

# Hospice Care and the Emergency Department: Rules, Regulations, and Referrals

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Emergency clinicians often care for patients with terminal illness who are receiving hospice care and many more patients who may be in need of such care. Hospice care has been shown to successfully address the multidimensional aspects of the end-of-life concerns of terminally ill patients: dying with dignity, dying without pain, reducing the burden on family and caregivers, and achieving a home death, when desired. Traditional emergency medicine training may fail to address hospice as a system of care. When they are unfamiliar with the hospice model, emergency clinicians, patients, and caregivers may find it difficult to properly use and interact with these care services. Potential poor outcomes include the propagation of misleading or inaccurate information about the hospice system and the failure to guide appropriate patient referrals. This article reviews the hospice care service model and benefits offered, who may qualify for hospice care, common emergency presentations in patients under hospice care, and a stepwise approach to initiating a hospice care referral in the emergency department. [Ann Emerg Med. 2011;57:282-290.]

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## HOSPICE CARE SERVICES IN THE UNITED STATES: WHAT, WHERE, HOW, WHY, AND FOR WHOM?

### What is Hospice Care?

The word *hospice* comes from the Latin word *hospitium*, meaning a guesthouse of rest for weary travelers. Dr. Cicely Saunders began the modern hospice movement during the 1960s, when she established St. Christopher's Hospice near London.<sup>1</sup> There she provided comprehensive palliative care for dying patients. Currently, hospice care serves as a model for quality, compassionate care for those facing a life-limiting illness or injury and involves a team-oriented approach to medical care, pain management, and emotional/spiritual support tailored to the patient and family needs.<sup>1</sup> Hospice is not a place, but a care system. Care is provided in a place the patient calls home, including private residences, nursing homes, and residential facilities. The majority (70.3%) of patients receive hospice care at home.<sup>2</sup> Hospice care can also be provided in an inpatient hospice facility or an acute care hospital setting, and the percentage of hospice patients receiving such care has increased.<sup>2</sup>

### Who Is Eligible?

In 1982, Congress included a provision to create a Medicare hospice benefit, which has since become the standard for the provision of hospice care services. Patients are eligible for hospice services if they have a prognosis of 6 months or less if their disease runs its usual course because some patients may outlive this

prognosis.<sup>2-9</sup> In general, for a patient to receive hospice care, (1) 2 physicians, an attending physician and the hospice medical director, certify that, to the best of their judgment, the patient is terminally ill and more likely than not to die within 6 months if the disease runs its normal course; and (2) the patient/family consents to the hospice philosophy of a comfort care approach with respect to their terminal illness. There is no penalty if a patient survives longer. Patients may become ineligible for hospice services with improvement in their health status, a so-called hospice graduate, but may re-enroll if their clinical condition declines. Hospice care emphasizes quality of life and "living until you die."<sup>10</sup> Patients may have any diagnosis to qualify, with noncancer primary diagnoses now comprising greater than 58% of all admissions to hospice.<sup>2</sup> To assist physicians in determining prognosis and initiating a hospice referral, broad guidelines for many cancer- and non-cancer-related conditions exist (Table 1).<sup>4</sup> These are not hard-and-fast rules, and coexisting conditions or a rapid functional decline can outweigh strict adherence to these guidelines.

### Scope of Services and the Hospice Agency as the Patient's Care Manager

The hospice agency is paid a per-diem rate for all care provided to the patient related to the hospice diagnosis and in turn is the patient's care manager. Hospice care is provided by a multidisciplinary team: physician, nurse, social worker, chaplain, home health aide, volunteers, and therapists. Members of the hospice team make regular visits to assess the patient and provide

