PALLIATIVE CARE CASE OF THE MONTH

"Transfer Home for Hospice Patients"

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Case: Mr. H is a 66-year-old man with widely metastatic lung adenocarcinoma that has progressed despite multiple therapies. He was initially admitted with pneumonia and had a complicated hospital course with recurrent respiratory failure, acute kidney injury, and worsening delirium. Oncology ultimately told him and his wife that there were no further cancer-directed therapies available. He wanted to go home with hospice as soon as possible. He did not switch to comfort care in the hospital because he did not want to die in the hospital, but a hospice agency was chosen, with plans for transportation back home the following day. Unfortunately, the scheduled transportation got cancelled, and the patient had to remain in the hospital.

Levels of transportation

There are different levels of transport, depending on the patient's care needs. These reflect the acuity of care that the crews are able to handle. Basic Life Support (BLS) can handle a standard patient with minimal medical needs but cannot provide any comfort-directed medicines. These ambulances are staffed by EMTs, and are probably sufficient for low-acuity patients with few care needs. Advanced life support (ALS) ambulances are staffed by paramedics and can give medicines and continue many infusions. They also have more training and experience than EMTs, and are familiar with a greater range of therapies and devices.

How is hospice transportation arranged (and why is it seemingly so hard to confirm?)

UPMC does not have its own transportation service for BLS and ALS transportation. Instead, UPMC coordinates transportation out of their central hospitals through two internal call centers. PARC (412-647-7180) facilitates transportation for Mercy, Presbyterian/Shadyside, Magee Women's Hospital, East, McKeesport, and Children's Hospital of Pittsburgh. NORCOMM (412-366-2323) helps with St. Margaret, Passavant, Jameson, and Horizon. Other hospitals farther from Pittsburgh do not have a coordinating center and rely on case managers to contact local EMS agencies directly. Requests for transport are typically completed by the discharge planner and should specify the level of care required. At PARC/NORCOMM, an agent contacts various EMS agencies, starting with contracted services, to see if a unit is available to transport the patient from the hospital. Staffing shortages are rampant and sometimes no trucks are available. Occasionally, transport is scheduled but cancels or no-shows at the last minute, usually because they are redirected to respond to an emergency in the community or a higher priority interfacility transport.

Things to do to help ensure smooth transport

EMS personnel have probably cared for hospice patients in the past, but may not be very knowledgeable about how best to manage a patient's symptoms at end of life or the best way to communicate with grieving families.[1]

Transportation may be long and uncomfortable for the patient. For patients with pain or anxiety, it is often helpful to premedicate the patient prior to transfer. If the patient lives far away and is likely to need additional medicines, it can be helpful to suggest orders for the transport services to follow. Most ALS ambulances carry fentanyl and ketamine for pain, and midazolam for anxiety. Some ambulances also carry Morphine. For nausea, ALS ambulances carry ondansetron, and some may also carry droperidol. BLS ambulances do not have access to any pertinent medications except oxygen.

If the patient is tenuous enough to potentially die in transport, some extra preparation may be warranted. A POLST is not a legal document in Pennsylvania, and EMS providers must call their medical oversight for instructions not to perform CPR on a patient without a pulse. On the other hand, an "Out of Hospital DNR" is a separate legal document that is recognized as an order for EMS personnel, and should be completed, particularly for tenuous patients. It might also be helpful to discuss with family what to do if the patient dies in transport, either returning to the hospital for death pronouncement, or continuing to the destination for hospice to pronounce the patient.

Financial coverage of transportation home

Because patients going home with hospice have not technically been enrolled in hospice yet, insurance will only cover the cost of transportation if it is considered medically necessary. This may include patients who are bedbound or with very limited mobility, or patients with specific care needs. If medically necessary, their primary insurance should cover part or all of the cost of transportation, as long as it is to a different "level of care." In other words, insurance will generally cover transportation home, to nursing homes, or to an inpatient hospice unit, but will not cover the cost of transportation to a hospital closer to home when the transfer is purely for patient or family preference.

