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Heart Disease Now Most Common Non-Cancer Hospice Admitting Diagnosis

Concern remains about overall short periods of hospice service

Non-cancer diagnoses accounted for nearly three-quarters of all hospice admissions in 2015, with cardiac and circulatory disorders being the most common. This is according to a newly revised overview report of hospice care delivery in the U.S. released by the National Hospice and Palliative Care Organization (NHPCO) in October 2017. The overview report found that periods of care still remain short, with more than 28% of patients receiving care for seven days or less.

“Individuals who access hospice care often do so too late to benefit fully, and additional strategies are needed to better address the high burden of distressing symptoms and disability at the end of life,” according to the findings of a recent study published in the *Journal of the American Geriatrics Society*, which the NHPCO cites in its report.

“The hospice interdisciplinary team is ideally suited to provide care and support to patients and family caregivers throughout the last months of life, not just the last days,” says Edo Banach, JD, NHPCO president and CEO. “We need to continue reaching out to patients, family caregivers, and other healthcare professionals to help them understand all the benefits that hospice care brings, particularly when provided in a timely fashion as part of a continuum of care.”

The report includes specific information on patient characteristics as well as level and location of care for the 1,381,182 Medicare beneficiaries (46% of all Medicare decedents) who were cared for by one of the nation’s 4199 hospices for one day or more before death in 2015.

- 28.2% of Medicare decedents were enrolled in hospice for ≤ 7 days.
- 41.0% received hospice care for ≤ 14 days.
- 74.9% received care for ≤ 90 days, while only 13.1% were enrolled for > 180 days.
- Most days of hospice care were provided in a private residence (56.0%) or nursing facility (41.3%).

Geographic variation in the proportion of Medicare decedents who died while under hospice care ranged from a high of 55% to 56% in Arizona, Florida, and Utah to a low of 23% to 25% in Alaska, Puerto Rico, and Wyoming.

PRINCIPAL ADMITTING DIAGNOSES

- Cancer: 27.7%
- Non-cancer: 72.3%
 - Cardiac and Circulatory: 19.3%
 - Dementia: 16.5%
 - Respiratory: 10.9%
 - Stroke: 8.8%

Entitled “Facts and Figures: Hospice Care in America,” the report uses new methodology to assess 2015 data derived primarily from the Centers for Medicare & Medicaid Services hospice claims data. A 2017 edition of the report is to be released in early 2018.

The full report is available at www.nhpc.org.

KEY FINDINGS

- Median length of hospice service was 23.0 days.

Trends Track Change in End-of-Life Care: Increasing Complexity of Care Needs, Unnecessary Aggressive Care, Short Hospice Enrollment

A review of data on epidemiology and care patterns at the end of life highlights recent trends in the way Americans are dying. Three key trends were identified: an increase in the diversity of primary diagnoses of decedents; an increase in the number of patients experiencing multimorbidity at the end of life; and changes in care, hospice utilization, and sites of death. These trends may warrant a re-evaluation of the way we approach end-of-life care, according to a report published in a special end-of-life care issue of *Health Affairs*.

“This changing epidemiology of those in the last phase of life puts new pressures on the Medicare hospice benefit to ensure the availability of high-quality end-of-life care,” write the authors. “In addition, health care policy makers must grapple with the fact that even with increasing use of hospice care, care intensity increases at the end of life.”

CHANGES IN CAUSE OF DEATH

The study describes a “dramatic shift in the primary causes of death” from 2000 to 2015, based on data from the Centers for Disease Control and Prevention. While heart disease remained consistent as the leading cause of death between 2000 and 2015, there was a change in the proportion of deaths from several of the national leading causes of death:

- Death from heart disease decreased by 10.8%.
- Death from stroke decreased by 16.3%.
- Cancer deaths increased by 7.7%.
- Alzheimer’s disease deaths increased by 123%.

The authors note that the massive increase in Alzheimer’s disease as a primary cause of death may be partly due to an increase in awareness of the disease, and thus to a higher incidence of its reportage. Even with the recent dramatic increases, the authors observe that Alzheimer’s disease and dementia are still considered to be

underreported on death certificates.

AN INCREASE IN MULTIMORBIDITY

Recent estimates indicate that multimorbidity (having more than one chronic condition) has been increasing among Americans. Self-reported data from the National Health Interview Survey show an increase in multimorbidity from the periods 1999-2000 to 2009-2010, with reports of multimorbidity increasing from 37% to 45% among Americans aged 65 years and older, and from 16% to 21% among those aged 45-64 years.

Multimorbidity, combined with functional limitations such as frailty and cognitive impairment, is now considered the key indicator of the complexity of a patient’s end-of-life care, note the authors, and is often a challenge for healthcare providers. Multimorbidity in dying patients can result in conflicting treatment recommendations, higher costs, a greater burden on family caregivers, and more aggressive care — such as hospital and ICU admittance and the use of feeding tubes — which can conflict with the patient’s and family’s goals of care.