**Table 1.** General hospice eligibility guidelines.\*

General guidelines	<p>Progression of life-limiting disease as documented by:</p> <ul style="list-style-type: none"> <li>Decline in clinical status: recurrent infections, intractable pain or vomiting/diarrhea, dysphagia</li> <li>Multiple hospital admissions or emergency department visits</li> <li>Decline in functional status: dependence on assistance with activities of daily living</li> <li>Impaired nutritional status: weight loss 10% during past 6 mo, serum albumin level &lt;2.5 g/L</li> <li>Disease-specific markers: physical examination, laboratory tests, previous imaging</li> </ul>
<b>Disease-specific general guidelines</b>	
Oncologic	Disease with distant metastases at presentation or progression from an earlier stage of disease to metastatic disease with either a continued decline in spite of therapy or patient refusal of further disease-directed therapy
Cardiac	<p>CHF symptoms at rest (NYHA class IV)</p> <p>Must be optimally treated with diuretics and after-load reduction</p> <p>The following help predict increased mortality: symptomatic supraventricular or ventricular arrhythmias, previous cardiac arrest, unexplained syncope, cardiogenic shock</p> <p>An ejection fraction of 20% or less is helpful but not required</p>
Pulmonary	<p>Disabling dyspnea at rest, unresponsive to treatment</p> <p>Progressive disease: declining FEV1 (&gt;40 mL/year) or increased emergency department visits/hospitalizations</p> <p>Cor pulmonale or right-sided heart failure (not caused by valve disease or left-sided heart failure)</p> <p>Hypoxemia at rest (PaO<sub>2</sub> &lt;55 mm Hg or sat &lt;88% on supplemental O<sub>2</sub>)</p> <p>Hypercapnia (PaCO<sub>2</sub> &gt;50 mm Hg) (records within last 3 mo)</p> <p>Resting tachycardia</p>
Dementia	<p>1. Patients with all the following characteristics:</p> <ul style="list-style-type: none"> <li>Stage 7 or beyond according to the Functional Assessment Staging Scale</li> <li>Unable to ambulate, dress, bathe without assistance</li> <li>Urinary and fecal incontinence, intermittent or constant</li> <li>No consistently meaningful verbal communication: limited to 6 or fewer intelligible words</li> </ul> <p>2. Presence of comorbid conditions associated with decreased survival, such as aspiration, pyelonephritis, septicemia, pressure ulcers (stage 3-4), fever despite antibiotics</p> <p>3. Nutritional impairment</p> <ul style="list-style-type: none"> <li>If patient has G-tube, nutritional impairment with weight loss &gt;10% during 6 mo, serum albumin &lt;2.5 g/L</li> <li>In the absence of G-tube, decreased oral intake</li> </ul>
Liver	<p>Not a transplant candidate</p> <p>Impaired synthetic function: albumin level &lt;2.5 g/L and INR &gt;1.5</p> <p>Ascites despite maximum diuretics</p> <p>Spontaneous bacterial peritonitis</p> <p>Hepatorenal syndrome</p> <p>Hepatic encephalopathy despite management</p> <p>Recurrent variceal bleeding</p>
Renal	<p>Creatinine clearance &lt;10 mL/min (&lt;15 if diabetic) and serum creatinine level &gt;8 (&gt;6 if diabetic)</p> <p>Signs or symptoms associated with uremia: hyperkalemia, pericarditis</p> <p>Oliguria</p> <p>Intractable fluid overload</p> <p>Not receiving dialysis or refusing dialysis</p>
HIV	<p>CD4 of &lt;25 despite antiretroviral therapy, decreased functional status plus one of the following:</p> <ul style="list-style-type: none"> <li>CNS lymphoma</li> <li>Persistent wasting</li> <li>Mycobacterium avium complex bacteremia</li> <li>Progressive multifocal leukoencephalopathy</li> <li>Visceral kaposi or systemic lymphoma resistant to chemotherapy</li> <li>Cryptosporidium or toxoplasmosis resistant to therapy</li> </ul>

CHF, Congestive heart failure; NYHA, New York Heart Association; FEV, forced expiratory volume; G-tube, gastrostomy tube; CNS, central nervous system.

\*Adapted from the Centers for Medicare & Medicaid Services, Medicare Coverage Database. LCD (local coverage determination) for hospice: determining terminal status (L25678).<sup>4</sup> Available at: [http://www.cms.gov/mcd/viewlcd.asp?lcd\\_id=25678&lcd\\_version=27&show=all#top](http://www.cms.gov/mcd/viewlcd.asp?lcd_id=25678&lcd_version=27&show=all#top).

additional care and support services. They are on call 24 hours a day, 7 days a week to meet patient and caregiver needs. The hospice team develops a care plan to meet each patient's needs and conducts regular interdisciplinary meetings to discuss ongoing issues.<sup>2</sup>

