

HOSPICE MATTERS for physicians

Montgomery HOSPICE

301-921-4400
www.montgomeryhospice.org

Volume 9, Issue 3

MEDICAL DIRECTOR
Geoffrey Coleman, MD

TEAM PHYSICIANS
Mark Goldman, MD
Steven Wilks, MD

CASEY HOUSE PHYSICIANS
Bindu Joseph, MD
Steven Wilks, MD

**MONTGOMERY KIDS
PHYSICIANS**
Shahid Aziz, MD
Caren Glassman, MD

NURSE PRACTITIONERS
Nicole Christenson, CRNP
Jennifer Jordan, CRNP
Kikikpa Kretzer, PhD, CRNP
Debrah Miller, CRNP
Anna Moretti, CRNP
Marisa Tamari, CRNP
Sylvie Tchuindjo, CRNP

**For questions or referrals,
call Montgomery Hospice
Intake Department at
301-637-1888.**

Contents

Page 1: Transitions in Care
Settings Common, Often
Multiple, Near the End of Life

Page 2: Emergency Medicine
Physicians Offered Quick
Tools for Assessing Patients'
Palliative and Hospice Care
Needs

Page 3: Automatic Palliative
Care Consultation Yields
Substantial Improvements in
Quality End-of-Life Care for
Advanced Cancer Patients

Page 4: Many Late Hospice
Referrals, Wide Variation Found
among Practices of Oncology
Divisions and Physicians

Transitions in Care Settings Common, Often Multiple, Near the End of Life

Discharge from hospital to hospice considered 'marker of good care'

More than 80% of Medicare beneficiaries have at least one healthcare transition in the last six months of life, with nearly 40% experiencing four or more transitions, which become more intensive as death approaches, according to a report published in the *Journal of the American Geriatrics Society*.

"The most frequent transition pattern (19.3% of all decedents) was home to hospital, back to home or skilled nursing facility, to hospital again, and then to settings other than hospital, ending with four or more transitions," write the authors.

Transitions from hospital to hospice "are markers of good care," whereas transitions back and forth to hospital may indicate poorly coordinated, fragmented care, which can be burdensome to patients and families and may not match their preferences, the authors note.

Investigators analyzed Medicare claims data for beneficiaries aged ≥ 66 years who died in 2011 ($n = 660,132$). Overall, 67.6% of subjects died in a home setting (which included nursing homes), either with or without hospice care.

KEY FINDINGS

- 80.5% of decedents had at least one transition in care in the last six months of life.
- 39.6% had four or more care transitions in the last six months.
- The average number of transitions was 2.9 (± 2.8).
- Of the 87.3% of decedents living at home six months before death, 68.1% were hospitalized as their first transition, with just 12.1% enrolled in home hospice as a first transition.

The authors also found that women, non-whites, those younger than 85 years, and those without dementia were more likely than others to have four or more transitions ($P = 0.05$). In addition, individuals with kidney, heart, or lung disease were at higher risk for multiple transitions, suggesting that health systems may need to address the vulnerability of these patients to poor care coordination.

VARIATION ACROSS STATES

Transition patterns exhibited wide geographic variation, from a low of 1.8 transitions in Alaska and 2.0 in Utah to 3.1 in New Jersey. The percentage of those with home deaths varied considerably, from 79.6% in Utah to 58.4% in New York. Median time spent at home from the final transition to death also varied greatly, from 70 days in Utah to five days in New York.

Source: "End-of-Life Care Transition Patterns of Medicare Beneficiaries," *Journal of the American Geriatrics Society*; Epub ahead of print, April 3, 2017; DOI: 10.1111/jgs.14891. Wang SY, Aldridge MD, Gross CP, Canavan M, Cherlin E, Bradley E; Departments of Chronic Disease Epidemiology and Health Policy and Management, School of Public Health; Cancer Outcomes, Public Policy, and Effectiveness Research Center, Yale Cancer Center and School of Medicine; and Section of General Internal Medicine, Department of Internal Medicine, School of Medicine, Yale University, New Haven, Connecticut; Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, New York City.

Emergency Medicine Physicians Offered Quick Tools for Assessing Patients' Palliative and Hospice Care Needs

Physicians in emergency departments (EDs) are uniquely placed to introduce and refer patients to hospice and palliative care, as they frequently encounter patients with serious illness who are in decline, and they can often focus with fresh eyes on what may be overlooked in routine office visits, according to an article published in *Annals of Emergency Medicine*, the official publication of the American College of Emergency Physicians (ACEP).

“EDs are an opportune entry point into the palliative care continuum,” writes David H. Wang, MD, an emergency medicine and palliative care physician practicing in the San Francisco area. “Palliative care is a win-win for patients and for health care systems. Rather than being ‘another thing for emergency physicians to do,’ intervening early for these patients has a palpable effect on lives.”

Research has shown that early palliative care can reduce ED visits and hospitalizations by as much as 50% across settings and disease populations, says Wang. Palliative care — of which hospice and comfort care are subcomponents — is delivered by an interdisciplinary team to provide

relief to patients and their families from the symptoms and stress of incurable illnesses throughout the entire disease course.

