

## A Newsletter for Healthcare Professionals

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### Hope Hospice Team Managers

Peter P. Wong, MD  
Medical Director

Michael Abdel-Malek, MD  
Associate Medical Director

Daniel Dinaburg, MD  
Consulting Psychiatrist

Helen Meier, MA  
Executive Director

Ann Noll, BSN, CHPN  
Director of Patient Services

Karen Archer, RN, CHPN  
Clinical Coordinator

Marci Crothers, RN, BSN, PHN  
Nurse Supervisor, RN Case Manager

Sherri Johnson, RNC  
Nurse Supervisor, RN Case Manager

Ann Felner, LCSW  
Social Work & Spiritual Care Supervisor

Barbara Hepner, Director of  
Medical and Community Outreach



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## Cancer Patients Have Improved Survival, Better Quality of Life with Early Palliative Care

Patients with non-small-cell lung cancer who received early palliative care in addition to standard cancer therapies reported better quality of life, lower rates of depressive symptoms, received less aggressive care at the end of life, and had longer survival, according to results of a study reported in *The New England Journal of Medicine*.

“Early integration of palliative care with standard oncologic care in patients with metastatic non-small-cell lung cancer resulted in survival that was prolonged by approximately two months and clinically meaningful improvements in quality of life and mood,” write the authors.

Metastatic non-small-cell lung cancer is the leading cause of cancer death worldwide, with an estimated prognosis after diagnosis of less than one year. However, palliative care has traditionally been delivered late in the course of the disease, despite previous research suggesting that “late referrals to palliative care are inadequate to alter the quality and delivery of care provided to patients with cancer,” note the authors.

Researchers analyzed patient-reported outcomes and electronic medical records of use of health services for 151 patients newly diagnosed with non-small-cell lung cancer (mean age, 65 years; white, 70% to 77%) between June 2006 and July 2009 at a thoracic oncology care site in Boston. Patients were randomly assigned to receive either early palliative care integrated with standard oncological care, or standard oncological care only.

### Key Findings Include:

- Patients receiving palliative care lived nearly two months longer than those in

the standard care group (11.6 months vs 8.9 months).

- Fewer patients in the palliative care group than in the standard care group received aggressive end-of-life care (33% vs 54%).

*“With earlier referral to a hospice program, patients may receive care that results in better management of symptoms, leading to stabilization of their condition and prolonged survival.”*

~ Temel et al, *The New England Journal of Medicine*

- Palliative care patients had significantly higher scores in measures of quality of life compared with those receiving standard care (98.0 vs 91.5, on a scale of 0 to 136).
- Half as many patients in the palliative care group as in the standard care group reported depressive symptoms, despite no between-group difference in the use of antidepressants.
- Patients in the palliative care group were more likely to have their resuscitation preferences documented compared with those in standard group (53% vs 28%)
- Median duration of hospice care, although short in both groups, was nearly three times longer in the palliative care group than in the standard group (11 days vs 4 days).

“Previous data have shown that a lower quality of life and depressed mood are associated with shorter survival among patients with metastatic non-small-cell lung cancer,” write the authors. “We hypothesize that improvements in both of these outcomes among patients assigned to early palliative care may account for the observed survival benefit.”

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## Successful Nursing Home-Hospice Collaborations Continue to Grow, Despite Design of Medicare Hospice Benefit

The use of the Medicare hospice benefit by residents dying in nursing homes has more than doubled over the past decade, researchers from Brown University have found, thus providing more patients with the documented benefits of better pain management, fewer hospitalizations, and greater family satisfaction that hospice care provides in this setting.

“At present, given current understanding of nursing home end-of-life care and of the benefits and use of hospice in nursing homes, the provision of nursing home-hospice collaborative care appears to be the most feasible option for widespread improvement of dying residents’ quality of care and life,” write the authors of a report on the study in the *Journal of the American Geriatrics Society*.

“The current study provides new information showing that almost one-third of Medicare beneficiaries dying in nursing homes accessed Medicare hospice in 2006, and given the observed trends, this growth in use is probably continuing,” they add.

The team analyzed nursing home assessment data from the Minimum Data Set and Medicare claims and enrollment

data on all persons who died in nursing homes in the U.S. from 1999 through 2006.

