

Palliative Care

Hospice is not enough

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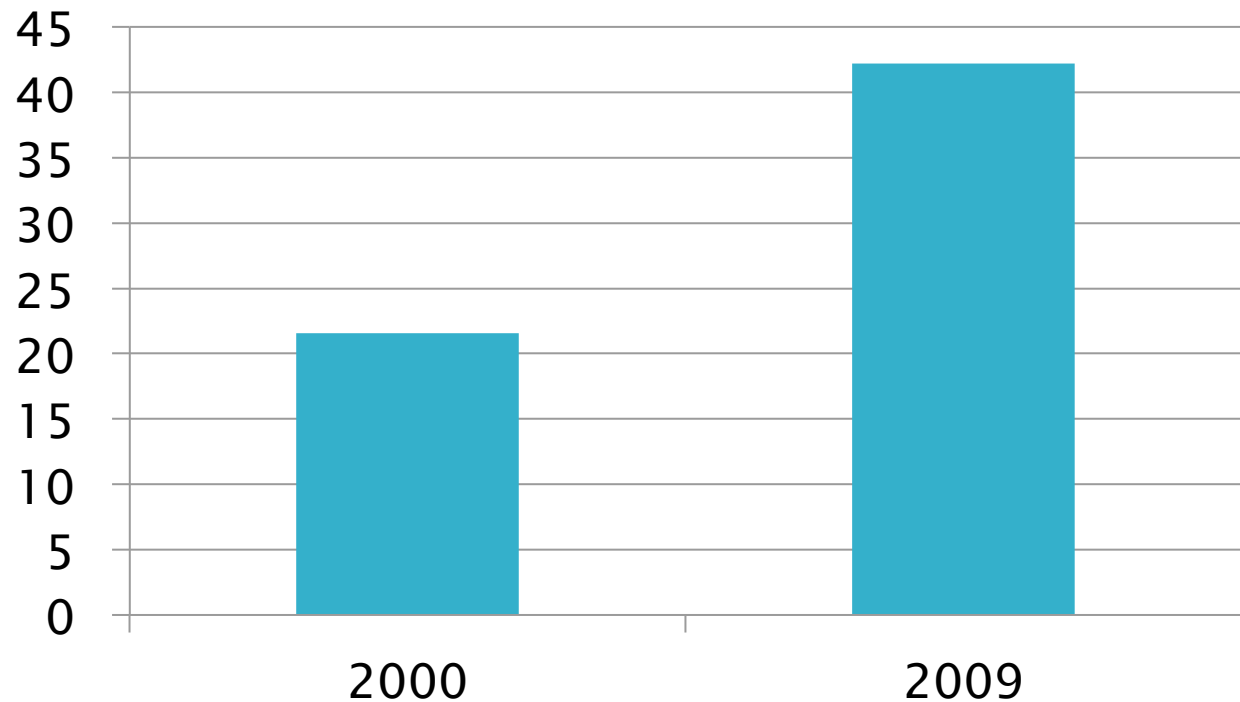
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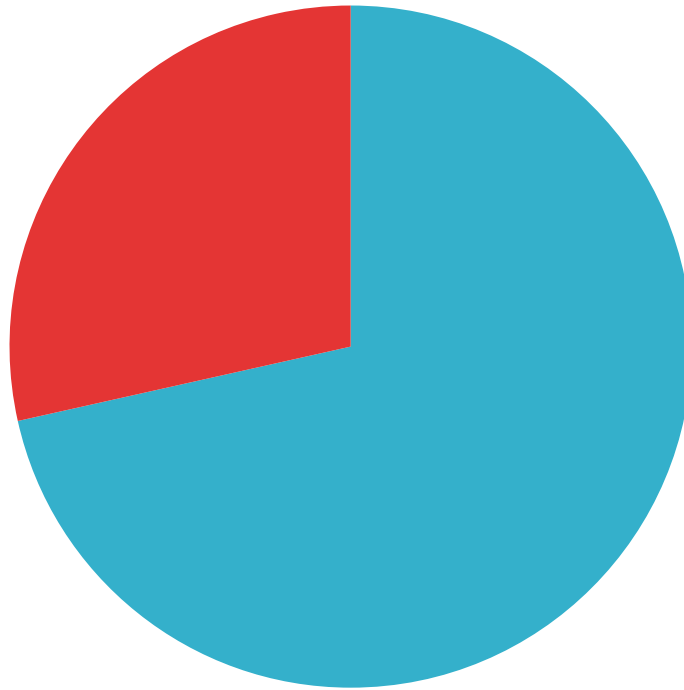
Hospice Successes