Hospice care includes management of the patient's pain and other distressing symptoms; assisting the patient with the

emotional, psychosocial, and spiritual aspects of dying; provision of symptom and comfort-related pharmacotherapies, medical supplies, and durable medical equipment, including home oxygen; coaching of caregivers on how to care for the patient; speech and physical therapy; short-term inpatient care when active dying occurs or when symptoms become difficult to manage at home or when the caregiver needs respite time; and

bereavement care, as well as counseling to the surviving family and caregivers for 1 year after the patient's death.<sup>2-9</sup>

### How Is Hospice Care Paid for?

Hospice care is typically fully covered under Medicare, Medicaid, and private insurers. Additionally, uninsured persons may access it through local hospice agencies willing to provide unreimbursed care.<sup>11</sup> Current Medicare daily reimbursement rates are approximately \$143.10 for home care, \$643.64 for inpatient hospice, \$155.61 for respite care, and \$834.43 for continuous home care.<sup>12</sup> Patients may continue to follow up with their primary care provider as well. The hospice is responsible for *all* care related to the hospice-qualifying condition for which the patient is certified. Because hospice is the care manager, the agency will typically ask patients and their surrogates to call them first before seeking emergency care outside of hospice to determine whether the condition is related to hospice certification diagnosis and whether the hospice can manage the crisis without an emergency department (ED) visit.

While receiving hospice care, patients may present to the ED for conditions related to or not related to their hospice diagnosis, and reimbursement responsibility may vary. For example, when a patient receiving hospice care for cancer presents to the ED with a laceration from a minor injury that is unrelated to the cancer, the regular insurer is billed and pays for related charges. In contrast, if the same patient presents to the ED for a pathologic femur fracture, the condition *is* related to the cancer (primary certifying diagnosis), and the hospice would be held fiscally responsible for hospital services. If a patient does not call hospice before seeking ED care, the patient may be held fiscally responsible for all related ED charges.

### Hospice Is an Underutilized Resource

For a patient to be referred for hospice care, the clinician would need to recognize the signs of an end-of-life trajectory with limited prognoses. Function and clinical decline with serious, chronic, irreversible illness at the end of life generally follow one of 4 trajectories: (1) a relatively short period of obvious steady decline at the end, after a diagnosis of advanced malignancy; (2) long-term disability, with periodic exacerbations/remissions and an unpredictable timing of death, characteristic of those dying with chronic organ-system failure; (3) a slowly dwindling course with self-care deficits, usually from frailty or dementia; (4) sudden death. It is estimated that 90% of patients will experience one of the first 3 trajectories.<sup>13,14</sup> Admittedly, recognition of these trajectories in the emergency setting can present a significant challenge.<sup>15</sup>

Despite widespread availability, hospice care is globally underutilized.<sup>16</sup> In 2007, of the total 2.4 million deaths in the United States, 38% of patients received hospice care.<sup>2</sup> When patients do receive hospice care, the median length of service is about 20 days, with approximately one third (31%) of patients served by hospice receiving care for only 7 days or fewer.<sup>2</sup> Reasons for late hospice referrals are multifactorial and include reluctance of physicians to prognosticate and communicate the

resultant prognosis, unwillingness of patients or surrogates to accept the terminality of their illness, considering hospice only for those who are imminently dying, and racial/ethnic factors.<sup>16-21</sup> Patients and families may feel that hospice care "hastens" death and is equal to "giving up." Although the main focus of hospice care is on quality of life and not curative treatments, some evidence suggests that patients do not have shorter lives as a result of hospice enrollment alone. The improved psychosocial support under hospice may sometimes even prolong mean survival.<sup>22</sup>

### Termination of Hospice Service and Advance Directives in Hospice Care

An ED visit does not equate to stopping hospice care, and hospices typically do not automatically terminate patients from hospice if they seek emergency care. Sometimes hospice providers in the home or inpatient setting may themselves initiate the call to emergency services for a transfer if hospitalization is indicated and the hospice is unable to manage that aspect of care. Although it may seem reasonable to expect that a patient or surrogate who accepts the hospice philosophy of comfort care would naturally choose a do-not-resuscitate (DNR) status, this is not always true, especially in the initial phase of hospice care, when patients and families may have a difficult time accepting the terminality of the disease. A DNR status is not a requirement for hospice service. Therefore, patients under hospice care who do not have a DNR order in place may present to the ED, regardless of the hospice care manager, insurance carrier paying for hospice care, or region of practice. When death is imminent, efforts are usually made to renegotiate code status before the initiation of transfer; however, this may not be achieved and resuscitation may then occur.

