

HOSPICE NEWS...

A Report from Hospice Association of America

HOSPICE, AIDS, AND LONG-TERM CARE



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In the realm of long-term care, hospice is not often thought of as a resource for the management of patients with long-term, yet terminal illnesses. Indeed, the preponderance of hospice patients are short-term, acutely and terminally ill cancer patients who have an average length of stay in the hospice program of forty-five days. In addition, restrictive reimbursement policies, particularly Medicare hospice reimbursement, virtually preclude admission of patients with long-term illnesses to hospices, including even the cancer patient who, with aggressive therapy, may live longer, but still have a terminal prognosis.

These perceptions and care patterns are changing as more and more hospices begin to accept AIDS patients. In the care of the AIDS patient, hospice becomes a part of the case-management system. Here, the patient's care is coordinated among in-patient acute care, outpatient clinic, physician office, home health, and hospice care programs. In this coordinated system, the hospital is no longer the central focus for acute care services. The patient becomes the central focus, and the care setting becomes dependent on the patient's physiologic and psychosocial state. Not only is this more humane, it is also cost effective. Demonstration studies in New York and San Francisco utilizing a coordinated approach to care of the AIDS patient were able to reduce the costs of care per patient and per total treatment course by as much as \$120,000.

Because the care is planned and coordinated based on the patient's needs, hospice services may be provided at any point during the course of disease. Many AIDS patients associate hospice with "giving up." For others, hospice has come to mean a variety of services for the AIDS patients and for the families of AIDS patients. The case-management system allows the AIDS patient and family to utilize many of the supportive therapies available through hospice early on in treatment, while at the same time a home health agency may be providing aggressive therapy. Both patient and health care provider are aware of the inevitable outcome of the disease and that aggressive treatment is only palliative at best. But there is always the hope that, this time, things may be different and a cure may be effected. In many ways, this is not different from the concerns and hopes of many terminal cancer patients. But we tend to treat the AIDS patient differently, perhaps because the AIDS patient is rarely indifferent to or accepting of his disease, and because of the young age of the typical person with AIDS.

If AIDS is forcing a change in the way hospices view aggressive treatment and long-term care of the terminally ill, it may also be creating significant and overall changes in the health care delivery system. Long-term care is the major health policy issue on the federal agenda. As the greying of America progresses, policymakers are searching for cost-effective ways of providing necessary health care and social services. Lateralization of health care services and case management are proving to be highly cost-effective methods of providing care to individuals who require a variety of medical, social, and community services and aggressive high-tech care.

Kubler-Ross says that hospice is a "concept of care...to help a person live until he dies." Such a concept is fully compatible with aggressive care directed toward relieving symptoms and consequently lengthening the life of a terminal cancer or AIDS patient. Hospices must broaden their approach to long term care. The industry must be alert to the system changes that lie around the corners and release their tenacious hold on an inadequate reimbursement program that would limit their ability to change -- if there is to be a role for hospice in the future.

The Hospice Association of America will co-sponsor two all-day conferences on long-term care, AIDS and Alzheimer's disease, at our annual meeting and conference to be held in Washington, D.C., October 10, 1987, at the Grand Hyatt Hotel. Please join us there.

WELLCOVORIN® TABLETS (leucovorin calcium)

Leucovorin in convenient
5 mg and 25 mg tablets

Before prescribing WELLCOVORIN® Tablets, please consult complete prescribing information. The following is a brief summary.

INDICATIONS AND USAGE: Wellcovorin (leucovorin calcium) is indicated for the prophylaxis and treatment of undesired hematopoietic effects of folic acid antagonists (see WARNINGS).

CONTRAINDICATIONS: Leucovorin is improper therapy for pernicious anemia and other megaloblastic anemias secondary to the lack of vitamin B₁₂. A hematologic remission may occur while neurologic manifestations remain progressive.

WARNINGS: In the treatment of accidental overdosage of folic acid antagonists, leucovorin should be administered as promptly as possible. As the time interval between antifolate administration (e.g. methotrexate) and leucovorin rescue increases, leucovorin's effectiveness in counteracting hematologic toxicity diminishes.

PRECAUTIONS:

General: Following chemotherapy with folic acid antagonists, parenteral administration of leucovorin is preferable to oral dosing if there is a possibility that the patient may vomit and not absorb the leucovorin. In the presence of pernicious anemia a hematologic remission may occur while neurologic manifestations remain progressive. Leucovorin has no effect on other toxicities of methotrexate, such as the nephrotoxicity resulting from drug precipitation in the kidney.

Drug Interactions: Folic acid in large amounts may counteract the antiepileptic effect of phenobarbital, phenytoin and primidone, and increase the frequency of seizures in susceptible children.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Animal reproduction studies have not been conducted with Wellcovorin. It is also not known whether Wellcovorin can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Wellcovorin should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Wellcovorin is administered to a nursing mother.

Pediatric Use: See "Drug Interactions."

ADVERSE REACTIONS: Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

OVERDOSAGE: Excessive amounts of leucovorin may nullify the chemotherapeutic effect of folic acid antagonists.

DOSAGE AND ADMINISTRATION: Leucovorin is a specific antidote for the hematopoietic toxicity of methotrexate and other strong inhibitors of the enzyme dihydrofolate reductase. Leucovorin rescue must begin within 24 hours of antifolate administration. A conventional leucovorin rescue dosage schedule is 10 mg/m² orally or parenterally followed by 10 mg/m² orally every six hours for seventy-two hours. If, however, at 24 hours following methotrexate administration the serum creatinine is 50% or greater than the pre-methotrexate serum creatinine, the leucovorin dose should be immediately increased to 100 mg/m² every three hours until the serum methotrexate level is below 5 × 10⁻⁸M.^{1,2}

The recommended dose of leucovorin to counteract hematologic toxicity from folic acid antagonists with less affinity for mammalian dihydrofolate reductase than methotrexate (i.e. trimethoprim, pyrimethamine) is substantially less and 5 to 15 mg of leucovorin per day has been recommended by some investigators.^{3,4,5}

1. Bleyer WA: The Clinical Pharmacology of Methotrexate. *Cancer*, 41(1):36-51, 1978.
2. Frei E, Blum RH, Pitman SW, et al: High Dose Methotrexate with Leucovorin Rescue: Rational and Spectrum of Antitumor Activity. *Am J Med*, 68:370-376, 1980.
3. Golde DW, Bersch N, Quan SG: Trimethoprim and Sulpha-methoxazole Inhibition of Haematopoiesis *In Vitro*. *Br J Haematol*, 40(3): 363-367, 1978.
4. Steinberg SE, Campbell CL, Rabinovitch PS, et al: The Effect of Trimethoprim/Sulfamethoxazole on Friend Erythroleukemia Cells. *Blood*, 55(3): 501-504, 1980.
5. Mahmoud AAF and Warren KS: Algorithms in the Diagnosis and Management of Exotic Disease. XX Toxoplasmosis. *J Infect Dis*, 135(3): 493-496, 1977.