- ▶ Hospice use among Medicare beneficiaries increased to 42.2 percent in 2009, up from 21.6 percent in 2000



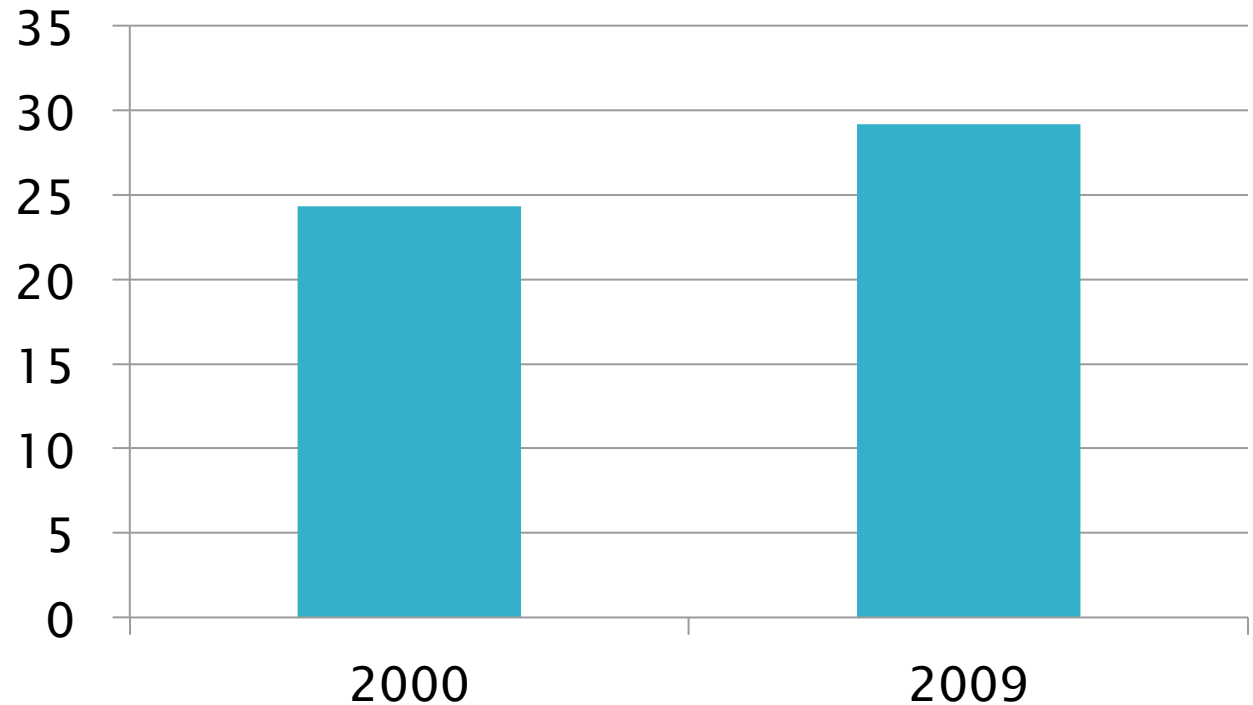
Hospice Failures

- ▶ More than 28 percent of these dying individuals received hospice care for three days or less



