CURRENT TRENDS OF REHABILITATION IN HOSPICE AND PALLIATIVE CARE

Introduction

Hospice and palliative care is an area of health care that has experienced significant growth in the past decade. As our population ages and lives longer, we will continue to see more patients utilize hospice and palliative care. The role of physical therapy in hospice and palliative care is a mystery to many health care professionals - and specifically physical therapists!
Objectives

1. Understand the philosophy of hospice and palliative care as it relates specifically to the role of the physical therapist
2. Understand the history of the hospice movement
3. Identify specific physical therapy evaluation and treatment techniques for hospice and palliative care patients with varying diagnoses and living settings
4. Explain specific evaluation tools, goal setting and treatment strategies for working with patients who are enrolled in hospice and palliative care programs
5. Identify resources available to patients and health care professionals regarding hospice and palliative care
Pre-course Quiz

1. Name of the first US Hospice?
2. What is the hospice philosophy based on?
3. List the three main goals of a Hospice PT Evaluation?
4. Most important treatment tool for Hospice patients / families?
5. Two resources for physical therapists interested in working with hospice / palliative care patients?
6. True or False? All Hospice patients will die within 6 months.
7. True or False? Patients have the right to medically appropriate pt under hospice medicare benefits.

Hospice 101

- Quality compassionate care for people facing a life-limiting illness
- Expert medical care, pain management and emotional and spiritual support
- Patient specific
- Support provided to both patient and family
- Locations of services in home, hospitals, hospice centers, SNFs, ALFs
Hospice Care

- Focus of Hospice is on Caring, not Curing
- Generally two medical doctors must deem the patient’s diagnosis as terminal with a survival length of 6 months or less
- Quality versus Quantity of life

Interdisciplinary Team Approach within Hospice Care
Palliative Care

- Any stage of illness
- Multidisciplinary approach to care
- Goal to improve quality of life for patient / family
- Focus on providing symptom relief and symptoms and stress of a serious illness

Palliative versus Hospice Care

- Biggest difference lies in the patient: where they are in their illness especially related to prognosis and their individual goals/wishes regarding curative treatment

- Outside the US: Hospice typically refers to a building or institution that specializes in palliative care versus a particular stage of care progression
How big is hospice in the US?

1.6-1.7 million patients received hospice services in 2014

How Long Are Patients on Service?

- Median (50th percentile) of length of service = 17.4 days
- Average Length of service = 71.3 days
- 35.5% died or were discharged within seven days of admission
- 10.3% remain under hospice for longer than 180 days

* Based on 2014 facts and figures from the National Hospice and Palliative Care Organization
When we treat hospice patients in their homes, where are we actually working with them?

- **36%** of the time in their private residence
- **15%** of the time in a skilled nursing facility
- **9%** of the time in an assisted living facility
Inpatient Hospice Facilities

- 1 in 3 hospice agencies operate a dedicated inpatient unit or facility
- Can provide a mix of general inpatient and residential care
- Freestanding or in a hospital campus
- Short term inpatient care

Hospice in Skilled Nursing Facilities

**Things to Consider:**

- Issues can arise as to which staff are responsible for patient
- Communication is imperative
- Therapists must communicate to all involved in care
Who do Physical Therapists treat when working with Hospice patients?

- Women > men
- Older > younger people
- Non-Hispanics > Hispanics
- Caucasians > any other race

Hospice patients broken down by gender

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53.7%</td>
<td>46.3%</td>
</tr>
</tbody>
</table>
Breaking it down by age...

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>85+</td>
<td>41.1%</td>
</tr>
<tr>
<td>75-84</td>
<td>26%</td>
</tr>
<tr>
<td>65-74</td>
<td>16.8%</td>
</tr>
<tr>
<td>35-64</td>
<td>15.3%</td>
</tr>
<tr>
<td>25-34</td>
<td>0.5%</td>
</tr>
<tr>
<td>24 and &lt;</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Breaking it down by ethnicity...

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanics / Latinos</td>
<td>92.9%</td>
</tr>
<tr>
<td>Non-Hispanics / Non-Latinos</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
Breaking it down by race...

