

HOSPICE MATTERS for physicians



301-921-4400

www.montgomeryhospice.org

MEDICAL DIRECTOR

Geoffrey Coleman, MD

ASSOCIATE MEDICAL DIRECTOR

DIRECTOR

Grace Brooke Huffman, MD

TEAM PHYSICIANS

Grace Brooke Huffman, MD

Steven Wilks, MD

CASEY HOUSE PHYSICIANS

Grace Brooke Huffman, MD

Bindu Joseph, MD

Steven Wilks, MD

MONTGOMERY KIDS PHYSICIANS

Shahid Aziz, MD

Caren Glassman, MD

NURSE PRACTITIONERS

Nicole Christenson, CRNP

Jennifer Jordan, CRNP

Kikikipa Kretzer, PhD, CRNP

Debrah Miller, CRNP

Anna Moretti, CRNP

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

Contents

Page 1: Burden of Activity-Restricting Symptoms Decreases Markedly Following Hospice Admission

Page 2: Physicians Receive Less Intensive End-of-Life Care than the General Population

Dying at Home May Improve Survival in Patients Receiving Palliative/Hospice Care

Page 3: Emergency Use and Admissions Drop Following Hospice Enrollment, But Hospice Stays Are Short

Page 4: Physicians Favor Medicare Reimbursement for ACP Discussions

Volume 8, Issue 3

Burden of Activity-Restricting Symptoms Decreases Markedly Following Hospice Admission

Symptoms leading to restrictions in daily activities are common among older persons at the end of life, increasing slowly during the final year, and then rising sharply about two months prior to hospice enrollment. However, a team of Yale researchers has found that there is a marked drop in both the prevalence and number of these symptoms following the start of hospice, regardless of diagnosis.

"These results, coupled with the short duration of hospice, suggest that earlier referral to hospice may help to alleviate the burden of distressing symptoms at the end of life," write the authors of a report published in the *American Journal of Medicine*, the official journal of the Alliance for Academic Internal Medicine.

Investigators analyzed data on 241 participants in an ongoing cohort study who had entered hospice from 1998 to 2013. Symptom burden was determined from monthly telephone interviews conducted with the subjects during the year prior to hospice admission and for up to three months following admission. The ongoing Precipitating Events Project (PEP) study, conducted out of the Yale School of Medicine over a 16-year period, is a unique longitudinal cohort study that has followed 754 community-dwelling adults who were aged ≥ 70 years with no disabilities at the time of enrollment.

OVERALL FINDINGS

- The median length of hospice stay was 15 days (range, 5–51 days).
- The most common diagnoses at hospice admission were cancer (31.1%), neurodegenerative disorders (22.8%), cardiovascular disease (21.6%), and organ failure (14.9%).

KEY FINDINGS

- The prevalence of any restricting symptoms dropped markedly from 69% to 48% following hospice admission, and then plateaued at 46%.
- Similarly, the mean number of restricting symptoms fell from 3.5 to 2.1 after the start of hospice, leveling out at 2.0.
- These results were the most striking for symptoms of fatigue, depression, anxiety, arm/leg weakness, and swelling in feet/ankles.
- Symptom trends before and after hospice did not differ by diagnosis or sex.

"For several of these symptoms, the prevalence after admission to hospice dropped to levels comparable to those observed 12 months before the start of hospice," note the authors.

"Both the prevalence and number of restricting symptoms decreased as the number of days increased between the time of hospice admission and the time of the first post-hospice interview."

Source: "Restricting Symptoms before and after Admission to Hospice," *American Journal of Medicine; Epub ahead of print, March 8, 2016;* DOI: 10.1016/j.amjmed.2016.02.017. Cheraghlo S, Gahbauer EA, Leo-Summers L, Stabenau HF, Chaudhry SI, Gill TM; Yale School of Medicine, Department of Medicine, New Haven, Connecticut.