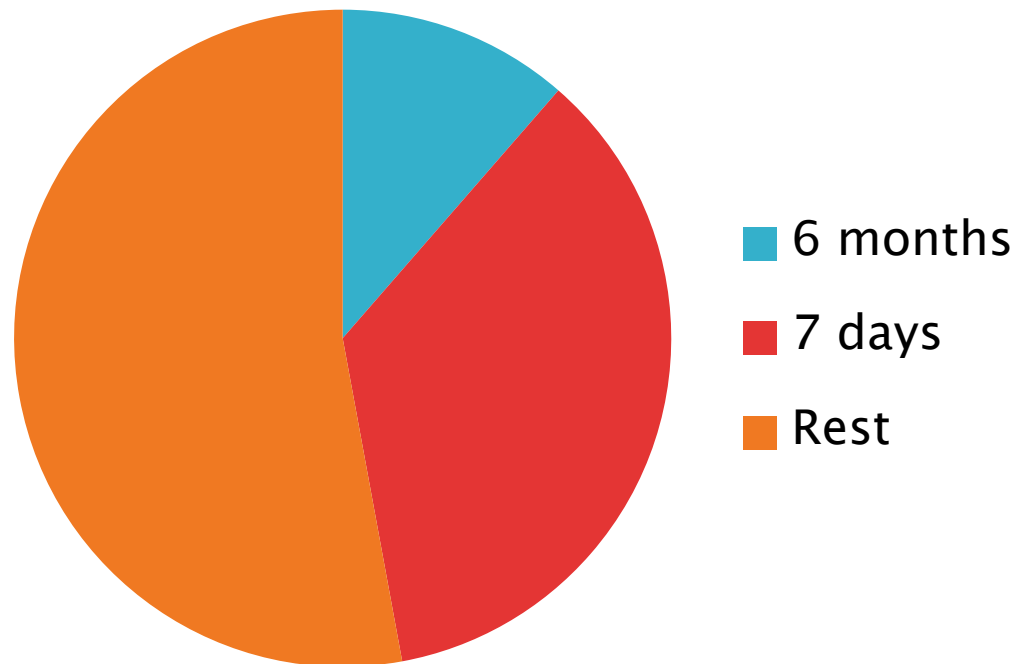
Hospice Failures

- ▶ The % of people who had a stay in an Intensive Care Unit in the last month of life increased to 29.2 % in 2009 from 24.3 % in 2000



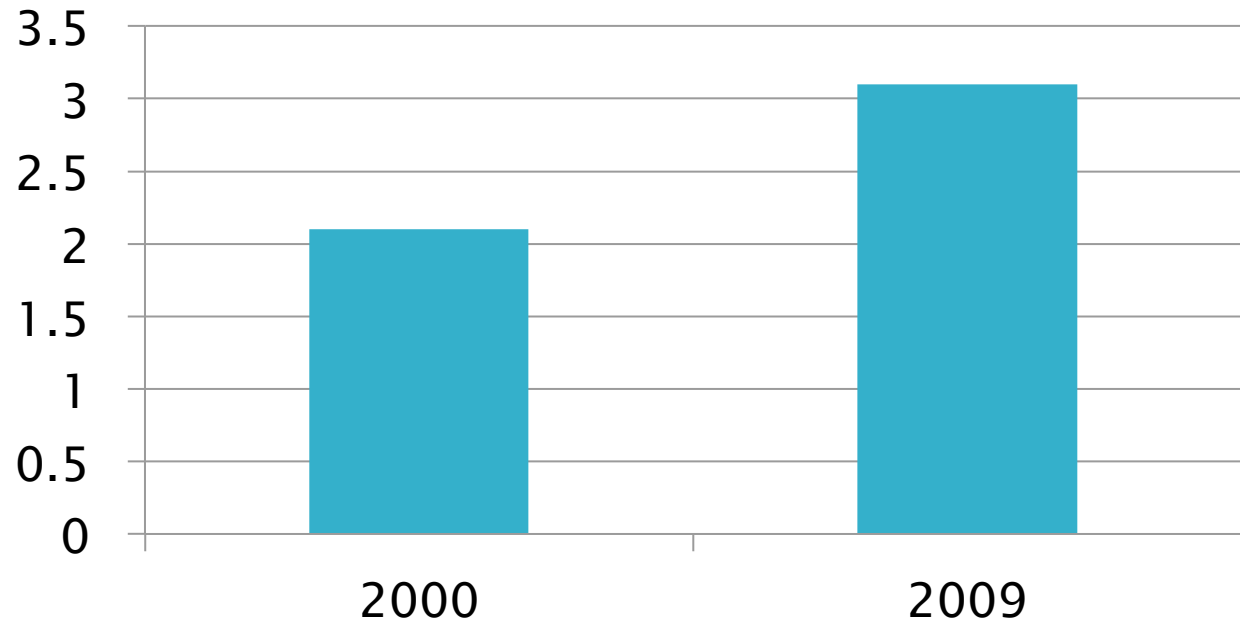
Hospice Failures

- ▶ 35.7 percent of hospice patients died or were discharged within seven days of admission
- ▶ Whereas, only 11.4 percent of patients were under care for longer than 180 days