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>76%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>13.1%</td>
</tr>
<tr>
<td>Black</td>
<td>7.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.1%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Primary Diagnoses

- Cancer
- Dementia
- Heart Disease
- Lung Disease
- Other
- Stroke or Coma
- Kidney Disease (ESRD)
- Non-ALS Motor Neuron Disease
- Debility (unspecified)
- Amyotrophic Lateral Sclerosis (ALS)
- HIV/AIDS
Cancer versus Non-Cancer Hospice Diagnoses

Then vs Now...

Hospice Agencies in the US

- 1st Hospice Program in the US began in 1974
- Located in all 50 states, DC, PR, Guam and US Virgin Islands
- Approximately 6100 Hospice Programs now in the US (last calculated 2014)
Hospice Agencies (2)

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Standing / Independent Hospice</td>
<td>59.1%</td>
</tr>
<tr>
<td>Part of a hospital system</td>
<td>19.6%</td>
</tr>
<tr>
<td>Part of a home health agency</td>
<td>16.3%</td>
</tr>
<tr>
<td>Part of a nursing home</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Funding for Hospice Care

- Medicare hospice benefit was enacted by Congress in 1982.
- Primary source of payment for hospice care is Medicare.
- 85% percent of hospice patients are covered by Medicare hospice benefits.
- 90.3% of patient care days are covered by Medicare Hospice Benefit.
Hospice Benefits

- Medicare reimburses Medicare-Certified Hospices a daily amount for all services and DME per patient on hospice.

- Includes: MD, SN, PT, OT, SLP, LCSW, HHA, Music Therapy, hospital bed, hoyer, w/c, walker, medicines, gloves, masks, etc.


Volunteer Component to Hospice

- Inherent in the hospice philosophy is a commitment to volunteer service.

- CMMS mandates that Medicare Condition of Participation requires that 5% of total patient care hours be volunteer hours.

- NHPCO estimates that last year 430,000 hospice volunteers provided 19 million hours of service.
Bereavement Support

- Phone calls
- Visits
- Mailings throughout post death year
- Support group meetings
- Bereavement education
- Min. of one year post death
Hx of Hospice

- “Hospice” is derived from the same linguistic root as “Hospitality”
- Traces back to medieval times, when it was referred to a place of shelter and rest for weary or ill travelers on a long journey
- Dame Cicely Saunders, a leader in pain management, founded hospice movement
- Hospice is based on LIVING WITH DIGNITY

Pre-hospice medical care in the US.

- Pain management had not evolved
- Suffering was thought to be part of dying
- People typically would die in hospitals versus homes
- Patients with terminal conditions were written off as living
- Focus was always on cure, not care and not much collaboration of services
- The social and emotional states of patients was not deemed to be as significant
“You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to **live** until you die.”

- Dame Cicely Saunders, nurse, medical social worker, physician, writer, and founder of hospice movement (1918 - 2005).

---

**Hospice in the beginning...**

1948: Cicely Saunders began her work in hospice

1963: Gave her landmark lecture at Yale about hospice

1965: Florence Wald, Dean of Yale Nursing, invites Saunders to become Yale faculty

1967: Dame Cicely Saunders creates St. Christopher’s Hospice in the UK

1968: Florence Wald visits St. Christopher’s for 1 year

1969: Elizabeth Kubler-Ross writes *On Death and Dying*

1972: Elizabeth Kubler-Ross testifies to the US Senate Special Committee on Aging re: benefits of home care

1974: Florence Wald and colleagues open *The Connecticut Hospice in Branford, CT*
Dame Cicely Saunders

- Insisted that dying people need dignity, compassion and respect, as well as scientific methodology in the testing of treatments
- Donated and raised funds for St. Christopher’s
- Defined “Total Pain” as physical, emotional, social and spiritual dimensions of distress
- Truly listened to patient narratives

www.ncbi.nlm.nih.gov/pmc/articles/PMC1179787/

THE CONNECTICUT HOSPICE, INC

*Founded in 1974*
Florence Wald, RN founded US hospice movement
- Collaborated with Dame Cecily Saunders
- Started and ran The Connecticut Hospice in Branford, CT

Florence Wald, RN

“The Experience Model” by Mary Labyak

Landmark article that called for the provision of hospice and palliative care services that are based on the unique values, end of life goals and wishes of each patient and family rather than on the disease itself.

http://www.nxtbook.com/nxtbooks/nhpco/newsline_201203/#/16
"When you learn how to die, you learn how to live.”

