Myths of Hospice

Myth #1: Hospice is a place.

Fact: Hospice is a philosophy of care that focuses on quality of life when a patient's illness has progressed to the point that a cure is no longer possible, and the patient has chosen comfort over cure. Hospice care is provided wherever a patient calls home, be it a residence, assisted living facility or long-term care facility.

Myth #2: Hospice is chosen when there is no hope or when "nothing else can be done."

Fact: Hospice IS the something else that can be done for patients and their families. Hospice is not an end to treatment – it is a shift to comfort-oriented care that centers on helping a patient live his or her life to the fullest. In addition to managing the pain and symptoms, Hospice of the Chesapeake provides extensive counseling and social service support to address the emotional and spiritual aspects of coping with an advanced illness.

Myth #3: Hospice is only for people with cancer.

Fact: While about half of the patients receiving hospice care are cancer patients, the other half suffer from illnesses such as heart disease, lung disease, dementia, CVAs/strokes, HIV/AIDS, debility and neuromuscular diseases, among others.

Myth #4: Hospice services are only for dying people.

Fact: Hospice is family-centered care. It concentrates as much on the family as it does on the patient. Hospice of the Chesapeake provides counseling and grief services for family, friends and the community at large.

Myth #5: Hospice can only help when family members are available to provide care.

Fact: Recognizing that patients with an advanced illness may live alone or with family members unable to provide care, Hospice of the Chesapeake will coordinate community resources to make home care possible or will help to find an alternative location where the patient can effectively receive care.

Myth #6: Hospice is for people who don't need a high level of care.

Fact: Hospice is serious medicine. Hospice of the Chesapeake is Medicare-certified, requiring that we employ experienced medical and nursing personnel with skill in symptom control. And since state-of-the-art palliative care is part of the hospice program, advanced technologies are used to prevent or alleviate distressing symptoms.

Myth #7: Hospice is only for people who can accept death.

Fact: While those affected by advanced illness may struggle to come to terms with death, Hospice of the Chesapeake gently helps them find their way at their own pace. Inquiries are welcomed from families who are unsure about their needs and preferences. Hospice staff members are readily available to discuss all options and to facilitate family decisions.

Myth #8: Hospice care is expensive.

Fact: Most people who use hospice are over age 65 and are entitled to the Medicare hospice benefit. This benefit covers virtually all hospice services and requires little, if any, out-of-pocket expense. Even for younger patients whose private insurance may not fully cover hospice care, end-of-life care with hospice can be far less expensive than the alternative of hospital or nursing home care.

Myth #9: Hospice is not covered by managed care plans.

Fact: While managed care organizations (MCOs) are not required to include hospice coverage, Medicare beneficiaries can use their Medicare hospice benefit anytime, anywhere they choose. They are not locked into the end-of-life services offered by the

MCOs. On the other hand, while those under age 65 and not eligible for Medicare are confined to the MCO's services, they are likely to gain access to hospice care upon inquiry.

Myth #10: All hospice care is the same.

Fact: All licensed hospice programs must provide certain services, but the range of support services and programs may differ. Hospice of the Chesapeake is a not-for-profit organization – our revenues are used to provide patient care and community services. Other programs are administered by for-profit groups, which are accountable to their shareholders.

Myth #11: Patients die sooner with hospice care than without it.

Fact: Hospice neither hastens nor prevents death. However, it is believed that hospice patients may actually live somewhat longer once their pain is adequately managed.

Myth #12: Hospice will only treat symptoms related to the terminal diagnosis.

Fact: Hospice specializes in palliative care – that is, care designed to provide comfort. Providing that comfort requires treating illnesses unrelated to a patient's terminal illness. Illnesses or injuries such as UTIs, pneumonia, and broken bones always receive appropriate attention.

Myth #13: Therapies such as blood transfusions and radiation automatically exclude a patient from hospice.

Fact: Many therapies that once prohibited a patient from obtaining hospice services are now considered on a case-by-case basis. These therapies must be used for palliative (pain and symptom management) purposes only, and not as an attempt to "cure" the illness.

Myth #14: Patients must sign a Do Not Resuscitate (DNR) order prior to admission to hospice.

Fact: Although the majority of hospice patients choose to sign a DNR order prior to entering hospice care, it is not required for admission. If the patient or family makes the decision to sign a DNR order, the document may be signed at any time. DNR status has no bearing on the care that a patient receives while enrolled in hospice services.

Myth #15: In order to refer a patient to hospice, a physician must be certain the patient will die in six months.

Fact: The familiar language for a hospice referral has traditionally been "a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course." However, recent legislation has revised this wording to send a more supportive message to physicians: "Terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." This new language allows physicians to comfortably refer patients to hospice early enough in their illness to experience the full benefit of hospice care.

Myth #16: Physicians lose control of the plan of care when their patients enter hospice.

Fact: The referring physician is a vital member of the hospice team. In fact, many physicians find that hospice greatly enhances and extends the care they can provide. Hospice of the Chesapeake encourages physicians to follow their patients through the hospice journey. And, while the physician remains the attending physician for that patient, it is appropriate to bill insurance carriers for all services that the physician provides related to the terminal diagnosis.

Myth #17: It is complicated to refer a patient to hospice.

Fact: It is actually easy. Simply ask yourself, "Would I be surprised if this patient were still alive a year from now?" If the answer is yes, consult with the patient's physician about a hospice referral or call the Hospice of the Chesapeake Admissions office at 410-987-2003. A member of the Admissions team will be glad to contact the patient's physician.

References

Miller, G., Williams, J., English, D. & Keyserling, J. (2002) Delivering Quality Care and Cost Effectiveness at the End of Life. National Hospice and Palliative Care Organization (http://www.nhpco.org).
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