### *Findings Include:*

- The rate of nursing home decedent hospice use more than doubled (from 14.0% to 33.1%) from 1999 to 2006.
- During that same period, the number of hospices providing care in nursing homes rose from 1850 to 2768.
- The proportion of nursing home hospice decedents with noncancer diagnoses grew from 69.2% to 82.6%.
- There was significant growth in the proportion of all nursing home decedents with diagnoses of cancer (from 23% to 51.3%) and noncancer (from 11.9% to 31.4%) who accessed hospice from 1999 to 2006.
- While the proportion of nursing home decedents with longer hospice stays (more than 180 days) rose from 6.6% to 15.6%, the proportion of those with stays of 7 days or less remained steady over time at about 30%.

“Calls for elimination of Medicare hospice in nursing homes based on its underuse appear unfounded,” state the authors. “Additionally, the notion that

the complexity of nursing home-hospice collaborations is a major obstacle to the viability of hospice care in nursing homes also appears unfounded, given the high proportion of the U.S. nursing homes contracting with hospice providers and the documented outcomes resulting from this collaborative care.

“Nevertheless, the argument that the design of the Medicare hospice benefit creates barriers to its access is undeniable,” they continue, influencing as it does the timing of referral for patients with non-cancer diagnoses, who comprised 83% of all nursing home decedents in 2006.

“The challenge in nursing homes is how to balance the need for hospice access with the timing of referral for nursing home residents in the last stages of (noncancer) chronic terminal illnesses for which predicted survival is poor at best.”

*Source: “The Growth of Hospice Care in U.S. Nursing Homes,” Journal of the American Geriatrics Society; August 2010; 58(8):1481-1488. Miller SC, Lima J, Gozalo PL, Mor V; Center for Gerontology and Healthcare Research and Department of Community Health, Alpert Medical School, Brown University, Providence, Rhode Island.*

## Palliative Care Consultations Found to Significantly Lower Hospital Costs and Improve Patient Care and Satisfaction

Care of inpatients with serious, life-limiting illness by a palliative care team substantially reduces overall hospital costs, laboratory and radiology testing costs, and utilization of intensive care units (ICUs), a team of researchers report in the *Journal of Palliative Medicine*.

“Hospital-based palliative care programs, focused on pain and symptom management, communication and goals of care, and assistance with transitions among sites of care, have become an increasingly common way to improve

hospital care for patients with advanced disease and their families,” write the authors of the report.



“This study adds to prior research on the benefits of palliative care consultation. It shows that palliative care is associated to substantial reductions in hospital costs...”

Their study is the first to compare average direct hospital costs and to examine the relationship between palliative care consultation and ICU admission (which in itself usually accounts for approximately 20% of overall hospital costs) by using an instrumental variables approach to produce unbiased estimates of the treatment effect, the authors point out.

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## POLST Form Documenting End-of-Life Wishes as Medical Orders More Effective Than Traditional Methods

Patients who document their wishes using Physician Orders for Life-Sustaining Treatment (POLST), a brightly colored, standardized medical order form that transfers across care settings, are more likely to receive their preferred level of end-of-life care than are patients using more traditional methods, researchers have found.

The authors of a report published in the *Journal of the American Geriatrics Society* examined the records of 1711 patients (mean age, 84.2 years) from a random sample of 90 nursing facilities in Oregon, Wisconsin, and West Virginia, states in which similar versions of the POLST program are in use.

### Key Findings Include:

- Patients with POLST forms were more likely to have treatment preferences beyond CPR documented as medical orders compared with patients with traditional advance directives (98.0% vs 16.1%).

- Those residents whose POLST orders indicated comfort measures only were significantly less likely to receive life-sustaining medical interventions than were those who had traditional full code orders, traditional DNR orders, POLST full treatment orders, and POLST limited intervention orders (71%, 59%, 67%, and 42% less likely, respectively).

“Advance directives and CPR status orders often fail to take into account a person’s specific medical condition, and lack an immediate effect on treatment,” the authors state. Patient-generated directives — such as living wills — are generally too vague to be helpful in the clinical setting and rarely indicate when a patient’s preferences are to be acted upon, they add, while DNR orders are relevant only for patients in cardiopulmonary arrest.

“The POLST program is built upon a coordinated system of care across treatment settings that includes emergency services, hospitals, primary care practices, hospices, and nursing

facilities, and relies on standardized, specific orders for a range of treatments, which makes the POLST program unique and may explain its apparent success,” the authors suggest.

Initially developed in Oregon, the POLST program — or versions similar to it in design — is now used in more than 30 states. The border along the top of the form states prominently: “HIPAA permits disclosure of POLST to other health care professionals as necessary,” while the bottom border reads: “Send form with person whenever transferred or discharged.”