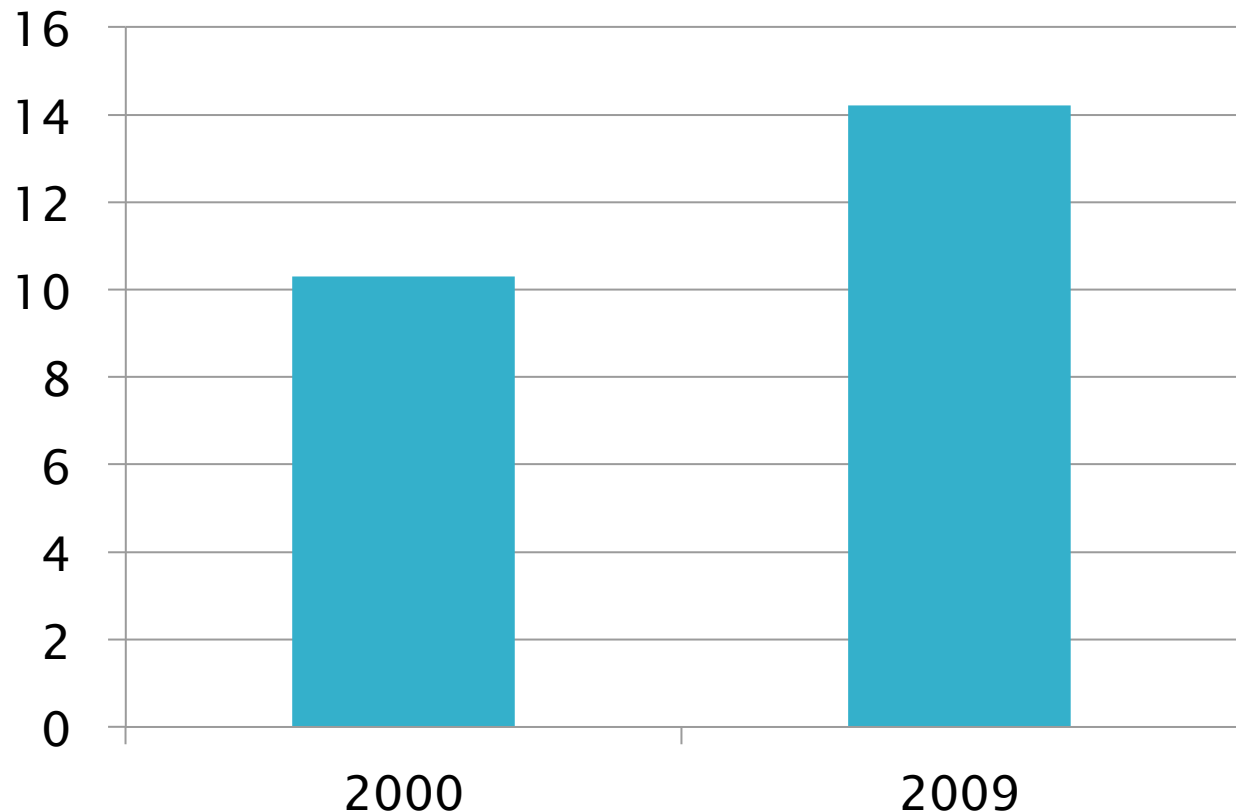
Hospice Failures

- ▶ The average rate of health care transitions in the last 90 days of life increased from 2.1 per decedent in 2000 to 3.1 per decedent in 2009, including multiple hospitalizations



Hospice Failures

- ▶ Transitions in the last 3 days of life increased from 10.3 percent to 14.2 percent in 2009.



Joan M. Teno, M.D., M.S., of the Warren Alpert Medical School of Brown University, Providence, R.I

- ▶ “Our findings of an increase in the number of short hospice stays following a hospitalization, often involving an ICU stay, suggest that increasing hospice use may not lead to a reduction in resource utilization. Short hospice lengths of stay raise concerns that hospice is an ‘add-on’ to a growing pattern of more utilization of intensive services at the end of life”

Palliative Care

- ▶ Addresses
 - Pain
 - Suffering
 - Quality of life
- ▶ Across all stages of treatment
- ▶ *It does not exclude life-prolonging treatment and rehabilitation*

Current Care Model

“Curative” or
“Life-Prolonging”
Treatment

Symptom
control
and
Palliative
Care

Doing Everything

- ▶ Dichotomy between “doing everything” versus providing comfort care—a dichotomy that often fails to focus on relieving suffering and improving quality of care

