



[Print](#) :: [Close](#)

FAST FACTS AND CONCEPTS #139

Author(s): Tara C Friedman MD

Background The transition from hospital to home for the patient about to be enrolled in home hospice care is complex. Miscommunication between hospital staff and hospice care providers regarding goals of care and medications occurs commonly and only heightens existing stress and fear among patients and their caregivers. This Fast Fact reviews key steps in the transition from the acute care hospital setting to home hospice care.

Clarify goals *Fast Fact* #38 reviews key do's and don'ts of the initial hospice discussion with patients and families. Prior to discharge additional steps to clarify the goals of care include:

- Confirm in the records that you believe the patient meets hospice eligibility requirements (see *Fast Fact* #82): "In my medical judgement, the patient has a prognosis of less than 6 months if the disease follows its usual course."
- Review all medications and interventions (e.g. tube feedings, oral antibiotics). Any medications and interventions that do not help the patient and family meet their goals of care or enhance quality/comfort should be discussed with patients/families, and a recommendation made to discontinue them.
- Project ahead to the coming days to weeks: what symptoms/problems do you anticipate will likely occur (e.g. dyspnea in a lung cancer patient)? Ask yourself if the current medications/interventions will likely meet these needs or do additional medications/ interventions need to be made available in the home?

Contact the Hospice Agency Whoever makes the initial contact with a hospice agency (physician, discharge planner, palliative care nurse, etc.) should have the following information in hand:

- Patient's address – confirm the patient lives within the hospice's catchment area.
- Birth date and medical insurance information.
- Terminal diagnosis (e.g. dementia, cancer).
- Name of physician who will be physician of record for hospice care.
- Overall goals of care and special issues (e.g. family needs special bereavement support for children who live in the home or patient has two days of palliative radiation left).
- Medical equipment needs (e.g. hospital bed, oxygen).
- Anticipated discharge date/time.

Coordinated Discharge

- Whenever possible, have someone from the hospice program meet the patient and their caregiver in the hospital prior to discharge to review hospice eligibility and covered services. If not feasible, arrange for the initial hospice referral visit to occur when the patient arrives home, or within 24 hours of hospital discharge at the outside.
- Include the hospice staff in the discharge plan.
- Review symptoms and confirm treatments for the terminal illness with hospice staff.
- Review symptoms and confirm treatments for diseases unrelated to the terminal illness.
- Plan to have durable medical equipment and medications available when the patient arrives at home; coordinate this with your hospice agency provider. Most hospice agencies need at least 24 hours to coordinate the delivery of these items to the home.

With careful planning, the stress of transitioning to home hospice care will be minimized, allowing your patients,

their families and yourself the opportunity to focus on important issues near the end of life.

References

1. Turner R, Rosielle D. Medicare Hospice Benefit – Part I: Eligibility and Treatment Plan, 2nd Edition. Fast Facts and Concepts. November 2007; 82. Available at: http://www.eperc.mcw.edu/fastfact/ff_082.htm.
2. von Gunten CF. Discussing Hospice, 2nd Edition. Fast Facts and Concepts. July 2005; 38. Available at: http://www.eperc.mcw.edu/fastfact/ff_038.htm.

Fast Facts and Concepts are edited by Drew A Rosielle MD, Palliative Care Center, Medical College of Wisconsin. For more information write to: drosiell@mcw.edu. More information, as well as the complete set of Fast Facts, are available at EPERC: www.eperc.mcw.edu.

Version History: This Fast Fact was originally edited by David E Weissman MD and published in June 2005. Current version re-copy-edited in April 2009.

Copyright/Referencing Information: Users are free to download and distribute Fast Facts for educational purposes only. Friedman TC. Hospice Referral: Moving From Hospital to Home. Fast Facts and Concepts. June 2005; 139. Available at: http://www.eperc.mcw.edu/fastfact/ff_139.htm.

Disclaimer: Fast Facts and Concepts provide educational information. This information is not medical advice. Health care providers should exercise their own independent clinical judgment. Some Fast Facts cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

ACGME Competencies: Patient Care, Systems-Based Practice

Keyword(s): Communication, Ethics, Law, Policy Health Systems

© 2008 Medical College of Wisconsin

Medical College of Wisconsin

8701 Watertown Plank Road, Milwaukee, WI 53226

www.mcw.edu | 414.456.8296

[Print](#) :: [Close](#)