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Spiritual Support from Medical Teams May Result in Less Aggressive End-of-Life Care

Terminally ill patients who report being well supported by religious communities access hospice care less and aggressive interventions more near the end of life. However, when these patients also receive spiritual support and end-of-life care communication from their medical teams, they are more likely to choose comfort measures as death approaches, according to a report published in *JAMA Internal Medicine*.

“Provision of spiritual support by the medical team and end-of-life discussions were associated with reduced aggressiveness of end-of-life care,” write the authors. “The findings suggest that by addressing end-of-life decisions in a manner that embraces patients’ spiritual values and goals, the medical team is assisting patients in avoiding aggressive interventions at the end of life.”

Investigators analyzed patient and caregiver interview responses and medical records for 343 patients with advanced cancer (mean age, 58.3 years) from seven outpatient sites. Recruited between 2002 and 2008 for the Coping with Cancer Study, patients were followed until death (a median of 116 days after baseline interview). Aggressive end-of-life care was defined as receipt of intensive care unit (ICU) care, ventilation, or resuscitation in the last week of life.

STUDY RESULTS

“In all cases, the associations between spiritual support from religious communities and end-of-life outcomes were significantly different from, and in the opposite direction of, spiritual support from medical teams,” observe the authors. This finding highlights “spiritual care as a key component of end-of-life medical care guidelines.”

Patients reporting high spiritual support from religious communities were:

- Less likely to receive hospice care (adjusted odds ratio [AOR], 0.37; 95% confidence interval [CI], 0.20-0.70 [$P = .002$])

- More likely to receive aggressive end-of-life measures (AOR, 2.62; 95% CI, 1.14-6.06 [$P = .02$])

- More likely to die in an ICU (AOR, 5.22; 95% CI, 1.71-15.60 [$P = .004$])

Those who also received spiritual support from the medical team had:

- Higher rates of hospice use (AOR, 2.37; 95% CI, 1.03-5.44 [$P = .04$])

- Fewer aggressive interventions (AOR, 0.23; 95% CI, 0.06-0.79 [$P = .02$])

- Fewer ICU deaths (AOR, 0.19; 95% CI, 0.05-0.80 [$P = .02$])

Medical teams’ understanding of the realities of the illness progression may help inform and support patients’ care choices near death, suggest the authors. “Medical teams providing spiritual support may be better at addressing spiritual needs that become increasingly central to patient quality of life as terminal illness progresses, such as finding acceptance and spiritual peace in dying.”

Source: “Provision of Spiritual Support to Patients with Advanced Cancer by Religious Communities and Associations with Medical Care at the End of Life,” *JAMA Internal Medicine*; June 24, 2013; 173(12):1109-1117. Balboni TA, et al; Center for Psychosocial Epidemiology and Outcomes Research, McGraw/Patterson Center for Population Sciences, and Departments of Radiation Oncology, and Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston; Departments of Radiation Oncology, Psychiatry, and Medicine, Harvard Medical School, Boston.

Strategies Suggested for Reducing Racial Disparities in End-of-Life Care

Barriers to the access and use of quality end-of-life care by African Americans have been well documented, yet few effective interventions aimed at reducing racial differences in care have been developed. Two articles published in the *American Journal of Hospice & Palliative Medicine* offer suggestions for improvement. The first examines provider viewpoints; the second reports encouraging results of a hospital-based palliative care intervention.

PROVIDER PERSPECTIVES

Investigators analyzed interview responses from a multidisciplinary sampling of 10 health care providers from diverse institutions and regions in the U.S., as well as two representatives from a national health care organization. All participants had experience in hospice and palliative medicine. The percentage of African Americans cared for in the participants' programs varied from 5% to 50%.

Participants were asked to identify observed barriers to quality care for their black patients and to suggest possible intervention strategies for increasing awareness of end-of-life care options (such as completion of advance directives, palliative care, and hospice) among this population and other underrepresented minorities.

BARRIERS TO QUALITY CARE

- **Lack of knowledge about prognosis:** Patients and families were often unaware of the illness severity and thus unprepared for the suggestion of comfort-only care.
- **Desire for aggressive treatment and mistrust of the medical system:** Changing goals of care and changing code status seemed to be particularly hard for black patients. Providers noted that patients seemed to fear that such a decision would deprive them of medical care offered to other patients.
- **Family resistance to accepting hospice:** Participants observed that patients who felt ready for comfort care were often reluctant to go against their families' urging to continue seeking a cure.

- **Lack of knowledge and misperceptions about hospice and palliative care:** Choosing hospice was often perceived as "giving up," rather than as what one provider called a different "mechanism of care."

SUGGESTIONS FOR IMPROVEMENT

- Augment cultural sensitivity through provider education and training.
- Increase staff diversity.
- Improve communication.

"Most providers believed that communication about the end of life was a gradual process that often required ongoing conversation," observed the authors. Because of the importance of spirituality to many African-American patients, some providers felt it was also important to address the issue of faith. Those uncomfortable discussing spirituality preferred referrals to chaplaincy support.

Participants agreed that the black patients they served would be receptive to culturally sensitive education programs. However, none of their institutions had programs in place to increase the awareness of end-of-life care options among African Americans and other minorities.