Advance directives are a key component of patient-centered, end-of-life care. Ideally, advanced care planning is a longitudinal process of structured discussion and documentation that is woven into the regular process of hospice care and gets reviewed and updated regularly. These advance planning documents usually fall into 2 categories: those that relate to *instructions* for medical care and those that involve the designation of a *proxy* decisionmaker for the patient. Instructional directives are the do-not-intubate, DNR, and do-not-transfer orders, simple medical directives that cover a single topic. In terminally ill patients, advance directive accessibility and validity may often be a source of misunderstanding or anxiety for ED providers and is therefore discussed further in the "Caring for the Hospice Patient in the ED" section.

A lack of a DNR order or initiation of a transfer to the ED does not necessarily terminate hospice services, but a patient may decide to opt out of hospice care for a number of reasons, which include the following: (1) patient or surrogates may disagree with a comfort care approach and have difficulty accepting the natural decline of terminal illness; (2) they may request care directed at prolonging life that cannot be provided by hospice; (3) they may desire a second opinion; and (4) they may be dissatisfied with the hospice care model or service. From

the perspective of hospice services, a patient may also be discharged from hospice care if “beneficiary behavior is disruptive, abusive, or uncooperative to the extent that delivery of hospice care is seriously impaired.”<sup>7</sup>

## CARING FOR THE HOSPICE PATIENT IN THE ED

Emergency physicians experience ambivalence and discomfort in treating patients with hospice and palliative care needs, as outlined in a recent study on ED provider perspectives.<sup>23</sup> This study highlighted structural barriers to the provision of optimal palliative care in the ED, such as a chaotic environment, competing demands, and long wait times, as well as communication challenges. ED providers expressed distress and conflict over cases in which patients’ wishes or written advance directives were in conflict with the wishes of family. Resident trainees expressed concern that training in pain management is inadequate and expressed regret that dying patients they had cared for received suboptimal pain management. The study also outlined an earlier introduction to hospice as a possible solution to educate family members, reduce family fear, and prevent some of the ED visits.<sup>23</sup>

### Triggers of an ED Visit

Despite the fact that patients who receive hospice services are made aware of the 24-hour on-call hospice provider, some will still activate emergency services because this is perhaps an ingrained “learned behavior” and an automatic response to the trigger of perceived distress. Patients and caregivers often face difficulty because end-of-life approaches and a visit to the ED may signal a physical, spiritual, or psychosocial crisis. The crisis may therefore be related to poor symptom control or a conflict in goals of care between the patient (who may desire life-improving measures) and caregivers (who insist on life-prolonging measures). The crisis may occur when the patient needs a medication unavailable in the home or faces loss of a support device (such as tracheostomy or gastrostomy). Also, like all care systems that can sometimes become overwhelmed, a hospice nurse on call may not be able to respond in time. Because a patient is not required to elect a DNR status, the patient/surrogates may even be instructed by the hospice to call emergency services as the patient deteriorates, if they are a “full code.” These calls to 911 may not always represent a desire for aggressive care but rather an expression of fear, panic, and an inability to cope with distressing signs and symptoms or impending loss of life.<sup>24,25</sup> This panic is also exacerbated by late referrals to hospice care, as previously described. When such a patient presents to the ED, general management principles apply and establishing early contact with the hospice and primary care provider is essential (Figure 1).<sup>24,25</sup> Attention to advance directives and goals of care are paramount while pain and nonpain symptoms are simultaneously managed.<sup>26-28</sup> The following is a suggested approach to managing some of the common ED presentations in a patient receiving hospice care.

**Addressing advance directives and reconciliation of goals of care.** In general, advance directive completion rates are variable, but in a multistate analysis of nursing home residents, rates of written DNR orders as a component of advance directive completion have been shown to be higher for patients under hospice care (86%) compared with nonhospice patients (67%).<sup>29</sup> Similarly, in a large cohort of decedents the advance directive completion rate was reportedly highest for those receiving home hospice care (82%).<sup>30</sup> Often, in the context of life-threatening situations in a hospice-care patient, decisions about resuscitation and the use of life-sustaining interventions will frequently arise in the ED.<sup>23</sup> Sometimes, changes in health status, interfamily conflicts, and issues with institutional protocols pose challenges to the implementation of pre-existing advance planning documents and make discussions of relevant decisions necessary. This process is difficult when the patient has loss of capacity or is unable to participate in decisions while in the midst of a crisis.