Physicians Receive Less Intensive End-of-Life Care than the General Population

According to a research letter published in a special theme issue on death and dying in the *Journal of the American Medical Association*, physicians—who are more likely to have first-hand experience with the “burdens and futility” of aggressive care at the end of life—are less likely than the general public to die in a hospital, and less likely to have surgery or be admitted to an intensive care unit (ICU) in the last six months of life.

“Patients often ask their doctors what they would do or what they would choose for their own family members,” says co-author Zara Cooper, MD, MSc, a trauma surgeon and faculty member at the Center for Surgery and Public Health (CSPH) at Brigham and Women’s Hospital in Boston. “This research could have a significant impact on clinical practice, especially in the way that healthcare professionals communicate with patients and family members about end-of-life care options.”

Investigators examined Medicare claims linked to death records of more than 670,000 beneficiaries aged 66 years or older who died between 2004 and 2011 in the four U.S. states for which all data were available (Massachusetts, Michigan, Utah, and Vermont).

Measures of end-of-life care intensity during the last six months of life were compared between physicians and the general population (excluding other healthcare professionals and lawyers) and between physicians and lawyers (presumed to be similar to physicians in socioeconomic and educational status).

COMPARED WITH THE GENERAL POPULATION, PHYSICIANS WERE:

- Less likely to die in a hospital (27.9% vs 32.0%; $P = .001$)
- Less likely to have surgery in the last six months of life (25.1% vs 27.4%; $P = .01$)

- Less likely to be admitted to an ICU in the final six months of life (25.8% vs 27.6%; $P = .04$)

“Although not large, the differences suggest less aggressive care for physicians,” write the authors. A possible reason for this lower use of intensive end-of-life care could be physicians’ “knowledge of its burdens and futility,” they suggest, as well as their having more likelihood than the general public of having sufficient economic resources to afford full-time caregivers and skilled nursing services.

Compared with lawyers, physicians were less likely to die in the hospital (27.9% vs 32.7%), but did not differ from lawyers in other areas of end-of-life care intensity. This lower rate of hospital deaths among physicians when compared with a similar socioeconomic group suggests that while having greater economic resources may promote avoidance of aggressive care, “actual experience with hospital deaths may differentially motivate physicians to avoid them,” the authors note.

“This information is extremely relevant to what is happening in the health field, especially now that Medicare has agreed to compensate doctors for the time they spend counseling patients about end-of-life care decisions,” says lead author Joel S. Weissman, PhD, chief scientific officer and professor of health policy at Harvard Medical School and CSPH deputy director.

Source: “End-of-Life Care Intensity for Physicians, Lawyers, and the General Population,” *Journal of the American Medical Association*; January 19, 2016; 315(3):303–305. Weissman JS, Cooper Z, et al; Center for Surgery and Public Health, Brigham and Women’s Hospital, Boston; Department of Anesthesiology, Mayo Clinic, Rochester, Minnesota; and Center for Research on End-of-Life Care, Weill Cornell Medicine, New York City. “Association of Occupation as a Physician with Likelihood of Dying in a Hospital,” *ibid.*, pp. 301–303. Blecker S, Johnson NJ, et al; Department of Population Health, New York University School of Medicine, New York City; National Longitudinal Mortality Study Branch, U.S. Census Bureau, Suitland, Maryland; and Division of Cancer Control and Population Sciences, National Cancer Institute, Rockville, Maryland.

Dying at Home May Improve Survival in Patients Receiving Palliative/Hospice Care

Terminally ill patients with cancer who died at home while receiving palliative/hospice care survived four days to a week longer than did those who died in a hospital with palliative care, a research team in Japan has found.

“To the best of our knowledge, this is the first large-scale, prospective, multicenter study to explore the potential association between the place of death and the survival

time,” write the authors of a study published in *Cancer*, a journal of the American Cancer Society.

