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**For questions or referrals,
call Montgomery Hospice
Intake Department at
301-921-4400.**

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Discharging Patients to Home Hospice Reduces Risk of 30-Day Hospital Readmission

Seriously ill older adults discharged to home from the hospital with hospice or palliative care services have a much lower risk of rehospitalization within 30 days than do those discharged home with no such in-home multidisciplinary services, or those discharged to a nursing facility.

That is according to a report published in the *Journal of Palliative Medicine*.

“This study, one of the first to examine hospital readmissions among seriously ill patients, found receipt of palliative care to be positively associated with lower odds of readmission, and provides preliminary evidence for the need for improved longitudinal access to palliative care for some seriously ill patients following inpatient palliative care consult and hospital discharge,” write the authors.

Investigators conducted a retrospective cohort study of an ethnically diverse sample of 408 older, seriously ill hospitalized patients (mean age, 80.1 years) discharged from an urban, managed care medical center between 2007 and 2009. All patients had received an inpatient palliative care consultation. Overall findings:

- More than half of patients (58.8%) were discharged to hospice; 14.7% were discharged to home-based palliative care (a service provided by this study site); 14.2% to a nursing facility; and 8.6% to home with no care.
- 10% of all patients were readmitted to the hospital within 30 days.
- 25.7% of those discharged home with no in-home multidisciplinary care were readmitted within 30 days.

Significant predictors of rehospitalization include:

- Patients discharged home with no home hospice or palliative care were 3.73 times more likely to be readmitted within 30 days.
- Patients discharged to nursing facilities were 4.97 times more likely to be readmitted to the hospital.
- Although probability of death and lack of an advance directive were significant predictors of readmission in the first analysis, when discharge disposition (i.e., use of post-hospitalization health services) was factored in, these factors lost their significance.

“[E]pisodically oriented approaches to care don’t serve chronic illness well,” comment the authors. There is a potential mismatch between the hospital-oriented model of care and what seriously ill patients and their families need to ensure good provision of care in the home.

“Longitudinal palliative care models provide a natural platform to support patients and caregivers if disease progresses and they experience increased complications,” the authors point out. They recommend further research to test the effectiveness of such models of care for seriously ill patients following hospital discharge.

Source: “30-Day Readmissions Among Seriously Ill Older Adults,” Journal of Palliative Medicine; December 2012; 15(12):1356-1361. Enguidanos S, Vesper E, Lorenz K; University of Southern California, Leonard Davis School of Gerontology, Los Angeles.

Patients and Clinicians Consider Spiritual Care Important at the End of Life

Lack of training identified as main barrier to spiritual care provision

Spiritual care, defined as the recognition and support of the religious and spiritual dimensions of illness, is considered to be an important aspect of end-of-life care, but is provided by clinicians infrequently. Boston researchers have found that the major barrier to provision of spiritual care to terminally ill patients is not lack of perceived benefit or lack of time, but lack of training, according to a report published in the *Journal of Clinical Oncology*.

“Patients, nurses, and physicians view spiritual care as an important, appropriate, and beneficial component of end-of-life care,” write the authors. “Spiritual care infrequency may be primarily due to lack of training, suggesting that spiritual care training is critical to meeting national end-of-life care guidelines.”

SPIRITUAL SUPPORT IN END-OF-LIFE CARE IS ASSOCIATED WITH:

- Improved patient quality of life
- Satisfaction with care
- Increased use of hospice
- Decreased receipt of aggressive interventions

Ways That Clinicians Can Support Patients' Spiritual Health

Considered appropriate by 78% to 93% of study participants

1. Ask patients about their religious or spiritual backgrounds, to be aware of whether or not it is important to them.
2. Encourage patients in the spiritual activities or beliefs that they find helpful.
3. Ask questions inviting patients to talk about spiritual matters, if they wish to.
4. With patients who are religious or spiritual, ask if there are ways their faith affects how they make treatment decisions.
5. Ask patients who may want to talk about spiritual matters if they would like to speak with a chaplain.
6. If patients have religious or spiritual supports that are important to them, ask if they would like those supporters to be involved in their care in some way.
7. If a patient asks for prayer, pray with them.
8. If religious or spiritual oneself, offer prayer for the patient.

