VCHCP Ventura County Health Care Plan

Medical Policy:

Hospice Care Program

Effective: 02-27-07

Reviewed: Februarv 2012

Hospice care is available for members who meet criteria as defined below:

General Criteria for Admission into Hospice Program

The physician certifies that the member has an established diagnosis, whether from a malignant or non-malignant cause, with a life expectancy of twelve months or less if the terminal illness runs its normal course*, and members and their families have decided to forgo therapies with curative or life-prolonging intent; and
Member needs palliative treatment ("comfort care") since continued aggressive work-up, treatment and hospitalizations are deemed to be medically futile; and
The services must be provided according to a doctor-prescribed treatment plan; and
All hospice services must be provided by a licensed Hospice Care Organization with appropriately qualified/licensed personnel; and
Continuity of care must be assured for the member and family regardless of setting (home, outpatient, or inpatient); and
Hospice care is available 24 hours a day, seven days a week.

* Normal course defined as: steady, continual decline in function without unexpected remission of disease.

Hospice Care Program Description

A hospice care program consists of, but is not limited to, the following:

Professional services of a registered nurse, licensed practical nurse, or licensed vocational nurse;
Physical therapy, occupational therapy, and speech therapy;
Medical and surgical supplies and durable medical equipment;
Prescribed drugs;
In-home laboratory services;
Medical social service consultations;
Inpatient hospice room, board, and general nursing service;
Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family member or other persons caring for the individual;
Family counseling related to the member's terminal condition;
Dietitian services;
Pastoral services;
Bereavement services;
Educational services;
Home health aide services consisting primarily of a medical or therapeutic nature and furnished to a member who is receiving appropriate nursing or therapy services

Home Care Visits

VCHCP considers visits by all skilled services (i.e., skilled nursing and/or home health aide services, physical, occupational and speech therapies, medical social services and nutritional services) medically appropriate.

Inpatient Hospice Care

VCHCP considers acute inpatient hospice care** medically appropriate when any of the following is met:

1. Member requires short-term inpatient palliative hospice care consisting of discomfort evaluation and development of a program aimed at the reduction or abatement of pain and symptoms (physical, sociological, spiritual, emotional or psychological) which will make it possible for the member to enjoy quality of life after returning to the home setting in a few days.
2. Family members are unable to provide care or cope with the member at home, or when an illness results in problems which are difficult to deal with at home
3. The member requires skilled and professional acute or intensive care as the illness progresses
4. Member is admitted for short-term management of pain or symptoms to give family members relief for a brief period of time (known as respite care)

**** **Note**: Inpatient hospice presumes a plan of care that is primarily focused on symptom control and not on diagnostic work-up or aggressive therapy of the underlying disease.

Discharge criteria (from Hospice Care):

1. Member's condition improves and the disease goes into remission such that member can return home and go about daily life
2. Member or his/her legal decision maker wishes a return to aggressive therapy
3. Member requires a return to aggressive therapy for cure of disease modification to prolong life

Respite Care

VCHCP considers respite care only for a maximum of five (5) consecutive days at a time, but it can only be provided on an occasional basis.

Non-Covered Services

VCHCP does not consider any of the following medically appropriate, therefore not covered:

Homemaker services such as cooking and housekeeping, food or meals, or private duty nursing services;
Services provided to other than the terminally ill member, excluding bereavement counseling for enrollee family members which is a covered benefit;
Services performed by family members or volunteer workers;
Homemaker or housekeeping services, except by home health aides, as ordered in the hospice treatment plan;

Supportive environmental materials, including but not limited to handrails, ramps, air conditioners, and telephones;
Normal necessities of living, including but not limited to food, clothing and household supplies;
Food service, such as "Meals on Wheels;"
Separate charges for reports, records, or transportation.
Legal and financial counseling services;
Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit.

DEFINITIONS OF ILLNESS:

Cancerous Terminal Illnesses

The patient's condition is defined as terminal cancer disease only after all known effective acceptable oncological treatments have failed. It is also believed that the cancer will cause a rapid decline resulting in death within 6 months.

