ONE MINUTE CONSULT

BRIEF ANSWERS TO SPECIFIC CLINICAL QUESTIONS

Q: What is the difference between palliative care and hospice care?

MELLAR P. DAVIS, MD, FCCP, FAAHPM
Professor of Medicine, Cleveland Clinic Lerner School of Medicine Case Western Reserve University; Director, Clinical Fellowship Program, Palliative Medicine and Supportive Oncology Services, Division of Solid Tumor, Taussig Cancer Institute, Cleveland Clinic

TERENCE GUTGSELL, MD
Staff, Section of Palliative Medicine, Department of Hematology and Oncology, Cleveland Clinic

PAMELA GAMIER, RN, BSN, CHPN
Specialty Care Coordinator, Palliative Medicine and Supportive Oncology Services, Division of Solid Tumor, Taussig Cancer Institute, Cleveland Clinic

A: Hospice care generally falls under the category of palliative care, despite being an older subspecialty. However, the two have different indications and goals and are often provided in different settings.

ORIGINS OF PALLIATIVE CARE

Prompted by what he perceived as neglect of dying patients in the acute care setting, Dr. Balfour Mount opened the first acute inpatient palliative care unit in Royal Victoria Hospital in Montréal, Québec, in 1976.[1] His purpose was to provide a crisis-intervention service for patients who were actively dying, and this continues to be the main reason for consulting palliative care services in the hospital.

Palliative care has evolved since the 1970s and is now used in a variety of situations:

- A life-limiting illness in a patient who is not terminally ill
- A life-threatening illness in a patient who has symptoms but with the potential to recover
- A chronic illness such as heart failure or chronic obstructive pulmonary disease in a patient who is on disease-modifying therapy but has symptoms and will eventually succumb to the illness, but is expected to live longer than someone with advanced cancer.[2]

doi:10.3949/ccjm.82a.14145

PALLIATIVE CARE IN CANCER PATIENTS

In patients with advanced cancer, palliative care is utilized earlier in the course of serious and life-limiting illness and is even involved in patient care when cure is the goal. Importantly, it now includes outpatient clinics to provide patients seamless care in conjunction with their oncologist's care.[3]

Because palliative care focuses on the patient's experience of the illness (sickness) rather than on disease itself (pathology), symptom management, psychosocial support, and assistance in decision-making are foremost. Initiating palliative care early in advanced cancer improves multiple outcomes and limits overly aggressive, ineffective therapies at the end of life (eg, late chemotherapy, late referral to hospice care, death in the intensive care unit), without hastening death. In fact, it may prolong life.[3,4]

In advanced cancer, palliative care now plays a role early in the course

Palliative care is indicated in a number of situations in oncology:

- Symptomatic presentations of cancer, even when curative treatments are available
- At the time of a sentinel event such as recurrence or unanticipated hospitalization
- When palliative radiation is needed
- When changes in chemotherapy are needed because of disease progression.

Also, cancer patients may develop symptoms that require a palliative procedure such as thoracentesis for pleural effusion, paracentesis for ascites, or surgery for a fracture or spinal cord compression. A palliative care consultation is also appropriate when patients change their goals of care (ie, palliation rather than cure), and when an oncologic crisis occurs and there is a need to offer support to the family and to clarify the goals of care.

Downloaded from www.ccjm.org on May 5, 2025. For personal use only. All other uses require permission.

PALLIATIVE CARE IN OTHER DISEASES

For patients with illnesses other than cancer, palliative care may be helpful when disease-modifying therapy becomes burdensome or ineffective, or when patients are symptomatic despite maximum therapy. Palliative care should also be considered when goals of care need to be explored, when a second opinion is needed on goals of care, or if the primary care provider and family are at odds.

WHEN A CONSULT IS INAPPROPRIATE

Palliative care consultation is inappropriate when used in lieu of an oncology consult in advanced cancer. Palliative care specialists are not experts in cancer care, whereas oncologists are familiar with rapid advancements in cancer care, including targeted agents that may offer benefit to patients with advanced cancer.

