

As part of our Valor DoctorCare™ Program, this list of misconceptions is designed to inform medical professionals about the hospice and palliative care benefit and to assist with referrals to hospice programs.

Misconception One: Hospice is for the last days of life.

Hospice is a program of care with a goal of optimizing comfort and minimizing suffering for patients with incurable illnesses and their families. Their physical, psychological and spiritual needs are attended to by an interdisciplinary team. The benefits are optimized when referrals are made as early as possible. However, the national average for patients receiving hospice care is only 47 days, representing a failure in care for the whole person.

Misconception Two: Hospice care is only for six months.

The Department of Health and Human Services recognizes the difficulties involved in predicting the prognosis of an individual with a terminal illness and that a disease process runs a unique course in each individual. Therefore, we are provided with unlimited sixty day recertification periods after the first six months as long as the patient still qualifies for a possible six month prognosis. It is widely recognized that many patients, especially those with non-cancer diagnoses, can enjoy prolonged lives due to the care they receive in the hospice program.

Misconception Three: Hospice represents a failure of care.

It is understandable why this belief is common in a high-tech medical environment which emphasizes curative care.

Hospice is a specialty which is centered on controlling the tenacious and distressing symptoms associated with incurable and terminal illnesses. The true value of hospice becomes evident when we consider the high prevalence of severe, unrelieved suffering as revealed in a Robert Wood Johnson Foundation study of end-of-life care in five hospitals. Known as “The SUPPORT Study”, the results showed that:

- 38% of patients who died spent at least a week in ICU, in a coma or on a ventilator.
- Only 47% of physicians knew when their patients didn't want CPR.
- 46% of DNR (Do Not Resuscitate) orders were written within 2 days of death.
- 50% of conscious patients who died in a hospital experienced moderate to severe pain for at least half the time prior to death, according to their families.

The Support Study concluded that “Too often we die alone, in pain, attached to machines. The only failure was in not referring patients to palliative care and hospice programs earlier.” Or as the study concludes, “...the system doesn't know when or how to stop.”

Misconception Four: Hospice is a place – an inpatient or hospital unit where people go to live until death.

From a recent survey, it is the desire that people die at home – whether that means a private residence, adult care home, assisted living facility or nursing home – in a familiar and comfortable environment. Exceptions occur when inpatient admission is necessary due to the breakdown of family support or when there is a need for intense symptom control.

Misconception Five: Physicians are somehow liable if their six month prognosis is not accurate.

The Department of Health and Human Services realizes that a doctor cannot be expected to make accurate prognostications. Clinical guidelines have been published to help guide physicians in making prognostications for various non-cancer diagnoses and to guide in future research. The guidelines, based on large patient cohorts, are not expected to be accurate in the individual case since it is recognized that an illness often will follow a unique and unpredictable course.

Misconception Six: All hospice programs are the same.

Many hospices have their own individual character. For instance, Valor HospiceCare offers continuous care in addition to routine home care and inpatient care. Continuous care is high level, intensive care provided at home by trained, licensed hospice staff during large portions of the day. The purpose is to either control severe symptoms or to provide a transition from hospital or hospice inpatient care to routine home care. In addition to Valor HospiceCare's other unique programs, an integrative medicine program is offered to provide additional services for holistic care.

Misconception Seven: Most patients who need hospice care are in hospice programs.

According to Medicare, only 17% of patients eligible for hospice utilize the free benefit. Only 15% of eligible hospice patients who live in nursing homes or assisted living facilities enter into hospice programs. Every hospice would be filled to capacity if this weren't the case.

Misconception Eight: Hospice represents loss of control.

Upon entering hospice, a person may be getting the first chance to have a say in the course of his or her care since becoming ill. In hospice, the person's dignity and sovereignty are supported as the individual is given as much control over his or her care as possible. All diagnostic and therapeutic plans are made in terms of the sick patient and not according to the disease. Therefore, "routine testing" (e.g. a lipid panel), is not done. The person's function, not necessarily the length of life, is maximized while the suffering of the patient and family is minimized. Hospice offers hope for quality time, dignity, pain and symptom relief, and growth and development at the end of life.

Misconception Nine: General palliative care groups can practice hospice care.

Upon entering hospice, each patient's case is evaluated and team members are assigned to provide care according to each patient's needs. Team members may include physicians, nurse practitioners, registered nurses, social workers, home health aides and spiritual care providers. Volunteers are available to ease the burden on both the patient and the family. The best choice is to choose a Medicare-certified and licensed hospice and palliative care program, such as Valor HospiceCare, for the comprehensive benefits that are offered to patients and their loved ones.

Misconception Ten: The hospice physician must become the patient's own primary care physician.

Patients need not worry about giving up their relationship with their own physician. The primary care physician works with the hospice to maximize patient comfort. The patient's doctor may continue as the treating doctor.

Valor HospiceCare encourages medical professionals to discuss advance care planning options with patients and families for hospice and palliative care services.

For further information, please visit www.valorhospicecare.com.