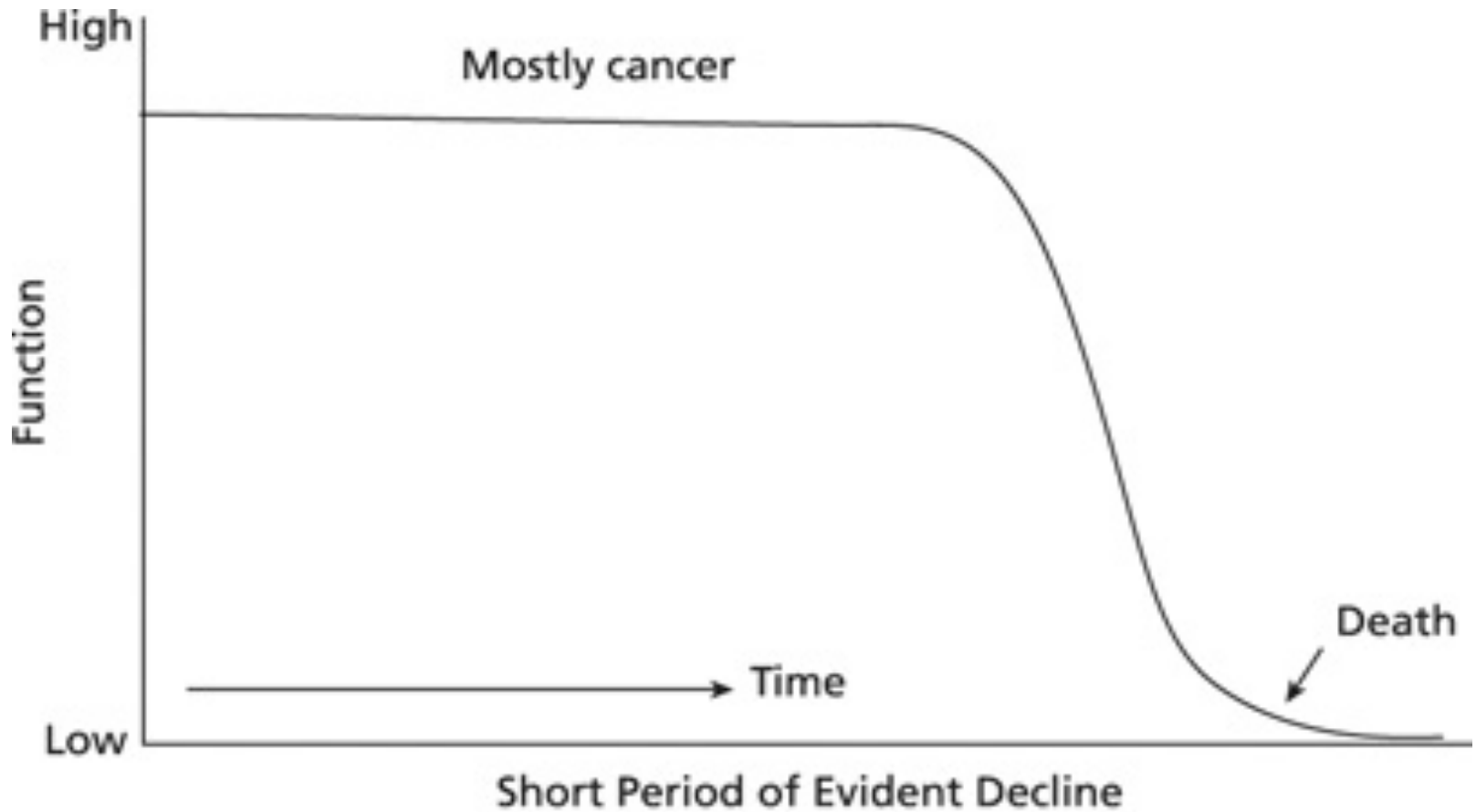
Proposed Care Model



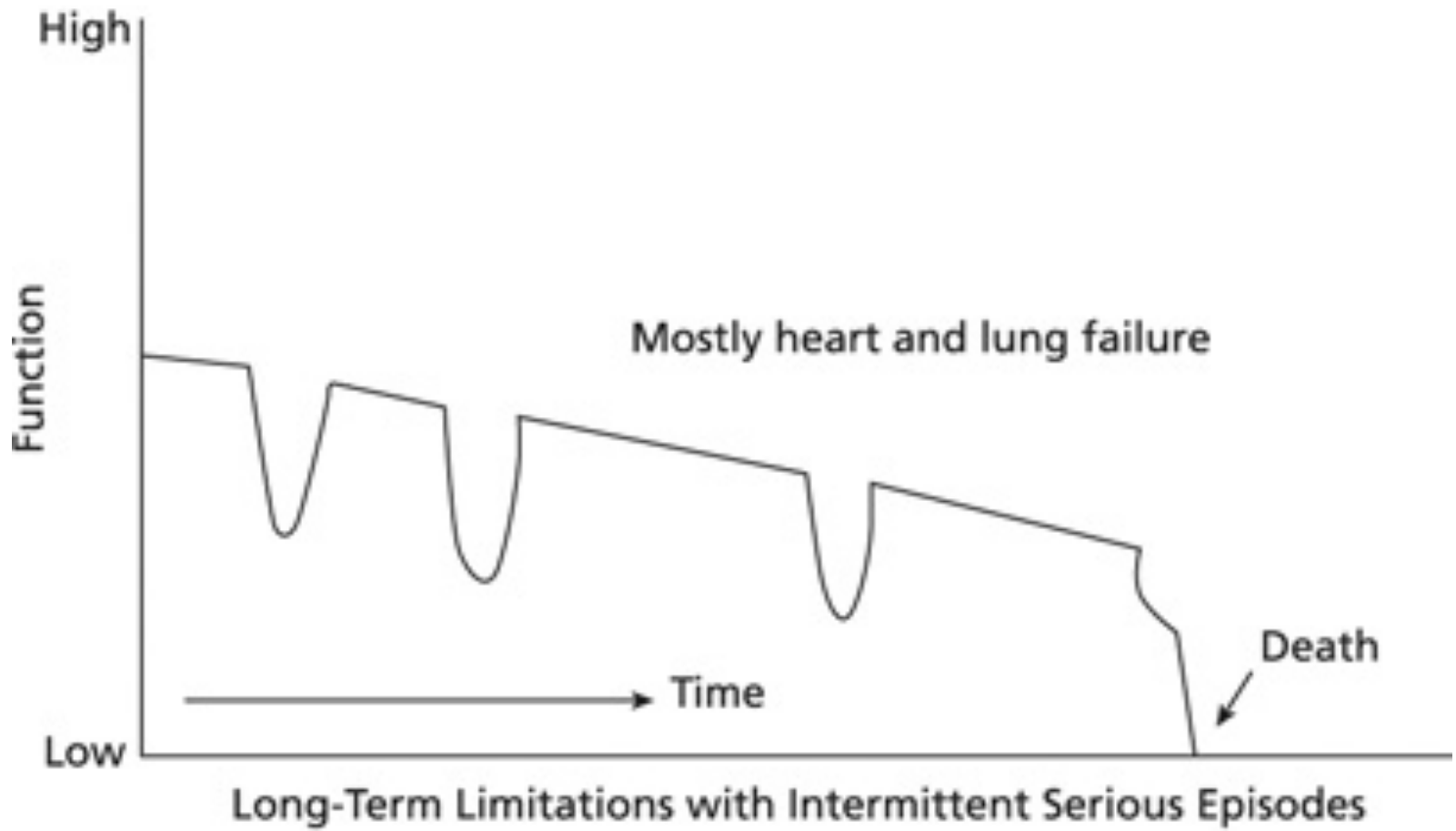
Palliative Care vs Hospice

- ▶ Nonhospice palliative care may be offered along with curative or life-prolonging therapies for patients with complex, life-threatening disorders
- ▶ Hospice palliative care is offered when patients reach their final weeks or months of life, when the likely harm of life-prolonging or curative therapies exceeds benefit, and these therapies are discontinued

