical director for several nursing homes. "I'm asked that question quite often, and I usually hedge it."

"We need to continue to fund research that helps us better determine the prognosis and life expectancy for patients in long-term care," he said.

Dr. Lynn recommended a change from the current all-or-nothing hospice model to a layered system that accounts for three trajectories toward death: after a short period of decline, after a sudden exacerbation of illness, and a slow process due to long-term health problems.

"We need care systems that are designed for specific populations," she said.

"I believe that we need to drop the '6-months-to-death' criteria for hospice certification," agreed Dr. Coll. "I feel that palliative care and hospice care are the same things.... I believe that you should qualify for hospice if you elect not to be hospitalized" for a terminal illness.

Hospice care is often complicated by a lack of clarity about its purpose. Not all programs require do-not-resuscitate (DNR) orders for enrollees, but "a person who is sick enough to be in hospice has very little chance of being helped by CPR," said Dr. Lynn.

Nevertheless, some prospective hospice patients say they want to be resuscitated because of religious beliefs, family concerns, or other issues, said Joan Teno, MD, a hospice medical director of Home & Hospice Care of Rhode Island and professor at Brown University, both in Providence. "I think that hospice does have an important role in clarifying the goals of care," she said. "There are difficult cases when we need to debate autonomy versus futility."

"The DNR conversation carries a lot of baggage," said Dr. Lynn.

Providing hospice care in long-term care facilities has its pros and cons, said Dr. Coll. Administrators at many facilities want to offer hospice services because the residents' families like it—they feel they are getting additional services.

But challenges include duplication of tasks and problems with communication if there is a separate staff for hospice care. "I believe we need to encourage long-term care facilities to provide palliative care services with their own staff," Dr. Coll suggested. In fact, doing so may qualify facilities for extra reimbursements from Medicare, as long as staff meet certain standards for hospice care.

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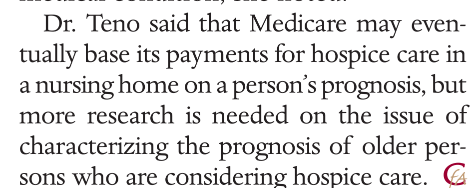
Also, Medicare has increased payment for complex medical illnesses, Dr. Lynn said. With that in mind, nursing homes and hospice programs may be able to negotiate agreements for palliative care services depending on a person's medical condition, she noted.

Dr. Teno said that Medicare may eventually base its payments for hospice care in a nursing home on a person's prognosis, but more research is needed on the issue of characterizing the prognosis of older persons who are considering hospice care.

Heidi Splete is a senior writer with Elsevier Global Medical News.

Diabetes management in long-term care



REACTIVE or

What do the guidelines tell us? Although sliding scale insulin (SSI) delivery is widely used in long-term care facilities, the clinical practice guidelines of the **American Medical Directors Association (AMDA), *Managing Diabetes in the Long-Term Care Setting,*** call for physicians to reevaluate patients on SSI within 1 week and switch them to fixed daily doses if possible.[1] In addition, they state that "*Widespread use of sliding scale insulin...[may result in] increased nursing time because patients' blood glucose levels must be monitored more frequently and more insulin injections given.*"[1]

Why reevaluate ongoing SSI? Sliding scale therapy may result in wide fluctuations in blood glucose levels because many SSI regimens do not require insulin until blood glucose concentrations increase above 200 mg/dL. This means that patients may experience prolonged periods of uncontrolled blood glucose