— Adapted from Balboni et al, *Journal of Clinical Oncology*

- Decreased medical costs

Investigators analyzed questionnaire responses of patients with advanced cancer (n = 69) receiving palliative radiation therapy at one of four Boston academic centers, as well as the facilities' oncologists (n = 204) and oncology nurses (n = 118). Survey questionnaires included a list of eight literature-based examples of the types of spiritual care clinicians can provide. [See sidebar, below.]

OVERALL:

- Most patients considered spiritual care to be at least a “slightly important” component of care provided by their physicians (86%) and nurses (87%). More than half of patients indicated it was “moderately” or “very” important that physicians (58%) and nurses (62%) consider their spiritual/religious needs.
- 80% of physicians and 87% of nurses thought that spiritual care should be provided at least occasionally.
- Physicians reported having provided spiritual care to 24% of recently seen patients; nurses, to 31% of patients they had recently seen.
- However, few patients reported having received any form of spiritual care from their oncology physicians (6%) or oncology nurses (13%).
- The eight examples of spiritual care were endorsed as being appropriate by 78% of patients, 87% of physicians, and 93% of nurses.
- No participants reported a negative outcome of a spiritual care encounter as part of the relationship between patient and practitioner.

KEY FINDINGS INCLUDE:

- Having prior training in spiritual care was the strongest predictor of spiritual care provision by physicians (OR, 7.22; 95% CI, 1.91 to 27.30) and nurses (odds ratio [OR], 11.20; 95% confidence interval [CI], 1.24 to 101).
- Only 14% of physicians and 12% of nurses reported having received training in spiritual care.
- Time, although frequently cited by clinicians (on average, 73%) as a barrier to providing spiritual care, was not a predictor of care provision in multivariate analysis. “[T]raining of medical practitioners in spiritual care provision is a primary means of better incorporating spiritual

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Hospitalization of Advanced Cancer Patients Must Not Be ‘Missed Opportunity’ for Addressing End-of-Life Needs

Most unplanned hospital admissions of patients with advanced cancer are due to uncontrolled pain and other symptoms, yet few of these patients are referred for consultation with a palliative care team, despite poor survival in this population, according to a report published in the *Journal of Oncology Practice*.

“On the basis of our data, an unscheduled hospitalization for a patient with advanced cancer strongly predicts a median survival of fewer than six months,” write the authors of the study report. “We believe that hospital admission represents an opportunity to commence and/or consolidate appropriate palliative care services and end-of-life care.”

Investigators analyzed data collected retrospectively on all patients with unplanned admissions to a Wisconsin inpatient oncology service in both 2000 (n = 151) and 2010 (n = 119). As part of a quality improvement project, the 2010 assessment included additional emphasis on the presence of palliative care consultation, hospice recommendation, and discharge disposition.

OVERALL FINDINGS

- Data in both surveys were similar in patient demographics, intervention, and outcomes.

- In both 2000 and 2010, gastrointestinal, lung, and breast cancers were the most common diagnoses.
- The majority of patients in both years were admitted for uncontrolled symptoms (70% in 2000; 66% in 2010).
- Median survival following discharge was 4.7 months in 2000 and 3.4 months in 2010.
- At one year, 73.5% (2000) and 74.8% (2010) of patients had died.
- Hospice was recommended during only 23% (2000) and 24% (2010) of admissions.

“Given the overall poor survival, any patient with metastatic cancer with an unscheduled hospitalization could be considered hospice eligible and appropriate for end-of-life planning, including discussion of advance directives,” write the authors. “Palliative care consultation would be a potential intervention to better address end-of-life care for these patients.”

FINDINGS FOR 2010

- Palliative care consultation was performed during only 6.8% of admissions in 2010.
- The four most common reasons for consultation were for procedural-based specialties. Despite the fact that the majority of patients (66%) were

admitted for uncontrolled symptoms, palliative care consultation was only the fifth most common consult.

- 70% of patients were discharged home without additional services.
- Only 18% of patients were enrolled in hospice following discharge.

Inpatient oncologists who reviewed the data indicated that they rarely initiated end-of-life conversations, being more comfortable if the decision to discuss and pursue hospice care were made between the patient and the primary outpatient oncologist, report the authors. “We believe that this represents a missed opportunity to provide supportive palliative care services and end-of-life care,” they state.