"We realize that barriers may continue to exist; however, efforts should continue to be made to improve the process of shared decision making," state the authors. "Health care providers must meet patients and families where they are and assist them with the often difficult transitions associated with the end of life."

PALLIATIVE CONSULTATION

Researchers analyzed data from the medical records and daily interaction logs for 2843 adult patients (white, 50.4%) who received a counselor-based palliative care consultation as requested by their attending physicians at a large southeastern U.S. hospital from 2008 to 2010.

The facility's palliative care service focuses on the family system, with master's-prepared counselors conducting numerous conversations with the patient and family,

in collaborations with interdisciplinary support teams. Prior to consultation:

- 72.8% of patients were full code; 22.6% had chosen DNR; 4.6% had chosen "care and comfort only" (CCO).
- Compared with white patients, black patients were more likely to choose full code (78.8% vs 67.3%) and less likely to choose DNR (17.7% vs 27.7%) or CCO (3.5% vs 5.0%).

Following consultation:

- Overall, only 17.6% retained full code status; DNR choice nearly doubled to 39.1%; patients choosing CCO increased nine-fold, from 4.6% to 43.3%.
- The percentage of patients choosing full code decreased drastically among both groups (black, from 78.8% to 22.2%; white, from 67.3% to 12.2%).
- CCO rose from 3.5% to 34.7% among black patients and from 5.0% to 49.2% among white patients.
- 53.3% died while hospitalized. Of survivors, 37.1% were discharged to hospice (black, 34.3%; white, 38.8%).

"Our results show much higher acceptance of comfort-based care among the black population after a comprehensive palliative consultation than those published in many other studies," note the authors. "This suggests that hospital palliative care not only impacts the choice of interventions at the end of life, but it may also act as a bridge across cultural and racial disparities."

Source: "Barriers to End-of-Life Care for African Americans from the Providers' Perspective: Opportunity for Intervention Development," American Journal of Hospice & Palliative Medicine; Epub ahead of print, October 4, 2013; DOI: 10.1177/1049909113507127. Rhodes RL, et al; Division of General Internal Medicine; Department of Clinical Sciences; and Geriatrics Section; University of Texas Southwestern Medical Center at Dallas. "The Influence of Race on End-of-Life Choices Following a Counselor-Based Palliative Consultation," ibid.; Epub ahead of print, October 1, 2013; DOI: 10.1177/104990911356782. Benton K, et al; St. Joseph's/Candler Hospital System, Savannah; Jiann-Ping Hsu College of Public Health, Georgia Southern University, Valdosta; Department of Family Medicine, Mercer University School of Medicine, Macon.

Care Delivered to Advanced Dementia Nursing Home Patients Varies by Medicare Plan Type

Nursing home residents with end-stage dementia have reduced frequency of hospitalization near the end of life, more access to primary care — particularly from nurse practitioners — and trend toward more hospice referrals when their health insurance is covered by a Medicare-managed care plan rather than by the traditional fee-for-service (FFS) method, according to a report published in *JAMA Internal Medicine*.

“Nursing home residents with advanced dementia commonly experience burdensome and costly hospitalizations that may not extend survival or improve the quality of life,” write the authors. “This study provides novel data suggesting that the model of health care delivery in nursing homes has important effects on the type of care received by individual residents.”

Investigators analyzed data from CASCADE (Choices, Attitudes, and Strategies for Care of Advanced Dementia at the End of Life), a prospective cohort study funded by the National Institutes of Health. The data set was linked to Medicare claims from 2003 to 2010 for residents (n = 291) of 22 Boston-area nursing homes.

Managed care residents with advanced dementia:

- Were more likely to have do-not-resuscitate (DNR) orders compared with those in traditional FFS plans (63.7% vs 59.9%; adjusted odds ratio [AOR], 1.9; 95% confidence interval [CI], 1.1 to 3.4)
- Were less likely to be transferred to the hospital for acute illness (3.8% vs 15.7%; AOR, 0.2; 95% CI, 0.1 to 0.5)
- Had more primary care visits per 90 days (mean, 4.8 vs 4.2 days; AOR, 1.3; 95% CI, 1.1 to 1.6)
- Had three times the number of nurse practitioner visits per 90 days (3.0 vs 0.8; AOR, 3.0; 95% CI, 2.2 to 4.1)

There was a trend toward a higher percentage of hospice referrals among managed care patients (23.3% vs 18.4%) and higher rates of family satisfaction with care. “For all other outcomes, including survival, residents with managed care fared as well as those with traditional Medicare,” report the authors.

“More than 90% of proxies for nursing home residents with advanced dementia state that their preferred goal of care is comfort, which should guide how complications [of end-stage dementia] are treated,” comment the authors. “Hospital transfers can be traumatic for these residents and their families and most often do not improve their clinical outcomes or comfort...”

Yet under the current reimbursement system, explain the authors, nursing homes have an incentive to transfer acutely ill patients or those requiring palliative care to hospitals, since the Medicaid care plan does not provide extra reimbursement for such care. But by transferring patients to acute care sites, the cost of care can be shifted temporarily to the Medicare FFS plan.