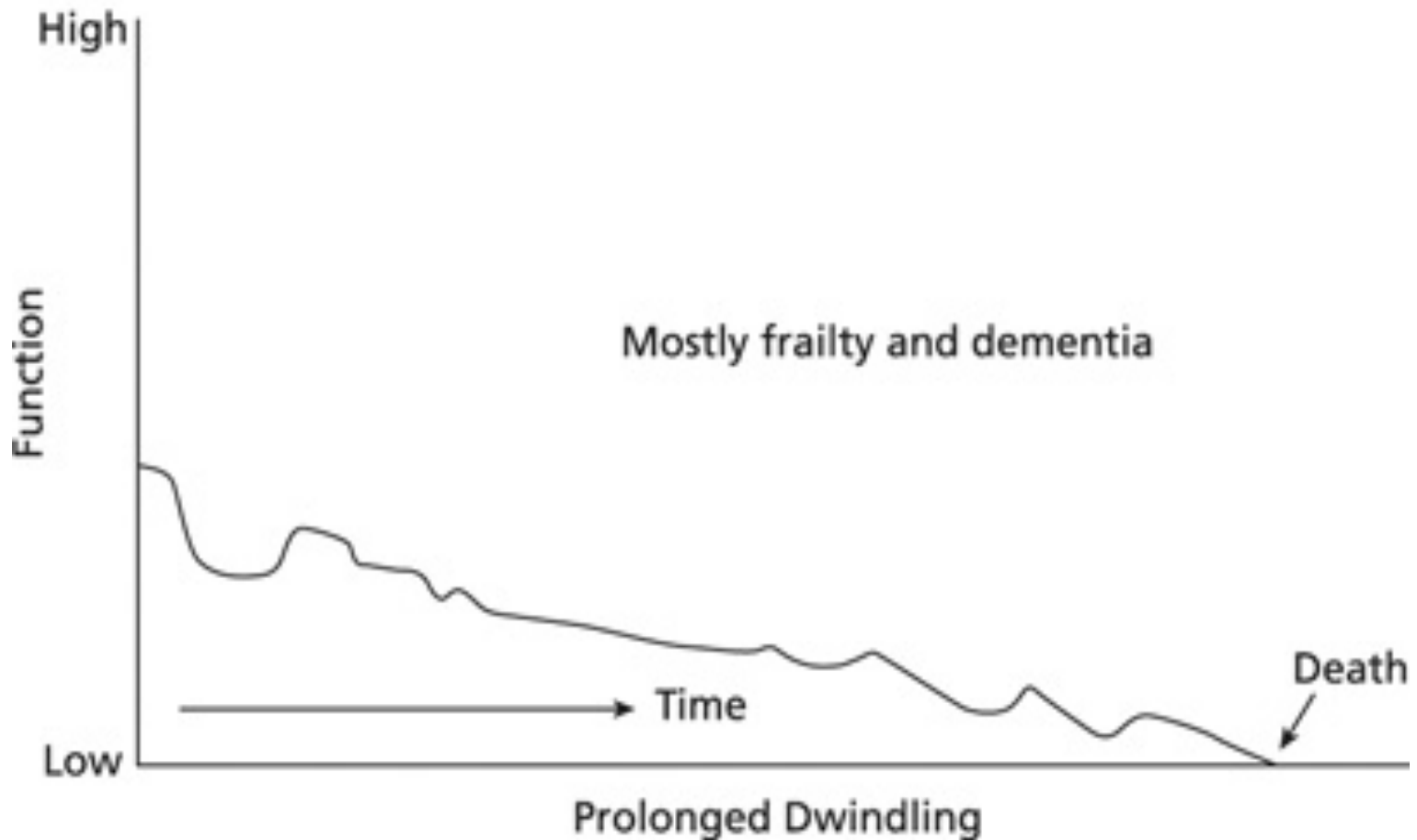
Courses of Illness: Cancer



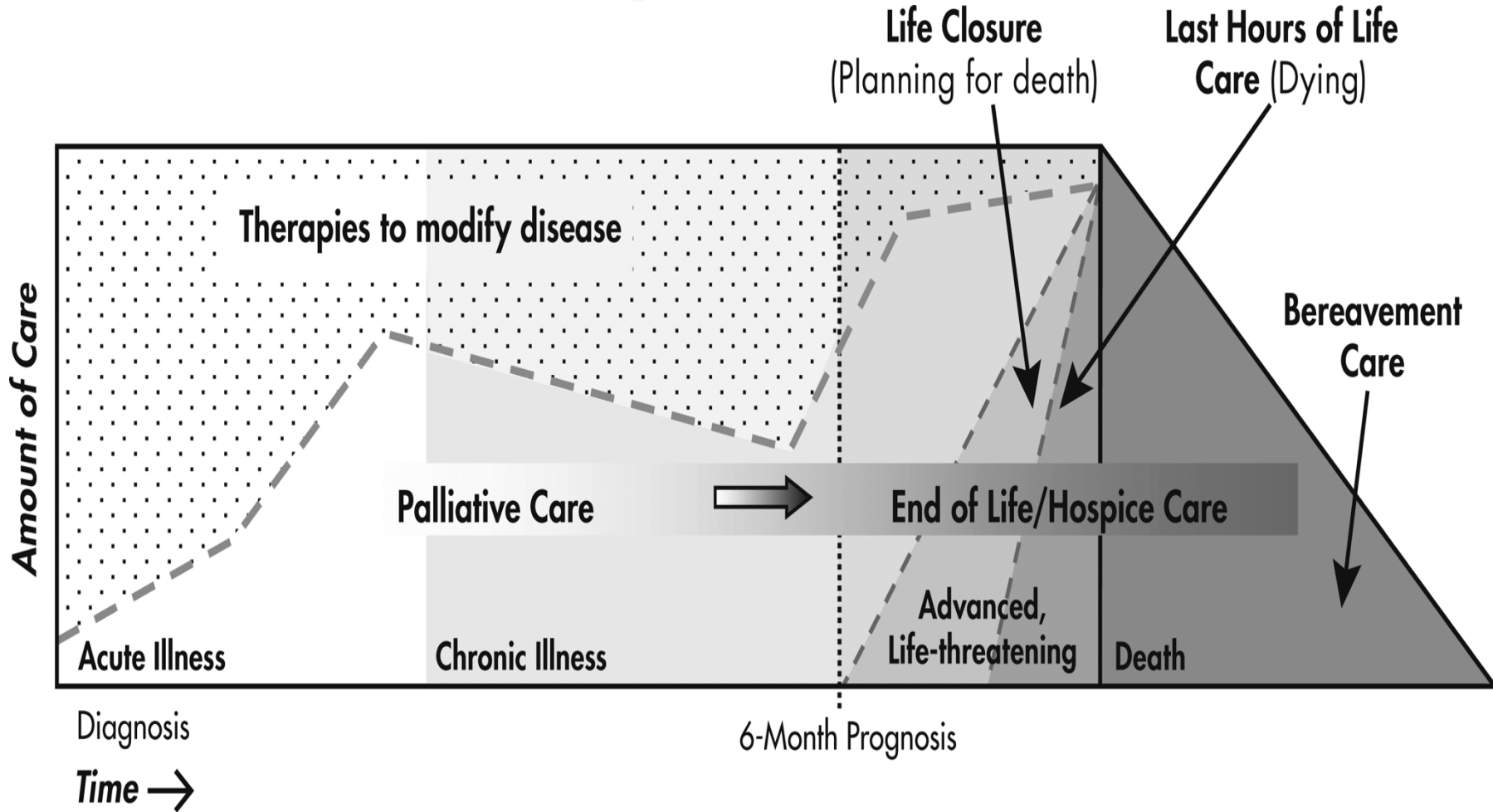
Courses of Illness: Heart and Lung



Courses of Illness: Frailty and Dementia



Real World Experience



Multifaceted approach

- ▶ Clarifying goals of treatment
- ▶ Communication

Multifaceted approach

- ▶ Managing symptoms
 - Pain
 - Constipation
 - Fatigue
 - Dyspnea
 - Nausea
 - Anorexia and Nutrition
 - Depression
 - Delirium

Multifaceted approach

- ▶ Mobilizing resources to optimize care and social support

Multifaceted approach

- ▶ Integrating care across settings

Palliative Care and Quality of Life

- ▶ Emerging data , concurrent palliative care intervention in the treatment of cancer suggest that patients using palliative care services have higher scores for quality of life and mood than those undergoing cancer treatment alone

Palliative Care and Life Expectancy

- ▶ Patients with newly diagnosed metastatic non-small cell lung cancer randomly assigned to standard oncologic therapy alone versus early palliative care with standard oncologic therapy, patients in the palliative care group had a mean survival of 11.6 months as compared with 8.9 months in the group not provided early palliative care.
- ▶ The intervention group also experienced less depression and better quality of life

Palliative Care and Costs

- ▶ Palliative care consultation programs are also associated with significant hospital cost savings, with an adjusted net savings of:
 - \$1696 in direct costs for patients discharged alive from the hospital, and
 - \$4908 net savings for patients dying in the hospital as compared with patients who receive usual care

Location of Palliative Care

- ▶ Hospitals
- ▶ Nursing Homes
- ▶ Home based

Providers of Palliative Care