Advance care planning discussions should ideally begin with the question, what are the patient’s goals of care? We recommend starting with a general context and addressing specifics later in the conversation, as needed.<sup>31,32</sup> Rapid advance care planning involves (1) determining current status of advance directives, ascertaining who is involved in the decisionmaking, and thinking through what element is being negotiated; (2) establishing patient expectations and goals; (3) making a recommendation and formulating a plan, for example, “According to your goals, I would/would not suggest . . .”; (4) confirming and supporting the decisions made by patient and family; and finally (5) documenting the overall plan and writing the orders.<sup>31,32</sup> Specific decisions should ideally be made in the context of the whole person, not isolated to discussing DNR in the context of cardiopulmonary resuscitation (CPR). CPR is only one therapeutic scenario that may or may not fit the overall goals of the patient and should not be presented as an “everything” or “nothing” option. It is also best not to use mechanistic terms (eg, “starting the heart” or “putting on a breathing machine”).<sup>31,32</sup>

**Noninvasive management of terminal dyspnea.** Dyspnea is a common symptom at the end of life. Patients receiving hospice care frequently present to the ED with respiratory distress as the main symptom in the last hours and days of living because this shortness of breath provokes significant anxiety and distress in the patient and the caregivers.<sup>23-28,33</sup> The extent of evaluation to discover reversible causes and determine further management is dependent on and guided by understanding where the patient is in the dying trajectory and what the patient’s identified goals of care are. If the goals of care are yet to be clarified, a rapid assessment to look for reversible causes that can easily be relieved is warranted; hypoxia, fluid overload, severe pain, or severe anemia should be identified through low-burden, noninvasive investigations that may include pulse oximetry, portable chest radiograph, and ECG. If the patient is clearly dying and the identified goals of care are comfort, then

**ED Patient Currently Receiving Hospice Care: Assessment and Management**

1. Treat distressing signs and symptoms. Provide physical and emotional support to the patient/caregivers. Maintain a supportive, patient-centered approach to care.
2. If deterioration is imminent, ascertain resuscitation status and the desire for life-extending therapy such as mechanical ventilation. (It is not necessary to have a DNR order to be under hospice care.)
3. Notify hospice of the patient's transfer to the ED.
4. May need to delay laboratory tests or other diagnostic studies until discussed with hospice nurse/physician. Follow patient's already determined goals of care.
5. Ascertain the pain level and medications for pain currently in use; maintain the baseline dosages despite seemingly high and continue in ED until disposition.
6. Avoid the initiation of invasive treatments, including intravenous lines/catheters, unless discussed with hospice nurse/physician and family; the patient may appear dehydrated because patients frequently stop drinking as death approaches, but this is normal and expected.
7. If the patient is actively dying, try to give the family privacy; involve the chaplain on family request.
8. Symptom-directed therapy for relaxation and agitation as needed; oxygen by nasal cannula may be freely given.
9. Do not admit to the hospital without discussion with hospice nurse/physician because an alternate disposition may be possible (eg, inpatient hospice care, home hospice with a higher level of continuous care).
10. If the patient is admitted, consult the inpatient palliative care service, if available.

\*Adapted from Reeves.<sup>24</sup>

**Figure 1.** Basic guidelines to follow while caring for a patient under hospice care in the ED.\*

invasive testing may not be indicated.<sup>28</sup> Management of terminal dyspnea can then be accomplished with a goal toward making the patient comfortable.<sup>33-37</sup> Opioids remain the first-line agents to break the dyspnea-anxiety cycle, and the typical dose is morphine 1 mg intravenously or 5 mg orally every hour, as needed. Benzodiazepines may also assist in refractory dyspnea management. Oxygen, upright positioning, and a fan to blow cool air over the face often help.<sup>34-37</sup> When goals of care are being clarified, emergency clinicians may also consider noninvasive ventilation, which may serve as a rescue therapy, provide a bridge while palliative medications are being administered, or offer time in cases in which clarification of life-extending therapies requires further discussion.

