Nephrology and Palliative Care

What are the barriers to palliative care for those with kidney diseases? How do I respond when my patient says they want to stop dialysis? These are among the questions addressed in the September 2017 special section on palliative care. We continue the discussion here, with articles on hospice access, integrating advance care planning into the care of patients with kidney diseases and kidney failure, and nephrologists' attitudes toward palliative care.

Access to Hospice

By Debra Hain

An aging ESRD population with complex medical issues demands our attention. As nephrologists, we must seek to discover the best ways to achieve quality care and quality of life for these individuals and their families within a cost-constrained health care environment.

Older adults with ESRD have the option of withholding dialysis or withdrawing from dialysis when the burden outweighs the potential benefits. In these situations hospice care is one intervention that supports quality care, quality of life, and reduced health care costs through symptom management, spiritual and psychosocial support, and avoidance of unnecessary hospitalizations. Hospice care, however, continues to be underutilized owing to several barriers such as lack of education in hospice care and ineffective training regarding advance care planning that includes preferences for end-of-life (EOL) care (1, 2). The percentage of Medicare beneficiaries receiving hospice care at the time of death has increased over the past decade, but opportunities for improvement in EOL care remain, including improvement in timely referral for hospice care.

As supported by epidemiological data, most patients receive hospice services only after discontinuing dialysis treatments. From 2004 to 2013, use of hospice care increased from 59% to 82% in those discontinuing dialysis and from 5% to 8% among those who did not discontinue dialysis (3). Evidence has indicated that many individuals with ESRD die in the hospital, which is not only costly but often is incongruent with the person's wishes for EOL care. Advance care planning, in which health care professionals, patients, and families engage in shared decision-making that considers what matters most to the person living with ESRD, can facilitate greater hospice utilization and avoid costly hospitalization (4). Initiating hospice care earlier may allow death to occur in the person's place of choice.

Medicare hospice criteria

The four criteria for enrollment in Medicare Part A Hospice care are:

1. US citizen who is eligible for Social Security or railroad retirement benefits and over age 65 or under 65 years and eligible for Medicare because of a long-term disability for >2 years and/or ESRD,
2. referral to certified Medicare provider (generally certified by CMS to provide services under the Medicare hospice benefit),
3. a statement signed by patient stating they are choosing hospice care instead of regular Medicare for the terminal diagnosis (Medicare does allow for regular reimbursement for incidental medical expenses unrelated to terminal diagnosis; the relatedness is determined by hospice medical director), and
4. certification by the individual's personal physician and the hospice medical director that the person has a terminal diagnosis and with a life expectancy of six months or less if the illness takes its normal course. The patient's treatment goals should emphasize symptom management, and outcomes should focus on comfort and quality of life.

The Medicare Hospice Benefit is divided into a number of certification periods with eligibility for two 90-day periods followed by unlimited periods of 60 days. The person on hospice requires recertification at each of these timeframes to determine continued eligibility. An important criterion for recertification is continued decline. Since 2011, Medicare has required a face-to-face encounter by a physician or nurse practitioner prior to recertification period. Acute inpatient hospice care can be provided in a hospice facility for those who are actively dying or for complex symptom management that cannot be addressed in the home.

Medicare hospice benefit specific for ESRD

Unless individuals with ESRD have another terminal illness (e.g., cancer, chronic obstructive pulmonary disease, heart failure) that meets hospice criteria as determined by the hospice physician, they will have to forgo life-sustaining treatment related to ESRD (e.g., dialysis or transplantation). For example, if individuals have a terminal diagnosis of cancer that meets the Medicare Hospice Benefit criteria they can opt to continue the dialysis Medicare ESRD benefit. If the terminal diagnosis is kidney failure and dialysis is provided then it becomes the responsibility of the hospice provider to pay for the dialysis treatments. This really is not feasible because hospice providers are not reimbursed for the dialysis treatments and therefore, may not be able to financially encompass the high cost of providing this service (Table 1). However, it is important to contact the hospice organization because there is variability in the services each organization provides. Some hospice organizations have more flexible services or may receive charitable donations that can be designated for services that aren't included in the Medicare Hospice Benefit (2).

Another important issue to consider is that many patients may not understand that after being enrolled in hospice, they can revoke hospice, return to dialysis, and still receive the Medicare ESRD benefit. Considering that the life expectancy after withdrawing from dialysis is about 7 days, this decision may not happen before death occurs. The Coalition for Supportive Care of Kidney Patients (CSCKP) has developed a flowchart, Medicare Hospice Benefit & ESRD Patients, that can support health care professionals to assess if, and when, an individual may meet criteria for Medicare Hospice benefit. The flowchart is available at www.kidneysupportivecare.org.

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References

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Table 1. CMS hospice criteria, benefits, and eligibility

CMS hospice criteria for kidney failure as a terminal diagnosis	CMS hospice benefits and eligibility specific for kidney failure
• Serum creatinine 8 mg/dL or greater (6 mg/dL or greater in patients with diabetes) or • Creatinine clearance <10 mL/min/1.73 m^2 (<15 mL/min/1.73 m^2 for individuals with diabetes) or • Symptoms	Home Health and Hospice Benefits Available for ESRD Beneficiaries, tagline 50.6.1. • "Medicare beneficiaries can receive care under both ESRD benefit and the home health or hospice benefits. The key is whether or not the services are related to ESRD." • "If the patient's terminal condition is not related to ESRD, the patient may receive covered services under both ESRD benefit and the hospice benefit. A patient does not need to stop dialysis treatment to receive care under the hospice benefit."