~ Morrie Schwartz, American educator and writer

Physical Therapy
In Hospice & Palliative Care

Center for Medicare and Medicaid Services
National Hospice and Palliative Care Organization
Oncology Special Interest Group of the APTA

http://www.apta.org/PatientCare/HospicePalliativeCare/
“Throughout the continuum of life, physical therapists are experts in diagnosing and treating movement dysfunction, ergonomics, and managing pain to optimize quality of life and function for the patient/client and caregivers.”

American Physical Therapy Association
www.apta.org

APTA Policy on Hospice Therapy

- Respect for the rights of all individuals to have appropriate and adequate access to Physical Therapy, regardless of medical prognosis or setting

- Patients enrolled in hospice and palliative care are entitled to PT Services just as much as patients who are not enrolled in hospice and palliative care

- An interdisciplinary approach, including timely and appropriate physical therapy referral and involvement, as well as case communication
Physical Therapy

**Traditional**
- Functional goals
- Focus on returning to normal functional level
- Emphasis on mobility and exercise
- Includes various techniques, typically to help patient return to their normal, healthy lifestyle
- Patient centered

**Hospice**
- Goals = comfort, safety, and QOL
- Focus on compassionate care
- Emphasis on education
- Includes pain management, prevention of decubitus ulcer formation, safety, assessment of DME needs, and improvement of QOL, mobility and strengthening
- Involves patient, family and caregiver

---

**Physical Therapy EVALUATIONS for Hospice Patients**

- Patient driven
- Emphasis on compassionate education
- Directed at patient, caregivers and family members
- Goals ALWAYS include comfort, safety, and quality of life
PT Treatments for Hospice patients

- Individualized for each case
- Emphasis on compassionate education
- Directed at patient, caregivers and family members
  - Can include mobility training
    - Relaxation Techniques
    - Pain management
    - Manual therapy
    - Visualization

Case Example 1

geriatric patient in private home
Joseph L.

- 92 y.o male married x 65 years
- Hospice diagnosis = Glioblastoma
- PMH = CHF, DM, Asthma, Arrhythmia, Cellulitis bilateral lower extremities, was on Hemodialysis 3x/week for past 7 years but recently discontinued due to diagnosis of glioblastoma, neuropathies bilateral Upper and Lower Extremities, severe gout, and Myocardial Infarct 3 years ago
- Primary issue is recent falls while trying to go to the bathroom independently
- Joe’s goal is to be able to go to the bathroom independently until the end of his life
- He is very resistant to anyone coming in his home and telling him what to do

Evaluation

- Wife is 86, petite and frail and has hurt her back helping her husband.
- 24/7 hired caregiver is present
- Bathroom is 50 feet away from bed on first floor and pt. sometimes can walk but has fallen three times recently trying to get to the bathroom with the HHA
- On oxygen 3 ml via nasal cannula and has a rolling walker in the home as well as a hospital bed but wants to sleep with his wife in their shared bed
- Joe values his independence and doesn’t like so many people in the house, first thing he says is, “I only allowed you to come to appease my wife but I never liked to have any kind of therapy for myself and I will have this be a one shot deal.”
How to perform a PT eval on this pt?

1) Start with a conversation and find out what Joe wants to work on and get out of having a PT evaluation. (Here you will find out what he values and what he feels give him Quality Of Life)

2) Include the wife and caregiver in this conversation to get a good and valid history.

3) Ask if there have been any recent falls. (Safety)

4) Discuss use of oxygen and endurance.

5) Inquire about pain and severity (rate on VNRS) and describe the pain. (Comfort)

6) Assess ROM, general strength, bed mobility, transfers and ambulatory status.