Investigators analyzed data from 58 specialist palliative care services across Japan from September 2012 through April 2014 on patients with locally advanced or metastatic cancer ($n = 2069$; mean age, 69.4 years) receiving hospital-based or home-based palliative care. The most

common reasons for patient referral were symptom control and care during dying. Subjects were grouped by predicted survival: days’ prognosis (survival time, 0–13 days), weeks’ prognosis (14–55 days), and months’ prognosis (> 55 days).

FINDINGS

- Survival time in those who died at home

Continued on page 3

Emergency Use and Admissions Drop Following Hospice Enrollment, But Hospice Stays Are Short

Most poor-prognosis cancer patients (81.3%) visit the emergency department (ED) during the last six months of life. But once enrolled in hospice, these patients have significantly fewer ED visits and hospital admissions in the final week of life than do those without hospice care, researchers from Harvard and Brigham and Women's Hospital in Boston have found.

"Given studies suggesting that most people prefer to stay out of the ED and hospitals in the days before death, the reduction in ED use and admissions indicates that hospice is an important correlate of quality of care at the end of life," write the authors of a report published in the *Journal of the American Geriatrics Society*. However, "nearly one-third of hospice enrollees enrolled in hospice as inpatients after an ED admission..., and this phenomenon was linked to shorter hospice stays."

Investigators analyzed patterns of ED use and inpatient admission rates before and after hospice enrollment among a nationally representative sample of 272,832 Medicare cancer patients with poor prognosis (defined as having a high risk of death within six months, and thus being eligible for hospice enrollment) who died in 2011. Hospice patients were matched to nonhospice individuals (controls) by region, age, sex, and time from diagnosis

of poor-prognosis cancer to death. Baseline was determined as one year prior to the first week of hospice care, or the equivalent period for nonhospice controls.

KEY FINDINGS

- At baseline, there were no significant differences in the number of ED visits between the two groups.
- However, in the final week of life, nonhospice controls were nearly 10 times as likely as hospice enrollees to visit the ED (69.9 vs 7.6 ED visits per 1000 beneficiary-days; rate ratio [RR], 9.7; 95% confidence interval [CI], 9.3 to 10.0).
- Nonhospice controls also visited the ED 10 times as often in the week before death as they had at baseline (69.6 vs 5.4), while the rate of ED visits for those two measures varied very little among hospice enrollees.
- There was no difference found between groups in rates of inpatient admissions from the ED at baseline or in the week before hospice enrollment (or in the equivalent time period for nonhospice controls).
- However, during the final week of life, nonhospice controls were 51% more likely than hospice patients to be admitted to the hospital from the ED (RR, 1.51; 95% CI, 1.45 to 1.57).

HOSPICE USE

- 28% of all hospice patients in the sample enrolled during inpatient stays originating from ED visits. These inpatient-enrolled hospice patients accounted for nearly one-third (35.7%) of all hospice stays < 1 month, but for only 13.9% of stays > 1 month.
- The median length of stay for hospice enrollees was 14 days, with less than 3.7% of stays exceeding six months.

"[B]eneficiaries who enrolled in hospice after being admitted through the ED were more likely to have short hospice stays than those who did not enroll as inpatients," write the authors. "These results reinforce the need to increase discussion of hospice and palliative care at multiple points in the care of individuals with advanced illnesses — including the ED and inpatient hospitalizations, but especially the routine outpatient setting."

Source: "Emergency Care Use and the Medicare Hospice Benefit for Individuals with Cancer with a Poor Prognosis," *Journal of the American Geriatrics Society*; February 2016; 64(2):323–329. Obermeyer Z, Clarke AC, Makar M, Schuur JD, Cutler DM; Department of Emergency Medicine, School of Medicine, Harvard University; Department of Emergency Medicine, Brigham and Women's Hospital; Ariadne Labs; Department of Economics, Harvard University, all in Boston; and National Bureau of Economic Research, Cambridge, Massachusetts.