**Management of severe uncontrolled pain.** Pain at the end of life is common, and pain assessment and management are particularly important in terminally ill patients with advanced malignancy because these patients may have a high burden of pain, be opiate tolerant, and already be receiving high doses of opioids.<sup>38</sup> There is no ceiling or maximal recommended opioid dose. ED staff is familiar with immediate-release medications used on an as-needed basis for acute intermittent pain. Patients with constant moderate to severe pain will need a fixed-schedule dosing (not just an "as needed" order), which may combine

sustained-release with immediate-release medications. An example would be the use of sustained-release morphine at a fixed dose every 12 hours, with immediate-release morphine for breakthrough pain every 4 hours, as needed. Equianalgesic opioid conversion charts assist in estimation of a starting analgesic dose in the opioid-tolerant patient or when formulations and mode of delivery need to be switched; for example, when oral medications can no longer be administered because of a declining ability to swallow (Table 2).<sup>38-41</sup> Dosing tables also help to convert an often complex array of multiple medications into a single opioid equivalent.<sup>38</sup>

Many Web resources exist to aid the clinician in managing severe pain in the opioid-tolerant patient.<sup>42-44</sup> General principles to follow include these: (1) calculate the morphine equivalent as a daily 24-hour dose; (2) determine the breakthrough dose, which is usually 10% to 15% of this calculated daily dose; (3) titrate doses upward if pain is not controlled or more than 3 breakthrough doses are being used daily<sup>38-40</sup>; and (4) reduce the calculated conversion dose of a new opioid by 25% to 50% when converting between different opioids because tolerance to one opioid does not imply equivalent tolerance to another because of variable opioid receptor affinity.<sup>41</sup> For example, a metastatic cancer patient

**Table 2.** Approximate opioid equianalgesic doses (adult).<sup>\*†</sup>

Drug	Dose, mg, Parenteral	Dose, mg, Oral
Morphine	10	30
Hydromorphone (Dilaudid)	1.5	7.5
Fentanyl (Sublimaze, Duragesic)	0.1	N/A
Codeine (Tylenol with codeine, #3 or #4)	N/A	200
Hydrocodone (Vicodin, Lortab)	N/A	30
Oxycodone (OxyContin, Percocet, Roxicet)	N/A	20

N/A, Formulation not applicable.

<sup>\*</sup>Adapted from <http://www2.massgeneral.org/painrelief/equianalgesia.pdf>.<sup>43</sup>

<sup>†</sup>These are not suggested starting doses; these are doses of opioids that produce approximately the same amount of analgesia. Titration to clinical response (and avoidance of intolerable adverse effects) is necessary, especially in patients with renal or hepatic insufficiency or other conditions affecting drug metabolism and kinetics.

receiving 60 mg morphine sulfate controlled release every 12 hours needs to switch to an intravenous hydromorphone drip. (1) Calculate total morphine equivalent daily dose;  $60 \times 2 = 120$  mg; (2) oral morphine to intravenous hydromorphone is 20:1, or 6 mg of hydromorphone daily (Table 2); and (3) reduce this dose by 25%, for a starting dose of 4 mg per 24 hours, or 0.1 mg per hour.

Another pain management issue to consider is how fast can the opioid dose be escalated to manage severe uncontrolled pain? Dose escalation of opioids is usually conducted on the basis of a percentage increase.<sup>42</sup> For example, some suggest that, for ongoing moderate to severe pain, increase opioid doses by 50% to 100%, irrespective of starting dose; and for ongoing mild to moderate pain, increase by 25% to 50%, irrespective of starting dose. The recommended frequency of dose escalation will depend on the half-life of the drug; that of short-acting agents such as morphine can be adjusted every 2 hours, whereas that of sustained-release medications can be adjusted every 24 hours.<sup>38-40,42</sup>