“The challenge is to understand the mechanisms that will encourage nursing homes to provide goal-directed care for acutely ill residents on site,” observe the authors. A focus on both “intensive primary care services” and “Medicare managed care programs may offer a promising approach to ensure that nursing homes are able to provide appropriate, less burdensome, and affordable care, especially at the end of life.”

CHANGES NEEDED IN CARE DELIVERY

“Present Medicaid reimbursement creates perverse incentives against the delivery of appropriate comfort and palliative care, such as hospice services,” states geriatrician William J. Hall, MD, in his commentary accompanying the report.

The decision to hospitalize patients with advanced dementia is ideally made with regard for best practices and family consideration, recognizing that advanced dementia is “a major primary cause of death, irrespective of the presence or absence of confounding chronic disease,” writes Hall. Despite the growing recognition of the terminal nature of this disease, there is wide variation in care strategies, especially concerning the decision to hospitalize nursing home patients.

“Often the decision to admit leads to a cascade of burdensome interventions, such as tube feeding and intravenous antibiotics, unlikely to benefit the patient,” writes Hall.

“Pain and comfort care are less commonly prioritized, and both the patient and family members suffer.” Hall offers suggestions for improving the quality of end-of-life care among this population.

SUGGESTED APPROACHES TO CHANGE

- Foster wider acceptance of advanced dementia as a terminal illness in itself, regardless of comorbidity. “More attention needs to be paid to realization that we subject these terminally ill patients to hospitalizations and procedures that would be unthinkable for those with other end-stage conditions such as malignancy, chronic obstructive pulmonary disease, or heart failure.”
- Ensure that families and caregivers are better informed of the gravity of end-stage dementia, and of the adverse effects of subjecting their loved ones to a burdensome hospitalization when comfort care is called for.
- Seize the opportunity provided by the current atmosphere of health care reform to improve the quality of palliative care delivered in nursing homes. Perhaps an example to follow would be that of managed care programs. “Such reforms are not a strategy of rationing hospital care, but rather are means to provide comfort and dignity to our patients.”
- Increase the intensity of primary care. Physicians are the ones who authorize the hospitalization of nursing home residents, notes Hall. “We, more than any other members of the health care team, have the authority and responsibility to advocate for the appropriate level of care for our patients during the terminal phase of advanced dementia.”

Source: “Health Insurance Status and the Care of Nursing Home Residents with Advanced Dementia,” *JAMA Internal Medicine*; Epub ahead of print, September 23, 2013; DOI: 10.1001/jamainternmed.2013.10573. Goldfeld KS, et al; Department of Population Health, New York University School of Medicine, New York; Department of Health Care Policy, Harvard Medical School, Boston. “The Right Care in the Right Place,” *ibid.*, DOI: 10.2001/jamainternmed.2013.8592. Hall WJ; Division of Geriatrics, University of Rochester School of Medicine and Dentistry, Highland Hospital, Rochester, New York.



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



It's Time to Revive the Medical Culture of Care and Caring, Expert Urges

Providing care for patients and caring about patients imply the two major aspects of medicine as practiced since antiquity, yet contemporary health care continues to struggle with how to combine them, according to an article published in the *Journal of Pain and Symptom Management*.

These two aspects “should go hand in hand,” writes Harvey Max Chochinov, MD, PhD, professor of psychiatry, University of Manitoba, Winnipeg. “How ironic that caring struggles to maintain a foothold in the caring professions.”

Patient “care” refers to evidence-based practices, while “caring” denotes providers’ fundamental attitude toward the patient and the ability to convey kindness, compassion, and respect.

Health care systems have been driven by necessity to become more complex, but have also become more impersonal and technology focused, notes Chochinov. “Although they have immense capacity to process patients, and procedures to administer care, caring, it would appear, has not been as well thought out.”

CARE WITHOUT CARING CAN AFFECT:

- **Patient satisfaction:** Patients and families are less satisfied with medical encounters.
- **Patient safety issues:** “Patients who do not feel the appropriate care tenor are less likely to say what is really bothering them, leading to missed diagnoses and more medical errors.”

- **Professional burnout:** Medical practitioners may view illness progression and death as personal failures and immerse themselves in the technical aspects of their work, developing a protective emotional armor, which can lead to burnout.
- **Liability consequences:** Studies consistently show that “most complaints levied against health care professionals derive, not from medical misadventure, but from a failure to communicate and the absence of caring.”

SUGGESTED ACTIONS

- Health care systems can set expectations and initiate compliance strategies to improve care tenor, empathy, and effective communication.
- Medical professionals can assess their own attitudes toward patients, as well as their own fears and vulnerabilities.
- Above all, health care providers need resources to help them reconnect with the idea that patients are not the embodiment of their ailments. “[F]irst and foremost, patients are people with feelings that matter,” says Chochinov.

Source: “Dignity in Care: Time to Take Action,” *Journal of Pain and Symptom Management*; *Epub ahead of print*, October 5, 2013; DOI: 10.1016/j.jpainsymman.2013.08.004. Chochinov HM; Department of Psychiatry, University of Manitoba, Winnipeg, Canada.