The Role of the Consultant Pharmacist in Hospice Care

Hospice and palliative care is a growing field in which pharmacists fill a key role in making patients more comfortable and enhancing quality of life.

Kathleen Y. Riley

Hospice has been growing rapidly for the past eight to ten years, spurred by its transformation from an alternative health care choice to a Medicare benefit with the 1985 enactment of the Medicare Hospice Benefit program.

Today, certification requirements govern quality of care, staffing, and physical facilities of hospice programs, and many of the costs of hospice services provided by certified facilities and agencies are reimbursed by Medicare and Medicaid and by private insurance companies. Covered areas usually include home-maker services, home health aide services, durable medical equipment, and pain medications.

For a patient to be eligible for hospice care under Medicare, death must be imminent within six months. Medicare will cover costs until the patient's death or for a six-month period; if a patient is admitted to a hospice program and subsequently gets better, he or she can be discharged with an option to be readmitted if the condition again warrants palliative care.

If the patient is stable and is not deteriorating clinically at the end of the Medicare-covered period, he or she can be discharged, but may call the hospice in the future when problems recur.

Patients who are considering hospice must agree to have all curative efforts stopped and to focus on palliative efforts alone.
Hospice care can be provided in many settings-in the home, in a certified facility, or as part of hospital or nursing home care. More than 210,000 patients are served annually by nearly 2,000 hospice programs in the United States.

Patients with cancer make up the majority of hospice clients, though an increasing number of people with end-stage heart, lung, liver, and renal diseases and AIDS are receiving hospice care at the end of life.

**Managing Pain**

Controlling pain is one of the central goals of end-of-life care, and hospice requires a whole new level of care by both nurses and pharmacists. It takes more time to take care of a hospice patient.

"Hospice professionals need to 'cue in' to the individual patient, pay close attention, and know the signs that a particular patient gives when he or she requires intervention," notes Mary Lynn McPherson, PharmD, of the University of Maryland School of Pharmacy. This means learning the subtle signs of uncontrolled pain in patients who may not verbally express the need for pain control, because they are either unable or unwilling to do so.

Hospice care has to be staffed differently-by some estimates, staffing can cost $10 to $15 more a day for hospice than for other types of long-term care. Staff members must be very good at assessment and evaluation, must know signs of renal or liver failure, for instance, and must know what questions to ask. They must have mature judgment, be "people persons," and be able to look behind what is said. In this specialty, more than in any other, staff members must be in tune with both the patient and the family.

**A Different Approach**

There may be more pharmacist involvement in a well-run hospice than in any other subspecialty except home I.V. care, and the pharmacist is an ideal person to sit on the interdisciplinary care team at a hospice—but an open-minded approach is required.

"Traditionally, pharmacists tend to be extremely conservative," says Charlie Brown, a consultant pharmacist in California specializing in hospice care. "When it comes to nausea and pain management in hospice, pharmacists must
overcome that conservatism. Many rules go out the door when dealing with a hospice patient, and you can't be a slave to the 'physician's bible,' the PDR.

**Creative Solutions**

Constipation and nausea are particularly troublesome for the hospice patient, because so many pain medicines cause severe constipation. The potential for addiction, which might cause concern with other patients, is not as much of a problem in hospice situations as respiratory depression, which should be watched for carefully in hospice patients.

Pharmacists in hospice must be innovative. One pharmacist told the story of an older woman in the dying process who wouldn't take "the red medicine" because she thought that meant she was near death. Her pharmacist took her "red medicine," a medication mixture containing oxycodone, and put blue food coloring in it. She took it for the remaining six months of her life.

Other creative solutions found by pharmacists working in hospice include rectal administration of phenytoin, use of cimetidine for pruritus caused by liver cancer, and one particularly unusual technique Brown uses with his patients: "For patients with high bowel impactions, I've taken Vaseline balls, wrapped them in waxed paper and then rolled them in foil, frozen them, then unwrapped them and rolled them in sugar. The patient swallows the frozen 'Vaseline ball,' and it really helps with the high impaction."

Pharmacists in hospice are not jealous or protective of the innovative solutions and information they develop, says Brown—they tend to share ideas.

**Getting Paid**

How do pharmacists get paid for working with hospice patients? Says one pharmacist quite simply: "You have to convince the hospice you're worth it." Despite its idealistic image, Medicare and Medicaid very much control the realities of hospice reimbursement. Brown tells the following hospice reimbursement story:

The wife of a terminally ill hospice patient called him at 2 a.m.; her husband needed lorazepam, an antianxiety medication. Brown delivered it.

She called again at 6:30 a.m., and Brown again went to her house with a
delivery-the patient was in the dying process and died later that day. The patient's managed care plan initially refused to pay the charges for the medication deliveries (which Brown would not have charged if the man had been one of his regular patients). Brown subsequently found a paragraph in the managed care organization's brochure saying the plan would reimburse for "emergency care"; he quickly pointed out to the plan's administrators that his charge for two visits was less than one-fourth the amount that would have had to be paid for emergency ambulance service-plus, the patient would have been put in the hospital when first brought in, and the plan would have been billed for a day's hospital stay. Brown got paid. (He added that if the plan had not paid him, he would not have charged the patient's family).

The bottom line is that states and insurance companies currently don't pay enough for this kind of care, in the opinion of many consultant pharmacists. Some insist that OBRA '90 regulations, which were designed for nursing homes, should not apply to AIDS and hospice facilities, which should have their own sets of regulations. For example, pharmacists cite the fact that many facilities are found out of compliance by running afoul of the "more-than-six-drugs-per-patient" rule-a totally unrealistic requirement in hospice or in AIDS units.

A Gratifying Endeavor

Consultant pharmacists who do get involved in hospice often say that it is the most gratifying part of their practices. Brown tells the following story:

One of his home hospice patients, a history professor, was taking 16 Percocets a day for pain and was suffering severe problems with mentation. Brown was able to switch the patient to an anti-inflammatory medication and was able to taper him off some of the Percocet.

Brown arrived at the patient's door one day, to be met by his wife. She asked, "Are you Charlie Brown? My husband wants to meet you. He says he wants to meet the man who gave him back his mind."

Hospice: A Place of Rest and Refuge

The concept of hospice care originated in medieval times in England, and referred to a place where weary travelers could rest on their way home from
the crusades. While respite and comfort are still primary goals of hospice care today, the focus has shifted to providing palliative care for dying patients during their last days.

Dame Cicely Saunders founded the first modern hospice in London in 1967, and hospice care was introduced in the United States in 1974. Most hospice programs depended on private contributions until 1985, when Congress enacted the Medicare Hospice Benefit program.

Today, Medicare covers a range of hospice services under federal guidelines similar to those for the regular Medicare and Medicaid programs, and many hospice services are also covered by private insurance.

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