Joe’s Physical Therapy Evaluation

- Joe does not like people helping him with things and he values his independence
- Balance in sitting and standing is impaired
- Unsteady gait, moderate assistance required for bed mobility and transfers
- Pain in head and legs= 8/10, fluctuates between 5/10 (best) and 10/10 (worst)
- Wife can’t physically help him but wants to. He doesn’t want her to help because he always helped her and is a bit macho so he doesn’t want to accept help from her.
- ROM WFLs, Strength grossly 4/-5 throughout.
Assessment

- Single visit only – no further physical therapy indicated at this time as Joe clearly articulated that he does not want therapy services and we have to value his feelings regarding the health care he receives (Compassion)

- DME Recommendations (so he can gain independence, live with dignity and QOL)

- Improved pain management (comfort and quality of life)

- Follow up with discussion with case managing RN and IDT (Collaborative care)

- Instruct pt., wife, and CG in safe handling and fall precautions (Education)

Case Example 2

older adult in memory care center at ALF
Factors associated with this case

1) Memo of understanding between hospice agency and Assisted Living Facility
2) Communication is crucial with both ALF and Hospice nurses prior to and after evaluation
3) Contact power of attorney to be present or discuss with prior to and following evaluation
4) Folks in memory care centers typically have schedules and programs
5) Visible name badge, sign into and out of the Assisted Living Facility

Hannah K.

- 90 y.o. female with hospice diagnosis of chronic lymphocytic leukemia
- PMH: Advanced Alzheimer’s Disease, severe bilateral shoulder osteoarthritis (inoperable), Vascular Ulcers bilateral lower extremities, very thin skin with multiple lacerations and scrapes due to long term steroid use, gastroesophageal reflux disorder, pain arms and knees, history of four hip replacements on right and one on left, hearing loss bilaterally, wears glasses
- Has had leukemia for over 50 years
- Incontinent
- History of two falls in past month
PT Evaluation

- Hannah wants to be able to walk to the bathroom and doesn’t like her depends
- Incontinence and urinary urgency causes her to rush to the bathroom quickly and she finds the walker a “pain in the neck”
- Energy level waxes and wanes
- Falls have been when patient goes to the bathroom by herself at night and she has been lucky so far and only has multiple bruises from these falls, but no breaks.
- Twice she has gone to the ER due to the staff finding her on the floor saturated in urine and unable to get up with ease

Hannah K

- ROM shoulders limited, longstanding
- Strength bilateral lower extremities 4-/5 to 4/5
- Marked pitting edema bilateral lower extremities with skin dry and with sores
- Pain shoulders and knees rated “3/10” but Hannah is not a complainer and says, “It could be worse. You know I’m 90 and almost 91. That’s pretty old. But I don’t feel as old as that.”
- Cognitive deficits, primarily short term memory deficits
- Balance impaired in static and dynamic standing, Timed Up and Go Score of 36
Hannah

- Bed mobility with min assist for lower extremities only
- Transfers with min assist of one and cuing for proper hand placement
- Ambulates with geriwalker x 150’ in room and in hallway with minimal assist of one and verbal and tactile cues to remain within the base of support of the walker
- Endurance poor and Hannah becomes fatigued after 10 minutes of activity
- Poor safety awareness

Plan of Care for Hannah K

- 2 visits per week for 4 weeks
- Impaired cognition makes it difficult for Hannah to learn new things
- However, she’s unsafe and with 2 falls already, a Timed Up and Go score of 36, and visual, hearing and cognitive deficits as well as urinary frequency and urgency, she’s at very high risk of falling again
- Assisted living facility doesn’t allow any rails up at night as they view this as a constraint
- Power of attorney is son and he wants her to have some therapy to help her get into shape and feels that the exercise can only help her brain and safety to prevent falls
Therapy

- Bed mobility training
- Transfer training
- Gait training
- Patient/family/caregiver education regarding elevation of legs above heart level
- Endurance Training
- Order bedside commode and instruct in proper strategic placement (perpendicular to bed) as well as transfer to commode and back to bed
- Instruct in use of a nightlight for evening commode visits
- Exercise / strength training

Additional Issues Surrounding this Case

- Alzheimer’s and ability to learn
- Appropriate amount of therapy visits
- Timing of Home Health Aides
- Frequency of caregiver support
Case Study 3
*pertinent patient*

If we don’t help, who will?
Sabrina P.