“Although we hope for a future where all patients, inpatient and outpatient, will be able to benefit from palliative care services, we believe that inpatient palliative care consultation is an important component of quality cancer care,” the authors conclude.

Source: “Inpatient Hospitalization of Oncology Patients: Are We Missing an Opportunity for End-of-Life Care?” *Journal of Oncology Practice*; January 2013; 9(1):51-54. Rocque GB, Barnett AE, Illig LC, Eickhoff JC, Bailey HH, Campbell TC, Stewart JA, Cleary JF; University of Wisconsin, Madison; Park Nicollet Methodist Hospital, St. Louis Park, Minnesota; Bay State Medical Center and Tufts University School of Medicine, Springfield, Massachusetts.

Spiritual Care Important at the End of Life (from Page 2)

care into end-of-life care in keeping with national palliative care guidelines,” comment the authors.

TRAINING IN SPIRITUAL CARE PREPARES CLINICIANS IN:

- Taking a spiritual history
- Prioritizing referral to chaplaincy or clergy
- Navigating spiritual and religious be-

liefs that intersect with medical decision making

“This is the first study to compare the attitudes and practices of spiritual care of patients with advanced cancer, nurses, and physicians within the same institutions,” note the authors.

“Our study suggests that spiritual training is necessary to advance the inclusion of spiritual care into the care

of patients with serious illness and to improve end-of-life outcomes.”

Source: “Why Is Spiritual Care Infrequent at the End of Life? Spiritual Care Perceptions among Patients, Nurses, and Physicians and the Role of Training,” *Journal of Clinical Oncology*; Epub ahead of print, December 17, 2012; DOI: 10.1200/JCO.2012.44.6443. Balboni MJ, Sullivan A, Amobi A, Phelps AC, Gorman DP, et al; Harvard Medical School; Dana-Farber Cancer Institute; Brigham and Women’s Hospital; Harvard School of Public Health; and Massachusetts General Hospital, all in Boston.



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



COPD Patients: Clinicians Offered Literature-Based Approach to Discussing End-of Life Care

Until fairly recently, the care of patients living with COPD has focused on active disease management, and palliative/end-of-life care needs have not been addressed. In 2008, the American Thoracic Society issued a policy statement declaring that palliative care should be available to patients throughout their illness. However, clinical challenges to implementing such care persist.

Conducting what they call “the first systematic literature review of the attitudes of patients with COPD and those of their health care professionals,” U.K. researchers synthesized findings from 30 papers published in peer-reviewed journals from 1987 to 2011. Their summary and recommendations have been published in *Thorax*, the official journal of the British Thoracic Society.

Studies report that patient preferences for information about their illness vary greatly, ranging from those who want to know everything, so they can plan ahead, to those (about half) who want no new information. “[P]atients’ understanding of COPD as a life-limiting illness is poor; when stating preferences for further information they may be unaware of the implications of such discussions,” write the authors.

Uncertainty of prognosis is a major barrier to initiating end-of-life care discussions with COPD patients, in whom death can often occur “before the patient is perceived

as being terminal.” The authors suggest that discussions useful to the patient might include explanations of functional decline common in COPD, the possibility of fatal exacerbations, and the potential for cardiovascular and other causes of death—including sudden death.

An approach to end-of-life conversations in patients with COPD includes:

- Respect the patient’s autonomy. Allow the patient to decide whether to have the conversation, as well as when, and with whom.
- Ensure that the conversation is patient-centered. Let the patient set the content, timing, and pace.
- Provide multiple opportunities for the patient to explore issues as desired.
- Maintain balance. Combine realistic hope with practical planning.
- Provide honest information, and acknowledge uncertainty.
- Enable documentation, so that other health care professionals have access to the patient’s care preferences.

Source: “Discussing an Uncertain Future: End-of-Life Care Conversations in Chronic Obstructive Pulmonary Disease. A Systematic Literature Review and Narrative Synthesis,” *Thorax*; September 2012; 67(9):777-780. Momen N, Hadfield P, et al; NIHR CLAHRC for Cambridge and Peterborough, Institute of Public Health, University of Cambridge, Cambridge, United Kingdom.