For information on states with active or developing POLST programs, visit [www.polst.org](http://www.polst.org).

Source: “A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program,” *Journal of the American Geriatrics Society*; July 2010; 58(7):1241-1248. Hickman SE, Nelson CA, et al; School of Nursing, Indiana University, Indianapolis; Schools of Medicine and Nursing, Oregon Health & Science University, Portland.

## Palliative Care Consultations Found to Significantly Lower Hospital Costs

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The team analyzed data on all adult patients (n = 3321) who were admitted to five Veterans Affairs (VA) hospitals between October 2004 and September 2006 with one of seven advanced diseases considered appropriate for palliative care.

### Results

- 18% of patients admitted with advanced disease were referred to palliative care by their attending physicians, while most patients (82%) received usual hospital care.
- Hospital total direct costs (including pharmacy, nursing, laboratory, and radiology costs) were \$464 per day lower for patients receiving palliative care compared to usual care.

- Palliative care patients were 43.7% less likely to be admitted to ICUs during hospitalization than were usual care patients.

*“We think it likely that palliative care consultation during an inpatient stay for advanced disease influences costs, in part, through the focus of palliative care providers on meeting with patients and/or families and the medical team to establish goals of care and treatments that are concordant with the goals, including lower intensity treatments,” the authors suggest.*

*Journal of Palliative Medicine, August 2010*

The authors caution that their results may not generalize to palliative care programs that are relatively new or less well organized than that of the VA health system, which — as the largest integrated health care system in the nation — has a well established palliative care program with relatively consistent operating parameters.

Nevertheless, they believe that their “findings provide support for expansion of hospital-based palliative care consultation teams.”

Source: “Hospital-Based Palliative Care Consultation: Effects on Hospital Cost,” *Journal of Palliative Medicine*; August 2010; 13(8):973-979. Penrod JD, Deb P, Dellenbaugh C, et al; Health Services REAP/GRECC, James J. Peters VA Medical Center, Bronx, New York; Department of Economics, Hunter College, New York City.

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### *The Benefits of Using Modern Palliative Care Teams*

The use by physicians of palliative care services delivered simultaneously with disease-focused treatment remains low, note the authors of an editorial accompanying the study. “This study is an example of research that shifts a long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying.

“The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this

suffering can be effectively addressed by modern palliative care teams.”

### *Palliative Care Supports Patients and Families by:*

- Assessing and treating symptoms
- Providing support for decision making and assistance in matching treatments to informed patient and family goals
- Offering practical aid for patients and their family caregivers
- Mobilizing community resources to ensure a safe living environment
- Ensuring collaborative and seamless models of care across care settings

“Perhaps unsurprisingly, reducing patients’ misery may help them live

longer,” comment the authors. “The fact that palliative care improved quality-of-life outcomes is consistent with the results of other studies of both nonhospice and hospice palliative care.”

*Source: “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer,” The New England Journal of Medicine; August 19, 2010; 363(8):733-742. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ; Massachusetts General Hospital, Boston; State University of New York, Buffalo; Adult Palliative Medicine, Department of Anesthesiology, Columbia University Medical Center, New York City; Yale University, New Haven, Connecticut. “Palliative Care — A Shifting Paradigm,” *ibid.*; pp. 781-782. Kelley AS and Meier DE; Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine, New York City.*

*As a physician, you know your patient best and when it is appropriate to recommend hospice as an option for care. When that time comes, Hope Hospice is here to support you, your patient and their family.*

### *The Hospice Talk: Steps for Physicians*

- Confirm the patient/family understanding of the underlying diagnosis and prognosis. “Tell me what you understand about your illness.” “What are you expecting?”
- Elicit goals. “What are you hoping for in the time you have left?”
- Summarize the patient’s goals, and introduce hospice. “For all my patients at this stage, I recommend hospice.”
- Explain why hospice care would be appropriate. “Hospice helps me take care of people like you and your family when the goals of the medical care are the things you just said you wanted. They take care of you at home; they are my eyes and ears.”
- Offer to contact the local hospice to arrange a meeting. “Let me ask the hospice program to call you. Someone can come out to your home to explain their services.”
- Confirm that you intend to remain involved. “You and I can discuss what they tell you. In my opinion, this is the best care I can give you at this time in your life.”

~ Adapted from Moore and von Gunten, *Chest*

### Hope Hospice Medical Directors



Peter P. Wong, M.D.  
Medical Director



Michael Abdel-Malek, M.D.  
Associate Medical Director