- 5 years old
- Hospice diagnosis = Astrocytoma
- Primary complaint = Pain right hip and left knee
- Family is Spanish speaking and has large support group
- Pt. recently discharged from hospital where she had a lot of therapy services and wants to continue

Terminal pediatric patient

- Often patients with cancer complain of pain at the end stage
- Brain cancers do not metastasize so Sabrina’s pain is not from the cancer spreading into bone
- Comfort, Safety, & Quality of Life
- Involve parents and family
- Comfort = Pain management
- Safety = Educate in importance of turning schedule, methods of transferring pt. without harming her or backs of others, and using pillows to help with positioning to decrease edema
- Quality of life = Patient wants to feel alive. Parents want to feel as though they are doing everything to make the last of this little girl’s life as pleasurable as possible. While therapy won’t cure Sabrina it’s the care she and her family need and want at this moment that provides them with the ability to feel as though they are doing everything within their power to help her.
Sabrina’s Evaluation and Plan of Care

- ROM WFLs passively
- STRENGTH grossly 2/5 but difficult to fully assess secondary to pain
- PAIN severe “8-10/10” without meds and meds give her side effects she doesn’t like
- MOBILITY fully dependent
- ENDURANCE very poor with increase in fatigue and drowsiness
- SPEECH impaired but has a family made communication binder

Sabrina

- LOVES Physical Therapists and wants to be able to walk again
- LOVES English language and hearing anyone speak or tell stories in English
- Distraction helps with pain management
- Watching health care professionals help Sabrina helps the family cope
As Hospice Physical Therapists, we don’t save lives; we simply enhance the lives of our patients and their families.

Case Study 4
43 year old father of 3
Lou G.

- 43 y.o. male diagnosed with ALS 3 years ago
- Has a young wife and three young children ages 6, 10 and 12
- On oxygen via mask and requires frequent breathing treatments
- Unable to talk and uses an ipad for communication
- Strength deficits marked and requires maximal assistance for all mobility
- Goal is to be able to watch his son play basketball at state finals in 3 weeks

Lou

Family is extremely supportive
All know that he has a terminal illness and is declining quickly
Spirits are generally up and he’s very hopeful that he will be able to watch the state finals
The interdisciplinary team requests a Physical Therapy evaluation for Lou and wonders if he will be able to keep his strength and endurance to go to this game that he wants to attend.
Evaluation

- Pain
- Strength
- Endurance
- Range of Motion
- Respiratory Status
- Durable Medical Equipment
- Safety of wife and caregiver’s providing assistance for bed mobility and transfers
- Home environment including stairs in home as well as leading to outdoors, automobile for car transfer

Plan of Care and Treatment

- Patient’s goal is to go to that game.
- He’s too weak to be able to participate in his transfers more than 10%
- We have three weeks to make this happen.
- Stairs in home as well as 2 to get into and out of home.
- Lou uses a wheelchair and has a mouthplate to operate it inside home
Helping Lou achieve his Physical Therapy goal of leaving the home for his son’s basketball game...

Plan of care is Physical Therapy twice weekly for three weeks

Discuss with skilled nursing who will follow up with interdisciplinary team members

In order to exit home, family must call ambulance to take patient to the game and then back.

Discussion with medical doctor regarding this is crucial

Transfer training to maximize safety with transfers with family

Energy conservation must be taught to Lou as he will fatigue and needs to be able to pace his breathing and relax himself

Lou

- Contact school to discuss entrance and follow up with ambulance
- Help arrange for portable oxygen tank (contact vendor)
- Instruct in range of motion exercises
- Instruct in breathing exercises
- Instruct in pacing self
Case Study 5

graduating Hospice patient

Does everyone on hospice die?

To be accepted onto a hospice program, two doctors must verify that the person has a terminal illness and life expectancy is 6 months or less.

Interestingly, some patients actually do better once they stop the traditional medical route.

Those who come off of hospice alive are called “graduates of hospice”.
Sylvie N.

- 78 y.o. patient with hospice dx of end stage CHF
- On hospice for 2 months
- At first was thought to pass within 2 weeks
- She stopped most medicines and had a big turnaround
- Now her needs are very minimal but she’s deconditioned because she’s been in bed for 8 weeks thinking she was going to pass soon.