Return to Case: Overnight, Mr. H had escalating oxygen requirements, likely from an episode of aspiration. He was placed on heated high flow nasal cannula. He remained clear that he did not want to die in the hospital, and still wanted to try to go home with hospice. Unfortunately, he lived a 3 hour drive away near the New York state border.

Complex Hospice Discharges

Patients sick enough to require ICU level of care are more complicated to transport home. These patients typically need critical care transport. There are fewer agencies capable of providing critical care transport, but they are capable of transporting very sick patients. Specifically, patients on vasopressors, BiPAP, ventilators, heated high flow nasal cannula, and chest tubes to suction all need critical care transport.

Complex Hospice Discharges (Continued)
For patients on high levels of oxygen (typically >15 LPM), it is important to consider how much oxygen they need, how that oxygen is delivered, and how long their journey home will take. If patients are on high flow nasal cannula and have a long trip home, the transport agency may not carry enough oxygen to last for the entire journey home; placing the patient on BiPAP, if the patient is willing and able to tolerate it, may help facilitate transport. Once home, some hospice agencies are able to provide heated high flow nasal cannula, if indicated, for the patient.

Transfer home for intubated patients is even more complicated, though not impossible. Certain hospice agencies have respiratory therapists who can extubate the patient once they get home.

For all patients requiring critical care transport or other patients who are likely to die rapidly once they arrive at home, it is crucial to ensure that the hospice agency can meet the patient at home. The EMS crews are not accustomed to nor trained to provide end of life care and should not be expected to do so. Transport crews often have difficulty contacting on-call hospice personnel,[2] so trying to ensure that the hospice agency can be at the house when the patient arrives helps the patient, the family, and can also help prevent moral distress in the EMS crews. Providing the transporting crews with contact information for the hospice agency may also help to close this loop.

STAT Medevac is the UPMC-owned agency that provides most of the health system's critical care transport. They primarily transport patients via helicopter but are also able to transport patients by ambulance. If you expect that the transportation home is going to be complicated, it may help to reach out to discuss the case with an EMS physician. In our system, the STAT Medical Director on Call (MDOC) is the best resource and can be reached 24/7 at 800-633-STAT. Complex discharges may require significant work to coordinate, so the earlier this process is begun, even a day in advance, the smoother and more predictable the discharge will be. The STAT MDOC may be used as a resource to discuss transportation-related medical questions at any stage of the planning process and can help ensure the needs of the patients will be appropriately addressed during transport.

Further discussions with family
Because discharging patients home with hospice gets so much more difficult when they are on higher levels of support, it is important to explore with yourself and the family the reasons for getting the patient home, and set expectations. Things to cover:
-Is the request to transfer home an emotional response?
-Find out what is so important about "home" versus the hospital and see what parts of home can be brought into the hospital
-Make sure the family is aware that the patient may not survive the journey home, and will likely die rapidly once they arrive at home
-Be clear that such a complicated discharge will not happen immediately, and may not be possible at all
For discharges that are clearly going to be complicated, consider whether it is even reasonable to offer to get the patient home. Often, we cannot prolong our patients' lives, so we want to do whatever we can to give them a "good" death. We need to think hard about whether we are treating our own distress about our impotence, or whether we are really acting in the patient and family's best interest.

Conclusion of Case
After further discussion with Mr. H and his wife about the challenges of getting home with hospice, they agree that it is not worth going through the long journey home to spend limited additional time at home. They decided that a nearby hospice inpatient unit sounded like a good compromise so that he was not dying in the hospital. A critical care transport agency transferred him to the hospice inpatient unit where he was able to die comfortably surrounded by family.

References:

1. Donnelly CB, Armstrong KA, Perkins MM, Moulia D, Quest TE, Yancey AH. Emergency medical services provider experiences of hospice care. Prehospital Emergency Care 2018 22(2): 237-243.
2. Wenger A, Potilechio M, Redinger K, Billian J, Aguilar J, Mastrenbrook J. Care for a dying patient: EMS perspectives on caring for hospice patients. J Pain Symp Mgmt 2022; 64:e71-e76