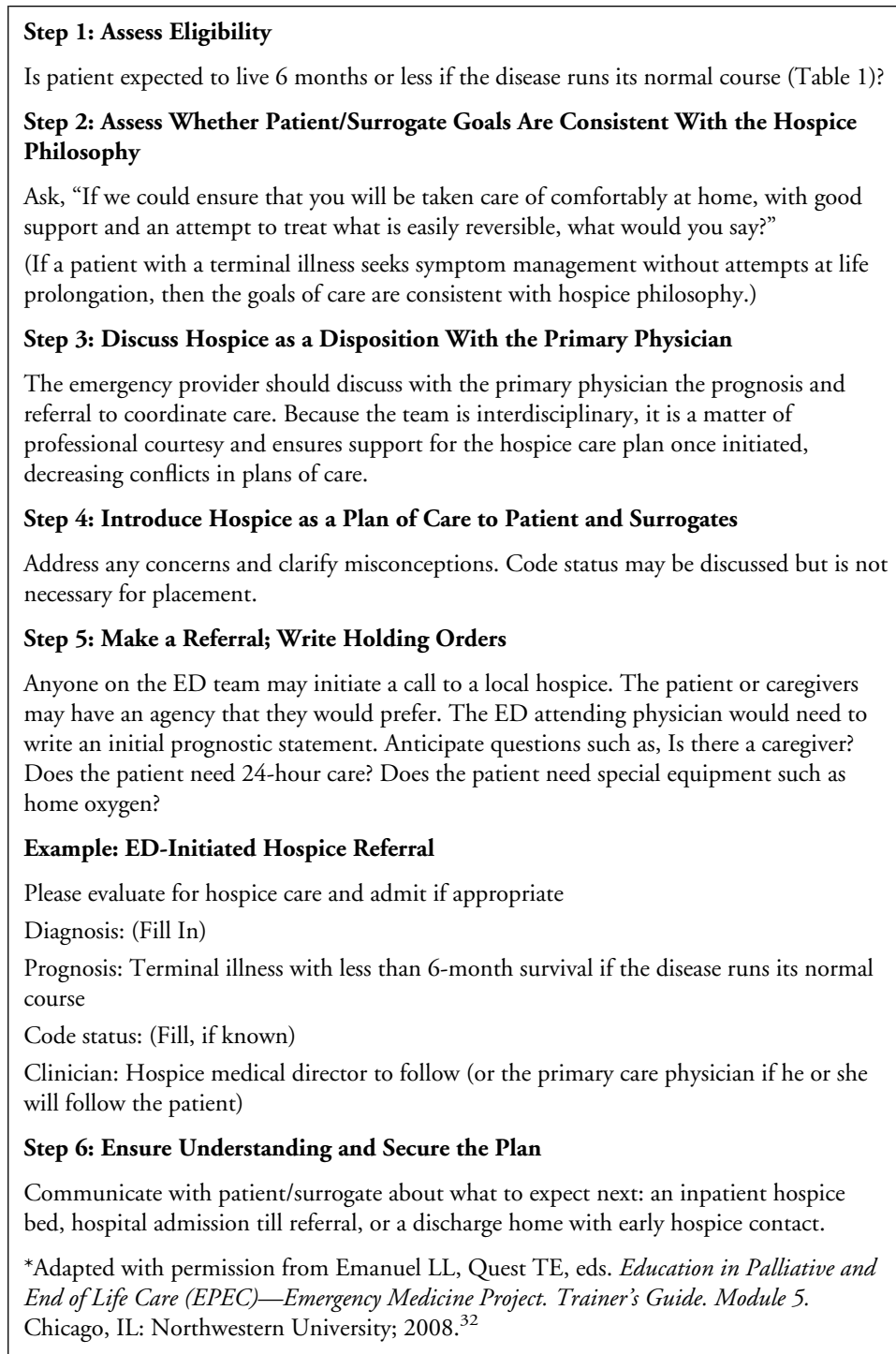
**Management of fever and infections.** In the early 1900s, most patients died of infection in the setting of terminal illness, the so-called old man's friend. Naturally, patients receiving hospice care often present to the ED with signs and symptoms of infection. Again, the extent of evaluation and further management is dependent on and guided by understanding where the patient is in the dying trajectory and the patient's identified goals of care.<sup>28</sup> Antibiotics are commonly used in hospice care to treat pneumonia and urinary tract infection. When goals of care are therefore to improve quality of life with reversal of infection, the clinician should treat empirically with low-burden options such as oral antibiotics. Blood cultures, intravenous access, and laboratory tests may be difficult to obtain for terminally ill patients, requiring increasingly invasive actions such as central venous access. These options should be discussed and arbitrated case by case. Frequently, if intravenous access is easily obtained, antibiotics by this route can be continued at home under hospice care. When a patient presents with overwhelming sepsis, it may be a sign of active death not to

be reversed, according to patient goals of care.<sup>28</sup> However, if one is uncertain, a discussion of the risks, benefits, and alternatives about early goal-directed therapy should ensue, along with a discussion of the need for admission to the ICU.

