PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #139
HOSPICE REFERRAL: MOVING FROM HOSPITAL TO HOME

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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.
- Inquire if the home hospice team can offer continuous care for patients with acute symptom management needs or in patients in whom discontinuation of life supporting therapies will be occurring during the transition to home. There is some published evidence that continuous care can significantly improve the chances that the patient can die at home.
- 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

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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.
3. Barclay JS, Kuchibhalta M, et al. Association of hospice patients' income and care level with place of death. *JAMA Intern Med.* 2013; 173(6):450-456

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