Palliative care consultation is also inappropriate if the patient does not want to see a palliative care specialist, or if the consult is used as a way to convince a patient to change advance directives or to choose not to be resuscitated. Also, cancer patients who are asymptomatic are unlikely to benefit from palliative care initially. The decision to consult palliative care should not depend on prognosis, and palliative care is more cost-effective when utilized early rather than as a crisis intervention near the end of life.[3]

Palliative care is more cost-effective when utilized early rather than as crisis intervention near the end of life

THE PALLIATIVE CARE EVALUATION

The initial palliative care consultation usually involves an evaluation of the patient's symptoms and concerns. Symptoms are targeted based on the patient's priorities and on an assessment using validated questionnaires. A validated questionnaire is a better way to comprehensively gauge symptom burden than depending on patients to volunteer symptoms.[5]

As the relationship develops between patient, family, and palliative care specialist and as the disease takes its course, advance directives, prognosis, and end-of-life care goals can be addressed in follow-up consultations.[3] Patients want to know about their prognosis, and they usually complete advance directives based on clinical circumstances rather than viewing them as an extension of patient autonomy, as originally intended.[6]

REIMBURSEMENT FOR PALLIATIVE CARE

Reimbursement for palliative care is similar to that for acute care and falls within the All Patient Refined Diagnosis-Related Group, or APR-DRG, system, and palliative care has its own V code for identification. Codes are used to designate disease, stage or location of metastases, disease complications, and symptoms, as well as for the discussion of goals of care.

WHAT PALLIATIVE CARE IS NOT

Palliative care has too often been tied to end-of-life care.[7] The two often appear together in titles of reports in the literature. As a result, patients and physicians may be confused and, thus, reluctant to utilize palliative care services. To avoid the confusion, certain programs have included the term "supportive" oncology care in their title. This appears to facilitate palliative care referral, but may be misleading.[8]

WHAT IS HOSPICE CARE?

Hospice care is a service funded and capitated under Medicare part A and is largely provided as outpatient home care for those deemed terminally ill.[9] An illness must be certified as terminal by two physicians. Medicare defines terminal illness as a life expectancy of 6 months or less if the illness runs its normal course.

The philosophy of hospice care is to provide comfort through intensive nurse management and home-based follow-up. In some cases, disease-modifying therapies are continued to control symptoms—eg, continuing angiotensin-converting enzyme inhibitors in heart failure patients. Hospice care is typically delivered at home, but it is also delivered in nursing homes, in hospital inpatient units, and at private or nonprofit hospice facilities.

Inpatient palliative care units are often mistaken for hospices. The purpose of hospice care is to provide quality of life and comfort and to avoid overly aggressive, expensive, and futile care at the end of life. The focus is on intensive, hands-on, personalized symptom care and family support at home. The goal is to provide a comfortable and dignified death among friends and family. The use of palliative radiation, transfusions, and antibiotics in hospice varies among hospice programs and is considered on a case-by-case basis.[10]

Downloaded from www.ccjm.org on May 5, 2025. For personal use only. All other uses require permission.

The Medicare per diem payment limits what hospices can afford, so they must be fiscally responsible. Hospice agencies are capitated and are responsible for providing medications and durable equipment necessary to treat symptoms related to the terminal illness. They also provide bereavement services for family members at no charge. Enrollment in hospice care can be revoked depending on circumstances and then reinstituted later as the goals of care change.

Care for nonterminal comorbid illnesses can be continued by a general practitioner or internist. This care is not covered under the Medicare hospice benefit, but it is covered under Medicare part B.

The patient and family can choose the hospice physician, who may be a family practitioner, internist, oncologist, or palliative care specialist, or may designate the hospice medical director as the hospice physician.

Criteria for hospice admission have been established for noncancer terminal illnesses and should be considered when practitioners decide to consult hospice.[11–13]

HOME-BASED PALLIATIVE CARE

Programs such as advanced illness management or home-based palliative care aim to improve the quality of care at home and prevent rehospitalization, particularly for patients with repeated hospitalizations.[14] Home-based palliative care services are provided either by a clinician who makes home visits or by a certified home health care agency. Services are particularly useful for patients with serious illnesses who do not qualify for hospice services but are homebound. Consultations are obtained for ongoing supportive care at home, assessment for medication compliance, and disease monitoring at home. Consultations are scheduled at the time of hospital discharge.