The authors stress that it is crucial for healthcare providers to address and consider the treatment of a patient’s comorbid conditions. Care that focuses only on what is required for a patient’s primary diagnosis at the end of life “misses the mark on the necessary resources and expertise of healthcare providers and caregivers to care for them,” they write.

CHANGES IN END-OF-LIFE CARE PATTERNS

Research shows that most Americans prefer to die at home and to not receive intensive care at the end of life. Furthermore, “[t]ransitions to the hospital at the end of life can lead to non-beneficial interventions, medical errors, injuries, increasing disability, worsening function, and adverse reactions for patients,” the authors report.

The good news is that trends in sites of death show that more Americans are dying at home or in hospice, and fewer are dying in the hospital. Hospice use has risen from approximately 10% of decedents in the 1990s to approximately 50% in 2014.

FROM 1999 TO 2015:

- The proportion of decedents dying in a hospital decreased from more than 50% to 30%.
- The percentage who died at home rose from less than 25% to 30%.
- The proportion dying in an inpatient hospice facility rose from 0% to 8%.

HOSPICE AS AN ‘ADD-ON’

However, while more and more Americans are using hospice, the authors report an overall increase in aggressive care at the end of life. Of great concern is the recent trend in which hospice enrollment is used as an “add-on” within days of death, after the extensive use of other healthcare services delivering increasingly aggressive care.

This trend is starkly apparent at the regional level, with U.S. referral regions having the highest intensity of care at the end of life also exhibiting significantly higher rates of very short hospice enrollment compared with low-intensity end-of-life care regions, note the authors.

Hospice care used as an add-on is “essentially layering hospice services on top of very intensive medical services, instead of substituting for intensive medical treatment, as the creators of the hospice model envisioned,” comments *Health Affairs* editor-in-chief, Alan R. Weil, JD, MPP, in an editorial introducing the special issue of the journal.

The study authors observe that current hospice eligibility criteria — which often require patients to forego all curative treatment for their admitting diagnosis — as well as the increase in terminal illnesses

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Rehospitalization, Longer Stays Linked to Unmet Needs for Symptom Control in Patients with Advanced Cancer

Hospitalized patients with advanced cancer experience a heavy physical and psychological symptom burden, and many of their symptoms — which are potentially manageable — are also significantly associated with a longer hospital length of stay (LOS) and higher risk for unplanned readmission within 90 days of discharge, a team of Harvard researchers has found.

“Our work represents the largest study to date highlighting the immense symptom burden of hospitalized patients with advanced cancer,” write the authors of a report published in *Cancer*. “To our knowledge, this is the first study to demonstrate the relation between patients’ self-reported physical symptoms and healthcare utilization among hospitalized patients with advanced cancer.”

Currently, nearly one-half of cancer patients are hospitalized during the last month of life and nearly 10% experience a readmission during that period, despite the preference of most patients with advanced cancer to avoid hospitalization and remain at home, the authors note.

Investigators analyzed inpatient symptom-burden questionnaire responses of 1036 adult patients with advanced cancer not receiving curative treatment who had unplanned hospitalizations between 2014 and 2015. Physical and psychological symptoms of the patients (median age, 63.4 years; male, 50.6%; white, 92.4%) were assessed using the self-administered,

revised Edmonton Symptom Assessment System (ESAS-r) and the Patient Health Questionnaire 4 (PHQ-4), respectively.

OVERALL

- More than two-thirds of patients reported symptoms of moderate-to-severe fatigue (86.7%), poor well-being (74.2%), drowsiness (71.7%), pain (67.7%), and lack of appetite (67.3%).
- More than one-quarter had clinically significant symptoms of depression (28.8%) and anxiety (28.0%).
- The mean hospital LOS was 6.3 days.
- Hospital readmission rate within 90 days was 43.1%.
- 90-day mortality rate was 41.6%.
- Nearly two-thirds (65%) died or were readmitted within 90 days.

KEY FINDINGS

- **LOS:** Physical symptoms ($P < 0.001$), total symptom burden ($P < 0.001$), total psychological distress ($P = 0.040$), and symptoms of depression ($P = 0.017$) were significantly associated with longer LOS.
- **Readmission:** Physical symptoms ($P < 0.001$), total symptom burden ($P < 0.001$), and anxiety symptoms ($P = 0.045$) were significantly associated with a higher risk of 90-day readmission.
- **90-day death or readmission:** Physical symptoms, total symptom burden, total psychological distress, and depression

symptoms (all, $P = 0.001$) were all significantly associated with a higher likelihood of death or readmission within 90 days, as were symptoms of anxiety ($P = 0.012$).

“Most, if not all, of the symptoms identified are treatable with intensive supportive care measures, which can be feasibly implemented, especially during hospital admissions,” write the authors. “Interventions to identify and treat symptomatic patients hold great potential for improving patients’ experience with their illness, enhancing their quality of life, and reducing their healthcare utilization.”

