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Constructing a hospice shared care model to improve hospice care for non-cancer terminal patients

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INTRODUCTION

The initiative of the International Association for Hospice and Palliative Care (IAHPC) is "available to everyone regardless of disease, all ages, and the entire course of the disease." As long as patients with "life-threatening diseases" need it, they can receive hospice and palliative care equally between illnesses.

Although the benefits of providing palliative care to non-cancer patients have been increasingly recognized, as compared with cancer patients, the use of palliative services among patients with non-cancer diseases is extremely low and the timing of referrals is typically late.

AIM

This study is proposed a project to improve the quality of end-of-life care for non- cancer terminal by hospice shared-care model.

Methods

1、Service objects:

According to the announcement by the National Health Insurance administration in June 2022, the eligibility criteria for hospice care had become widen. Non-cancer patients diagnosed with the following diseases with terminal state could be enrolled in hospice care, including:

(1)Dementia

(2) Other brain degeneration，such as cerebrovascular accident, multiple sclerosis, parkinson's disease, huntington's disease

(3)Heart failure

(4)Chronic Obstructive Pulmonary Disease,

(5)Other lung disease, such as cystic fibrosis, severe fibrotic lung disease

(6)Chronic hepatitis and severe liver cirrhosis

(7) Acute kidney disease

(8)Chronic kidney disease

(9)Myelodysplastic syndromes(MDS)

(10)Terminally frail elderly: Clinical Frailty Scale(CFS）scale 8~9

2. Establishing a standard operating model for hospice shared-care services

(1) Through various educational activities, we have substantial communication opportunities between hospice shared care team and the original medical team, and improve the clinical hospice care skills for medical staff in non-hospice wards.

(2) Import the age-adjusted Charlson comorbidity index (ACCI) as an assessment of comorbidity risk for admitted patients. Patients with a score greater than 10 must hold a family meeting.

(3) The original medical team holds a family meeting to explain the condition and discuss whether it is suitable for hospice care, and the patient or family is willing to accept or learn more about hospice care, the hospice shared care team was consulted to provide hospice and palliative care service.

(4) The hospice shared care team confirm the criteria and communicate the purpose of care needs to the original care team members and patients.

(5) Refer to the psychologists and spiritual care staff as necessary.

RESULTS

1.The coverage rate of non-cancer patients had increased annually from 25.7% (n =133/518) in 2020 to 40.5%(n =271/670) in 2023

2.The top 5 non-cancer diagnoses were: dementia, cerebrovascular accident, intracranial hemorrhage, chronic kidney disease and Parkinson's disease.

3.The average days from referral to death is the same, which was 8 days in 2020 and 7.3 days in 2023. The above results indicated that late referral is still troublesome which may influence the quality of end of life care in hospice team

CONCLUSIONS

Lack of knowledge regarding the needs of terminal non-cancer patients and their families is a key barrier associated with low use of and late referral to palliative care. In addition, the disease progression and survival estimates of non-terminal cancer patients are completely different from those of terminal cancer patients.

However, the length of survival is not the only factor in determining whether a patient has reached the terminal stage. Considering quality of life in terminal patients is more important.

Use the hospice shared care model to strengthen patient advocacy may help non-cancer terminal patients in relieving various physical distress and enhance holistic care.

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