**Removal of life-sustaining therapy.** Often, because of the unavailability of a clear advance directive, life-extending therapies are initiated by emergency medical service providers, who later find that these measures are not desired. Though withdrawal of such life-support measures is best done with full staff support in a private room, the lack of inpatient beds may necessitate that this procedure be performed in the ED. In these cases, the emergency clinician should be comfortable removing such therapies if they are found to be unwanted or unwarranted by the family or surrogate. The most commonly withdrawn therapy in the critically ill is mechanical ventilation, followed by vasoactive drugs.<sup>45</sup> Several commonly used algorithms for medical management of withdrawal of ventilator support exist.<sup>46-49</sup> Care should be taken to ensure that the family or surrogates are prepared for withdrawal of the ventilator, including the expectation that the patient may not die immediately and may in fact live for hours to days after removal.<sup>46,47</sup> In general, the clinician should discontinue all paralytics, allowing return of neuromuscular function; disable all alarms and titrate sedation (morphine/midazolam) to comfort<sup>46,48,49</sup>; and wean the patient off pressure support and volume. Only once the patient is comfortably sedated after the above settings have been initiated should the clinician proceed with extubation.

## NEW REFERRALS TO HOSPICE FROM THE ED

There is a growing interest for emergency physicians to become involved in initiating palliative and hospice care in eligible patients.<sup>15,50-53</sup> In the emergency clinical arena, no ideal palliative care model exists, and often clinicians face the barriers of a chaotic, busy environment with limited time to focus on these relevant conversations, as well as a reluctance to be listed as the primary provider in the referral.<sup>53</sup> But early consultation to palliative care and hospice care services can assist patients and families at achieving quality end-of-life care.<sup>10</sup> Hospice care enrollment may decrease hospital length of stay, reduce ED visits at the end of life, and enhance bereavement care in survivors, avoiding complicated grief.<sup>23</sup> Studies on health care costs at the end of life show that the majority of cost is incurred in the last year of life, without an increase in satisfaction with the quality of care.<sup>54,55</sup> It is now estimated that more than 1,000 US hospitals have a palliative care service that can assist the ED staff in the care of patients with end-of-life needs.<sup>56</sup> The emergency clinician may also be key in initiating discussions that lead to the early referral to hospice services, making familiarity with basic hospice eligibility guidelines helpful (Table 1).<sup>4,16</sup> If the patient's goals of care are aligned with a comfort care approach, then hospice referral from the ED is



**Figure 2.** Step-wise approach to initiating a hospice referral in the ED.\*

appropriate. Even when hospice care cannot be initiated directly from the ED, the clinician may begin the conversation. To further assist in establishing hospice care for the patient, emergency clinicians may want to use a stepwise approach to referrals as delineated in [Figure 2](#) and ensure clinician access to an up-to-date list of community hospice resources.<sup>32</sup> Step 5

([Figure 2](#)) also serves as a reminder to document specific follow-up physician care (hospice medical director or primary provider), which may help clarify the role of the emergency clinician as primarily that of the initial certifying physician and not the ongoing primary care provider, hence overcoming a key barrier to initiating referrals.<sup>32</sup>

## CONCLUSION

Emergency clinicians often care for patients with a terminal illness. An understanding of hospice as a care system may increase the overall emergency clinician comfort level in discussing hospice as a care option, when appropriate, with patients and families. Using the multidisciplinary approach that is central to the hospice model may also facilitate effective management of patients under hospice care who present to the ED. Because late referrals are common, hospice care patients may present to the ED as a full code and with uncontrolled symptoms. Skills to quickly adapt to a supportive role in the care of a terminally ill patient and empathy with patients who have to “switch gears” to a comfort approach when the health care system is focused on life-sustaining therapies may enhance patient-centered care at the end of life.

Hospice as a care system is the most comprehensive, interdisciplinary care system available to patients, families, and caregivers living with a terminal illness. Gaining familiarity with hospice eligibility and referral criteria and the hospice system of care as defined under the Medicare hospice benefit has the potential to enhance use of this underused service. Emergency clinicians working in concert with palliative medicine subspecialists, local hospices, and social services may assist in building better operational bridges of care.

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