Non-Cancerous Terminal Illnesses

Recognizing that determination of life expectancy during the course of a non-cancerous terminal illness is difficult, medical criteria for determining prognosis based on available scientific research appears to be a reasonable approach for determining prognosis. However, some members may not meet the criteria, yet still be appropriate for hospice care, because of other comorbidities or rapid decline. Coverage for these patients may be approved on an individual consideration basis.

Scientific Rationale

The National Hospice and Palliative Care Organization:

- defines hospice as support and care for persons in the last phase of an incurable disease so that they may live as fully and comfortably as possible.
- Hospice programs provide state-of-the-art palliative care and supportive services to individuals at the end of their lives, their family members and significant others, 24 hours a day, seven days a week, in both the home and facility-based settings. Physical, social, spiritual and emotional care are provided by a clinically-directed interdisciplinary team consisting of patients and their families, professionals and volunteers during the: (1) last stages of an illness; (2) dying process; and (3) bereavement period.
- Hospice is a specialized health care program for:
    - terminally ill patients who chose supportive and palliative care rather than curative measures and aggressive treatments for their terminal illness.
    - It focuses on symptom control, pain management and psychosocial support for patients with a life expectancy of less than 6 months.
    - Hospice does nothing to speed up or slow down the dying process. Rather, Hospice programs provide state-of-the-art palliative care and supportive services to individuals at the end of their lives, their family

members and significant others, 24 hours a day, seven days a week, in both the home and facility-based settings. It consists of a physician-directed, nurse-coordinated interdisciplinary team consisting of social workers, counselors, home health aides, clergy, physical and occupational therapists, and specially trained volunteers.

The American Board of Hospice and Palliative Medicine:

- Defines palliative care as a discipline and model of care devoted to achieve the best possible quality of life of the patient and family throughout the course of a life-threatening illness through the relief of suffering and the control of symptoms. Such relief requires the comprehensive assessment and interdisciplinary team management of the physical, psychological, social, and spiritual needs of patients and their families. Palliative medicine helps the patient and family face the prospect of death assured that comfort will be a priority, values and decisions will be respected, spiritual and psychosocial needs will be addressed, practical support will be available, and opportunities will exist for growth and resolution.
- Palliative care is provided through effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family needs, values, beliefs and culture(s).
- Evaluation and treatment is comprehensive and patient-centered, with a focus on the central role of the family unit in decision-making.
- Palliative care affirms life by supporting the patient and family's goals for the future, including their hopes for cure or life-prolongation, as well as their hopes for peace and dignity throughout the course of illness, the dying process and death.
- Palliative care aims to relieve suffering in all stages of disease, and is not limited to end of life care. Palliative care is included in hospice care; however, palliative care is not necessarily hospice care because it lacks the requirement to forgo curative or life prolonging treatments.
- Palliative care aims to guide and assist the patient and family in making decisions that enables them to work toward their goals during whatever time they have remaining.
- Comprehensive palliative care services often require the expertise of various providers in order to adequately assess and treat the complex needs of seriously ill patients and their families.
    - Members of a palliative care team may include professionals from medicine, nursing, social work, chaplain visits, nutrition, rehabilitation, pharmacy and other professional disciplines. Leadership, collaboration, coordination and communication are key elements for effective integration of these disciplines and services.
    - Treatments rendered with the primary purpose of curing the illness or treatments which extend the length of life, while compromising the

quality of the time remaining, are contrary to the Hospice philosophy of care.

A: Attachment: None

B. Author/Reviewer: Cynthian Wilhelmy, MD **Date**: 02-15-07

Committee Review: UM on 02/20/07 & QA on 02/27/07

Reviewed/Revised: Albert Reeves, MD Date: 02.9.12
Committee Reviews: UM on 02.09.12 & QA on 02.28.12
For Additional Committee Approval: UMC on 05.10.12 & QAC on 05.22.12

C. References*:*

1. Clinical Practice Guidelines For Quality Palliative Care. Brooklyn (NY): National Consensus Project for Quality Palliative Care; 2004. Available at: http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=5058&nbr=3542
2. Guidelines for Hospice Care and Treatment. 2002. Available at: http://www.hospiceathome.org/physicians3.html
3. Keay TJ, Schonwetter RS. Hospice Care in the Nursing Home. American Family Physician Vol. 57/No. 3 (February 1, 1998). Available at: http://www.aafp.org/afp/980201ap/keay.html
4. National Hospice Organization. Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases. 1996. Available at: http://www.abbeyhospice.com/clinical/guidelines.html
5. The care of dying patients: a position statement from the American Geriatrics Society. J Am Geriatr Soc 1995;43:577-8. Available at: http://www.americangeriatrics.org/products/positionpapers/careofd.shtml
6. Bookbinder M, Blank AE, Arney E, et al. Improving End-of-Life Care: Development and Pilot-Test of a Clinical Pathway. J Pain Symptom Manage. 2005 Jun;29(6):529-543.
7. Dobratz MC. Gently into the light: a call for the critical analysis of end-of-life outcomes. ANS Adv Nurs Sci. 2005 Apr-Jun;28(2):116-26

8.. Ryder-Lewis M. Going home from ICU to die: a celebration of life. Nurs Crit Care. 2005 May-Jun;10(3):116-21

9. .Oliver DP, Porock D, Zweig S. End-of-Life Care in U.S. Nursing Homes: A Review of the Evidence. J Am Med Dir Assoc. 2005 May-Jun;6(3 Suppl):S21-30.
10. Levy MH, Samuel TA. Management of cancer pain. Semin Oncol. 2005 Apr;32(2):179-93.
11. Sethi S. Hospice: an underutilized resource. J Okla State Med Assoc. 2001 Mar;94(3):79-84.
12. Lynn J, Harrell F Jr, Cohn F, Wagner D, Connors AF Jr. Prognoses of seriously ill hospitalized patients on the days before death: implications for patient care and public policy. New Horiz 1997;5:56-61

13. Lynn J. Measuring quality of care at the end of life: a statement of principles. J Am Geriatr Soc 1997; 45:526-7.

14. Harris NJ, Dunmore R, Tscheu MJ. The Medicare Hospice Benefit: fiscal implications for hospice program management. Cancer Manage 1996;3:6-11.

15. Cranmer KW. Hospice care in long-term care facilities: a gerontologist's viewpoint. Nurs Home Med 1996;4:219-22.

16. Leland J. The nursing home Medicare Hospice Benefit. Nurs Home Econ 1996;3:8-13

17. Schonwetter RS. Care of the dying geriatric patient. Clin Geriatr Med 1996;12:253-65.

18. Fortinsky RF, Raff L. Physicians in nursing homes: challenges and opportunities. Nurs Home Med 1996;4:8-13.

19. Ferrell BA, Ferrell BR, Rivera L. Pain in cognitively impaired nursing home patients. J Pain Symptom Manage 1995;10:591-8.

20. Leibowitz C, Browing S. The expanded —hospice in the LTC facility. Am J Hospice Palliat Care 1995;12:16-7.

21. O'Brien LA, Grisso JA, Maislin G, LaPann K, Krotki KP, Greco PJ, et al. Nursing home residents' preferences for life-sustaining treatments. JAMA 1995;274:1775-9.

22. Leland J. Terminal care in the nursing home part I: identifying the terminally ill and managing their pain. Nurs Home Med 1994;2:19-31

23. Leland J. Terminal care in the nursing home part II: management of symptoms other than pain. Nurs Home Med 1994;2:185-824.

24. Amar DF. The role of the hospice social worker in the nursing home setting. Am J Hospice Palliat Care 1994;11:18-23.

25. Keay TJ, Fredman L, Taler GA, Datta S, Levenson SA. Indicators of quality medical care for the terminally ill in nursing homes. J Am Geriatr Soc 1994;42:853-60.

26. Engle VF, Graney MJ. Predicting outcomes of nursing home residents: death and discharge home. J Gerontol 1993;48:S269-75.

27. Hurley AC, Volicer BJ, Hanrahan PA, Houde S, Volicer L. Assessment of discomfort in advanced Alzheimer patients. Res Nurs Health 1992;15:369-77.

28. Reisberg B. Functional assessment staging (FAST). Psychopharmacol Bull 1988;24:653-9.