Generalizability of their findings to other populations may be limited by the low rate of socioeconomic diversity in their study sample, note the authors. Nevertheless, “our investigation provides novel insights to help clinicians and policymakers critically assess the potential contribution of uncontrolled symptoms to excessive and costly cancer care.”

Source: “The Relationship between Physical and Psychological Symptoms and Health Care Utilization in Hospitalized Patients with Advanced Cancer,” Cancer; Epub ahead of print, October 23, 2017; DOI: 10.1002/cncr.30912. Nipp RD, El-Jawahri A, Temel JS, et al; Department of Medicine, Division of Hematology and Oncology; Department of Psychiatry; and Department of Medicine, Division of Palliative Care, Massachusetts General Hospital Cancer Center and Harvard Medical School, Boston; and Department of Psychiatry, Sylvester Comprehensive Cancer Center and University of Miami, Miami.

Trends of Change in End-of-Life Care (from Page 2)

with an unpredictable prognosis, contribute to the creation of “an artificial dichotomy between curative and palliative treatment that results in delays in hospice enrollment and reduces its potential benefit for patients and families.”

They suggest that “greater access to ‘upstream’ palliative care services has the potential to reverse the trend of increasingly intensive end-of-life care followed by late hospice use.” Such access could be achieved by more comprehensive reimbursement for and education and training of palliative care teams. In addition

to greater availability of palliative care, an increased awareness of patients’ complex end-of-life care needs, along with potential policy changes, may be necessary to meet the changing needs of terminally ill patients in the U.S.

*Source: “Epidemiology and Patterns of Care at the End of Life: Rising Complexity, Shifts in Care Patterns and Sites of Death,” Health Affairs; July 2017; 36(7):1175–1183. Aldridge MD, Bradley EH; Department of Geriatrics and Palliative Medicine, the Icahn School of Medicine at Mount Sinai, New York City; and Vassar College, Poughkeepsie, New York. “Advanced Illness and End-of-Life Care,” *ibid.*, p. 1167. Weil AR, Health Affairs editor-in-chief.*

Montgomery HOSPICE



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WHEN TO REFER TO HOSPICE

Call us if your patient exhibits the following indicators:

- Physical / functional decline
- Weight Loss >10% in last 6 months
- Multiple comorbidities

When life expectancy can be measured in weeks or months, hospice is usually the best option. For patients with **pulmonary disease (COPD)**, look for the following indicators:

- Dyspnea at rest
- Poor response to bronchodilators
- Recurrent pulmonary infections
- Right heart failure
- Unintentional weight loss
- Bed to chair existence

Call us any time, any day.

Geoffrey Coleman, MD
Medical Director
Montgomery Hospice



Advance Directive Completion Remains Unacceptably Low

Despite national efforts to improve the completion rates of advance directives (ADs), nearly two-thirds of American adults have not completed such a document, a statistic that has remained unchanged over recent years, according to a report published in *Health Affairs*.

“Most experts agree that some form of written directives is a key component of advance care planning, and yet rates of completion are low and do not appear to be increasing,” says senior author Katherine Courtright, MD, MS, an instructor of medicine at the University of Pennsylvania, Philadelphia, in the Division of Pulmonary, Allergy, and Critical Care.

“The treatments most Americans would choose near the end of their lives are often different from the treatments they receive,” notes Courtright, who is also a faculty member of the medical school’s Palliative and Advanced Illness Research Center (PAIR). “Unfortunately, this disconnect can lead to unnecessary and prolonged suffering.”

Investigators analyzed data on AD completion rates reported in 150 studies published from 2011 to 2016 and involving 795,909 U.S. adults, both healthy and with chronic illness.

KEY FINDINGS

- Only 36.7% of U.S. adults had completed an AD.
- Just 29.3% had completed a living will that

addressed specific end-of-life care wishes.

- 33.4% had designated a healthcare power of attorney.
- AD completion was only slightly higher among those with chronic illness than among healthy adults (38.2% vs 32.7%).

PAIR RECOMMENDATIONS FOR AD IMPROVEMENTS INCLUDE:

1. Better representation of issues discussed in advance care planning conversations incorporated into the format and content of ADs
2. Simplification of legal barriers to the execution of ADs
3. A focus on populations at high risk for poor end-of-life care by those working to increase the completion of ADs

“Advance directives remain the primary tool for people to communicate their end-of-life wishes and appoint surrogate decision makers, but improvements to the documents and completion process are clearly needed,” Courtright concludes.

Source: “Approximately One in Three U.S. Adults Completes Any Type of Advance Directive for End-of-Life Care,” *Health Affairs*; July 1, 2017; 36(7):1244–1251. Yadav KN, Gabler NB, Courtright KR, et al; Palliative and Advanced Illness Research Center; Center for Clinical Epidemiology and Biostatistics; Division of Pulmonary, Allergy, and Critical Care; and Fostering Improvement in End-of-Life Decision Science Program, all at the Perelman School of Medicine, University of Pennsylvania, Philadelphia.