Dying at Home (from page 2)

was significantly longer than in those who died in hospital, both in the days' prognosis group (13 days vs 9 days) and the weeks' prognosis group (36 days vs 29 days). There was no significant survival difference found in the months' prognosis group.

- Place of death had a significant influence on survival time in both unadjusted (hazard ratio [HR], 0.86; 95% CI, 0.78 to 0.96; $P < .01$) and adjusted models (HR,

0.87; 95% CI, 0.77 to 0.97; $P = .01$).

- Use of parenteral hydration in the 48–72 hours before death was significantly lower among those who died at home compared with those who died in the hospital (24.5% vs 67.9%), as was the administration of antibiotics during the three-week period following enrollment (13.9% vs 19.9%).

"Patients, families, and clinicians should be reassured that good home hospice care

does not shorten patient life, and even may achieve longer survival," says lead author Jun Hamano, MD, of the University of Tsukuba, Japan.

Source: "Multicenter Cohort Study on the Survival Time of Cancer Patients Dying at Home or in a Hospital: Does Place Matter?" *Cancer*; Epub ahead of print, March 28, 2016; DOI: 10.1002/cncr.29844. Hamano J, Yamaguchi T, Maeda I, Suga A, Hisanaga T, Ishihara T, Iwashita T, Morita T, et al; Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba, Tsukuba, Japan.



Nonprofit. Medicare & Joint Commission Accredited.

1355 Piccard Drive, Suite 100
Rockville, MD 20850

Non-profit
Organization
U.S. Postage
PAID
Bethesda, MD
Permit #2483

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 dementia, look for the following indicators:

- FAST Score stage 7
- Urinary and fecal incontinence (intermittent or constant)
- No consistently meaningful verbal communication
- Requires assistance with ADLs
- History of aspiration pneumonia or UTI, sepsis or decubiti within the past 12 months

Call us any time, any day.

Geoffrey Coleman, MD
Medical Director
Montgomery Hospice



Physicians Favor Medicare Reimbursement for ACP Discussions

Nearly 99% of physicians caring for Medicare beneficiaries consider advance care planning (ACP) conversations important, and support the new Medicare reimbursement benefit for these discussions, yet many cite lack of training and structural support as key barriers. More than two-thirds of physicians say they lack formal training in how to conduct such talks, a national poll has found.

“Respondents who have had formal training on talking with patients about end-of-life care are more likely to be having these conversations and say talking to patients about these issues is more rewarding than it is challenging,” states the report on the survey, which was conducted in early 2016 among 736 U.S. physicians (primary care physicians, oncologists, pulmonologists, and cardiologists) in all 50 states.

The Centers for Medicare and Medicaid Services recently began reimbursing physicians for holding ACP discussions as a separate service under the physician fee schedule. The benefit covers multiple conversations and is not limited to patients nearing death.

“Too many people at the end of life receive care that is completely at odds with their personal wishes,” says Terry Fulmer, PhD, RN, president of The John A. Hartford Foundation, one of the three health organizations that commissioned the survey.

“The new benefit, with its strong support from clinicians, is a promising first step in ensuring that more people remain in control of their healthcare experience to the very last day of their lives.”

KEY SURVEY FINDINGS

- 95% of physicians were in favor of the new Medicare benefit, although only 14% have so far billed Medicare for holding an ACP conversation.
- 46% report feeling unsure about what to say; only 29% report having had any formal training in end-of-life discussions.
- 75% believe they are responsible for initiating ACP discussions.
- Only 29% are part of a healthcare system or practice with a formal structure for assessing patients’ end-of-life care wishes and goals of care.
- Physicians’ primary motivations for ACP talks were to honor the patient’s values and wishes (92%) and to reduce unnecessary/unwanted hospitalizations at the end of life (87%).

The survey report, entitled “Conversation Stopper: What’s Preventing Physicians from Talking with Patients about End-of-Life and Advance Care Planning?” is available at www.jhartfound.org/advance-care-planning-poll.