PT Evaluation

- Discussion with case managing nurse indicates that nurse is concerned that patient needs to increase her strength and endurance in order for her to be safely discharged from hospice to standard home care.
- Patient is eager to move but is scared because she hasn’t been out of bed in so long
- PMH: HTN, COPD, osteoarthritis, SLE, and hx of decubitus ulcer on sacrum that’s healed fully, TKR 6 years ago
- Fear of falling
Evaluation

- Pt. goals
- DME needs
- Balance in sit and stand / Safety
- Strength, Endurance, Education regarding HEP
- Bed Mobility, Transfers, Ambulation
- Stairs if appropriate

Assessment

- We always want to ensure safety, quality of life, and comfort
- Patient’s goals will be to be safe for transition to standard home care, where she will have traditional home therapy services
- Comfort – need to increase activity gradually
- Quality of Life – living painfree and safely without falling
Sylvie’s Therapy

Plan of Care: Physical therapy intervention frequency 3x/wk for first week, 2x/week for second week and 1x/week for third week (total of 6 visits)

Therapy to include: strengthening, endurance training, bed mobility training, transfer training, gait reeducation, ensuring that all DME needs are met, and balance training

Case communication with case managing nurse frequently

Discharge plan: to homecare services when appropriate

Evidence Based Medicine combines science with clinical experience

More research is needed in hospice therapy
Role of Physical Therapy Intervention in Patients With Life-Threatening Illnesses: A Systematic Review

Authors: Kaitlyn Putt, Kelli Anne Faville, David Lewis, Kevin McAllister, Maria Pietro, and Ahmed Radwa


Background

Physical therapy encompasses the skilled treatment and care for patients across the life span through a multitude of different practice settings. This includes caring for individuals within end-of-life or palliative care settings. The goal of treatment in this stage of care is to relieve physical, social, psychological, and spiritual suffering in order to improve overall quality of life in patients with terminal illnesses. There has been limited research conducted to investigate the utilization of physical therapy interventions in palliative care settings.
Purpose

The purpose of this study was to contribute to the current research involving physical therapy and end-of-life care in terms of its efficacy, value, and how this value is perceived by patients and their caregivers.

Methods

This was completed by independently screening and reviewing the studies that were published between the years 1994 and 2014 and related to this topic. The databases and journals searched included CINAHL, PUBMED, MEDLINE, Cochrane, PEDro, the Journal of Palliative Care, the American Journal of Hospice and Palliative Medicine, and Google Scholar.
Results

13 qualitative articles were selected which met all inclusion criteria and discussed the role of physical therapy intervention in the palliative care setting. Methodological quality of articles were assessed using the QASP, scale and their findings were summarized and presented in table format.

Conclusion

These articles that were examined support the utilization of physical therapy in palliative care settings and emphasizes the impact of physical therapy on improving patients' physical, social, and emotional well-being.
In Summary...

- Hospice philosophy focuses on living with dignity
- Pain management is crucial to hospice and palliative care
- Hospice movement was founded in the US in 1974 and CT Hospice Inc was 1st agency
- 3 main goals of hospice evals and treatment: Safety, Comfort, & Quality of Life
- Compassionate Education should be focus of therapy
- Hospice is interdisciplinary in nature
- Sometimes people improve under hospice care
- People who are on hospice have the right to appropriate therapy services

Post Course Quiz

1. Name of the first US Hospice?
2. What is the hospice philosophy based on?
3. List three main goals of a Hospice PT Evaluation?
4. Most important treatment tool for Hospice patients / families?
5. Identify two resources for physical therapists interested in working with hospice / palliative care patients?
6. True or False? All Hospice patients will die within 6 months.
7. True or False? Patients have the right to medically appropriate PT under hospice medicare benefits
"... almost everything – all external expectations, all pride, all fear of embarrassment or failure – these things just fall away in the face of death, leaving only what is truly important. Remembering that you are going to die is the best way I know to avoid the trap of thinking you have something to lose. You are already naked. There is no reason not to follow your heart.”

– Steve Jobs

References

http://oncologypt.org/special-interest-groups/hospice-palliative-care-sig/index.cfm
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3012232/
www.hospice.com
http://www.nxtbook.com/nxtbooks/nhpco/newsline_201203/#/16
Thank you,

Caryn McAllister, PT, DPT