Unlike hospice care, home-based palliative care does not include 24-hour on-call service. Comprehensive services (eg, home health aide, durable equipment, medications) are not provided as they are under hospice care: patients must qualify under Medicare stipulations for such services outside of hospice care. For example, home oxygen can only be supplied if the patient's oxygen saturation is less than 90%, while under the hospice benefit it is provided without regard to oxygen saturation and is based on symptom need. For home-based palliative care, patients must be largely homebound or unable to be seen regularly in the outpatient clinic. This type of care can be a bridge to hospice care for patients who feel they are not ready for hospice care at the time of discharge from acute care. Those who receive palliative care at home are less likely to be hospitalized at the end of life, are more likely to be transitioned to hospice at an appropriate time, and are more likely to have relief of symptoms.[15]

REFERENCES

1. **Mount BM**. The problem of caring for the dying in a general hospital; the palliative care unit as a possible solution. Can Med Assoc J 1976; 115:119–121.
2. **Higginson I**. Palliative care: a review of past changes and future trends. J Public Health Med 1993; 15:3–8.
3. **Temel JS, Greer JA, Muzikansky A, et al**. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010; 363:733–742.
4. **Zimmermann C, Riechelmann R, Krzyzanowska M, Rodin G, Tannock I**. Effectiveness of specialized palliative care: a systematic review. JAMA 2008; 299:1698–1709.
5. **Homsi J, Walsh D, Rivera N, et al**. Symptom evaluation in palliative medicine: patient report vs systematic assessment. Support Care Cancer 2006; 14:444–453.
6. **Tang ST, Liu TW, Lai MS, Liu LN, Chen CH, Koong SL**. Congruence of knowledge, experiences, and preferences for disclosure of diagnosis and prognosis between terminally-ill cancer patients and their family caregivers in Taiwan. Cancer Invest 2006; 24:360–366.
7. **Bakitas M, Lyons KD, Hegel MT, Ahles T**. Oncologists' perspectives on concurrent palliative care in a National Cancer Institute-designated comprehensive cancer center. Palliat Support Care 2013; 11:415–423.
8. **Fadul N, Elsayem A, Palmer JL, et al**. Supportive versus palliative care: what's in a name: a survey of medical oncologists and midlevel providers at a comprehensive cancer center. Cancer 2009; 115:2013–2021.
9. **Rinaldo MJ**. Medicare to cover hospice services. J Med Soc NJ 1982; 79:1015–1016.
10. **Enck RE**. Palliative radiation therapy in hospice care. Am J Hosp Palliat Care 2002; 19:151–152.
11. **Luchins DJ, Hanrahan P, Murphy K**. Criteria for enrolling dementia patients in hospice. J Am Geriatr Soc 1997; 45:1054–1059.
12. **Fox E, Landrum-McNiff K, Zhong Z, Dawson NV, Wu AW, Lynn J**. Evaluation of prognostic criteria for determining hospice eligibility in patients with advanced lung, heart, or liver disease. JAMA 1999; 282:1638–1645.
13. **Stuart B**. The NHO medical guidelines for non-cancer disease and local medical review policy: hospice access for patients with diseases other than cancer. Hosp J 1999; 14:139–154.
14. **McKinney M**. Beyond hospice. New models of care focus on advanced illnesses. Mod Healthc 2013; 43:14–15.
15. **Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ**. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database Syst Rev 2013; 6:CD007760.

***ADDRESS**: Mellar P. Davis, MD, FCCP, FAAHPM, Department of Hematology and Oncology, R35, Cleveland Clinic, 9500 Euclid Avenue, Cleveland, OH 44195; e-mail: davism6@ccf.org*

Downloaded from www.ccjm.org on May 5, 2025. For personal use only. All other uses require permission.