- ▶ Nurses
- ▶ Nurse Practitioners
- ▶ Physician Champions

Payers for Palliative Care

- ▶ Hospices
- ▶ Accountable Care Organizations – Managed Care/At Risk Contracts
- ▶ Hospitals

Comatose Orphans

Challenges that family's have

- ▶ Ignorance of their medical condition and or the medical options
- ▶ Unrealistic goals and or denial
- ▶ Pre-existing dysfunction of relationships
- ▶ Cultural or other different perspectives
- ▶ Bereavement and Grief

Challenges that providers have

- ▶ Non acceptance of medical advice
- ▶ Complicated grieving or irresolvable emotional reactions
- ▶ Excessive expectations
- ▶ Lack of consensus among the provider team

Guiding Ethical Principles

- ▶ Autonomy
- ▶ Beneficence
- ▶ Nonmaleficence
- ▶ Justice

Primary Tools

- ▶ Communication
- ▶ Goal Setting

Who gets to decide

- ▶ Advanced Healthcare Directive
- ▶ Durable Power of Attorney
- ▶ Healthcare Proxy
- ▶ Next of Kin: Indiana laws – Spouse, Parent, Adult Child or Adult Sibling

Key Point 1

- ▶ Palliative care addresses pain, suffering, and quality of life across all stages of treatment and does not exclude life-prolonging treatment and rehabilitation

Key Point 2

- ▶ More aggressive care at the end of life does not improve either quality or duration of life

Key Point 3

- ▶ The first step in communication with patients, families, and caregivers regarding palliative care is to establish goals of care in a patient-centered, open-ended format

Key Point 4

- ▶ Most differences of opinion or perspective can be resolved with ongoing
 - Communication
 - Continually re evaluating and reassessing Goals of Care
 - Focus on the Guiding Ethical Principles of Healthcare: Autonomy, Beneficence, Nonmaleficence and Justice

Go home and spend time with your family:

