Editorials

Use of Hospice Care for Patients Without Cancer

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Since its inception in 1982, the Medicare hospice benefit has allowed terminally ill patients to receive symptom-oriented care at the end of life in a variety of clinical and home settings. Initially, hospice care included patients with terminal cancer, and subsequent prognostic criteria were developed for patients with terminal noncancer illnesses.[1,2]

The Medicare Payment Advisory Commission published a report in 2009 discussing the changing uses of hospice care in Medicare recipients.[3] In 2006, nearly two thirds of deaths among hospice patients were related to noncancer diagnoses.[4] The mean length of stay was 59 days, with less than 17 percent of patients receiving hospice care for more than 180 days.[3] Despite improved awareness by physicians and patients' families of the availability of hospice services, 60 percent of Medicare decedents were not enrolled in hospice care at the time of death.[3]

Currently, patients with an anticipated life expectancy of less than 180 days are eligible for the Medicare hospice benefit. Most persons without cancer die of chronic debilitating illnesses, such as cardiovascular, pulmonary, or neurodegenerative conditions, and may require hospice care. Terminally ill, noncancer patients may rely on a subspecialist or the primary care physician to define goals of medical care, whereas oncologists often direct the care of patients with cancer.

Although there is no definitive study describing the economic benefits of hospice care, one study suggested that hospice intervention for the final 50 to 108 days of life provides the maximal Medicare savings.[5] The study showed a savings of approximately $7,000 in patients with cancer and a savings of $3,500 in patients with other diseases. Beyond an economic impact, there are psychological benefits from timely hospice admission. The delay of interdisciplinary hospice care has been shown to worsen symptoms of depression for family members during the grieving process,[6] and most Medicare beneficiaries do not wish to die in hospitals.[7] This is congruent with a palliative care model for end-of-life care.

Physicians have a generally favorable opinion of hospice care, but many lack confidence in their knowledge of hospice practices.[8] Better-informed physicians are more likely to recommend hospice care and successfully facilitate the transition of appropriate patients to a hospice program.[9] This suggests a greater need among physicians, especially in the primary care community, to identify and establish goals of care for patients with advanced chronic illness who have limited life expectancy and may be hospice candidates.

Familiarity with the Palliative Performance Scale,[2,10] Functional Assessment Staging for Dementia,[2] and criteria of end-stage cardiopulmonary disease[1,2] is essential for identifying terminally ill patients early enough to maximize the benefits of interdisciplinary hospice care. The use of these tools to evaluate prognosis is the Medicare standard by which hospices are held accountable. Physicians who are uncomfortable establishing palliative care goals can involve a specialist in palliative care.[11]

As the Medicare population expands with the baby boomer generation, the need for greater mastery of clinical and interpersonal skills regarding end-of-life care is essential for meeting the wishes and needs of patients.

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