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FAST FACTS AND CONCEPTS #90

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Introduction This Fast Fact will discuss the use of interventions in hospice care that can be controversial due to high cost and/or uncertainty whether they constitute 'palliative' interventions. When a patient elects the Medicare Hospice Benefit (MHB), the patient, the doctor, and the hospice team develop a Plan of Care (POC) that lists a) the patient's goals for care and b) the services needed to achieve these goals. A hospice program is fiscally responsible for all services outlined in the POC, and these services are paid for from the pool of money the hospice program gets from per diem payments (physician fees are billed separately – see *Fast Fact #87*).

Note: Since there is no Medicare regulation that specifies what treatments are deemed 'palliative', it is up to the individual hospice agency to determine whether or not they can financially and philosophically provide the interventions listed below. Most hospice agencies are not able to provide high-cost interventions due to financial limitations; patients may elect to be discharged from hospice care if they wish to pursue these options. Hospices with a large number of enrolled patients have greater financial resources and thus are better able to provide high-cost treatments. Recently, some hospices have introduced 'open-access' programs which more freely provide costly and even life-prolonging therapies to dying patients who would otherwise benefit from hospice services. The hope is that the increased costs will be covered by increased revenue from enrolling more patients earlier in the course of their illness.

Indications for use in Hospice Care In general, the interventions listed below are potentially indicated in patients with a) a good *functional status* (up, out of bed > 50% of the time; Karnofsky Performance Status >50; ECOG ≤ 2 – see *Fast Facts #13, 124*), or b) a clear goal to be met (e.g. wedding anniversary in two weeks). These interventions are not indicated solely to assist patients or families psychologically cope with impending death – to give the impression that 'something is being done.'

- **Parenteral Fluids** Indication: symptomatic dehydration where there is a patient-defined goal (e.g. upcoming family event). Fluids are not indicated to treat dry mouth or solely to reverse dehydration occurring as a normal aspect of the dying process; fluids may be of benefit to treat delirium in selected patients (see *Fast Fact #133*).
- **Enteral feeding** Indication: patient is hungry and there is a reason oral nutrition cannot be given (e.g. upper GI obstruction from esophageal cancer). See *Fast Facts #10, 84* for a complete review of the indications/contraindications for tube feeding.
- **Total Parenteral Nutrition** Indication: patient has short-gut syndrome or bowel obstruction and good functional status and a functional goal. See *Fast Fact #190* for further discussion.
- **Radiation Therapy** Indication: symptoms of pain, bleeding, or neurological catastrophe (e.g. acute spinal cord compression) and the patient is expected to live long enough to experience benefit (> 4 weeks) and the potential benefits outweigh logistic burdens (e.g. travel to the radiotherapy site, getting on and off the treatment table). See *Fast Facts # 66, 67*.
- **Red Blood Cell Transfusions or Erythropoietin** Indication: Symptomatic anemia (dyspnea or fatigue) in ambulatory patients who demonstrate *continued functional* benefit from treatment.
- **Platelet Transfusions** Indication: active bleeding and severe thrombocytopenia (Platelet count < 10,000).
- **Chemotherapy** Indication: symptoms from the cancer are causing distress; the likelihood of effectiveness

is high (expected Response Rate greater than 25% - see *Fast Facts #14, 99*); patient will live long enough to benefit (> 4-8 weeks, ECOG 0-2); and benefits outweigh burdens.

- **Antibiotics** Indication: oral antibiotics are appropriate to treat simple symptomatic infections (e.g. UTI). Parenteral antibiotics are not indicated unless there is an identified susceptible organism, there is a clear functional goal to be met, the likelihood of successful treatment is high, and the patient is expected to live long enough to achieve benefit.
- **Laboratory/Diagnostic service** Indication: to monitor aspects of POC (e.g. warfarin monitoring) or as part of a diagnostic evaluation for a new symptom for which the testing is likely to substantially alter patient management. Note: diagnosis of a new problem that does not relate to the terminal illness can be evaluated and treated by the patient's primary care provider under usual Medicare billing (e.g. acute myocardial infarction).

References

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