“Palliative care teams preemptively address advanced care planning, caregiver needs (e.g., housing, resources), streamlined communication between disparate provider teams, psychosocial support, and introduce hospice at the earliest opportunity to benefit,” writes Wang.

Although the percentage of U.S. hospitals with palliative care programs has been increasing in recent years, the number of specialists in palliative medicine is not sufficient to meet the needs of patients, notes Wang. Thus, “most patients’ palliative needs can and must be addressed by medicine’s frontline providers. Emergency physicians must now develop ‘primary palliative care’ expertise unique to their practice climate.”

TIPS AND TOOLS FOR ED PHYSICIANS

Prognosis. “Although comprehensive screening tools are being developed and validated, perhaps the single easiest and most predictive tool remains the question, ‘Would I be surprised if this patient dies in the next 12 months?’” writes Wang.

This tool has potential to be actionable in a time-limited setting, he notes.

Goals-of-care discussion. Keeping in mind the time constraints and competing distractions of a busy ED, Wang provides a simple, five-minute framework for holding a goals-of-care discussion. [See sidebar.] This “crucial discussion” is as much about acquiring a sense of the patient’s/family’s emotional drivers as it is about information exchange, notes Wang, explaining that “families are better equipped to collaborate around ‘goals’ rather than specific interventions.”

Intentionally supportive phrasing. By being aware of the importance of word choice, minor rephrasing, and word substitution, physicians can help families understand options and make choices, Wang points out. “Given the significant information asymmetry between providers and patients, word choice is critical when options are being presented.”

SUGGESTED REPLACEMENTS FOR COMMONLY USED PHRASES

- Instead of “Do you want us to do everything possible?” physicians can ask, “*What is most important to your loved one right now?*”
- Instead of “Would [loved one’s name] want heroic measures?” physicians can ask, “*What was [name] like before the illness?*”
- Instead of “Do you want us to push on [loved one’s] chest, use electricity, and provide [name] with a breathing machine?” physicians can ask, “*Based on what you’ve told me about [name], do you think he/she would want to die a natural death?*”
- Instead of “I wouldn’t want this for my mother,” physicians can say, “*Tell me about your mother.*”
- Instead of “There is nothing more we can do,” physicians can say, “*We will aggressively make [loved one’s name] comfortable.*”

Step-Wise Approach to a Five-Minute Goals-of-Care Discussion in the Emergency Department

Minutes one to two:

- Elicit patient understanding of underlying illness and today’s acute change.
- If available, build on previous advance directives or documented conversations.
- Acquire a sense of the patient’s values and character, to help frame prognosis and priorities for intervention.
- Name and validate observed goals, hopes, fears, and expectations.

Minutes three to four:

- Discuss treatment options, using reflected language.
- Continually re-center on patient’s (not family’s) wishes and values.
- Recommend a course of action, avoiding impartiality when prognosis is dire.

Minute five:

- Summarize and discuss next steps.
- Introduce ancillary ED resources (e.g., hospice, observation, social work, chaplain).

— Adapted from Wang, *Annals of Emergency Medicine*

Continued on Page 3

Automatic Palliative Care Consultation Yields Substantial Improvements in Quality End-of-Life Care for Advanced Cancer Patients

The use of triggers for palliative care (PC) consultation among inpatients in an oncology solid tumor service resulted in significant post-discharge improvements in 30-day readmissions, hospice referral, chemotherapy receipt, and the use of support services, according to a report published in the *Journal of Oncology Practice*.

“Our results highlight the need to adopt this practice at acute care hospitals across the nation,” says senior author Cardinale B. Smith, MD, MSCR, of the Icahn School of Medicine at Mount Sinai, New York City.

“Palliative care involvement helps patients understand their prognosis, establish goals of care, and formulate discharge plans in line with those goals, and this study is the first to confirm the impact of using standardized criteria and automatic palliative care consultation on quality of cancer care.”

Healthcare use among those with advanced cancer is extremely high, note the authors, and the care received is often not beneficial, failing to improve either quality or quantity of life. In 2009, 80% of Medicare beneficiaries with cancer were

hospitalized within 90 days of death, and 20% transitioned to hospice only in the last three days of life. “As cancer progresses, this medically fragile population is often at high risk for physical pain, emotional distress, and financial hardship,” they write.

Investigators compared post-discharge outcomes for patients in the pre-intervention control group (n = 48) vs the PC intervention group (n = 65) who were cared for in late 2012 by the inpatient oncology service at Mount Sinai in New York, a city the authors note has one of the highest in-hospital cancer mortality rates in the U.S.

Patients were eligible for the intervention if they had any of the following: advanced cancer (stage IV solid tumor or stage III lung or pancreatic cancer); prior hospitalization within the past 30 days; hospitalization of > 7 days; or any active symptoms (such as pain, nausea/vomiting, dyspnea, delirium, and psychological distress).

KEY FINDINGS, INTERVENTION VS CONTROL SUBJECTS

- PC consultations doubled, rising from 39% to 80% ($P \leq 0.001$).

- 30-day readmissions declined from 35% to 18% ($P = 0.04$).
- Hospice referrals increased from 14% to 26% ($P = 0.03$).
- Chemotherapy receipt post-discharge decreased from 44% to 18% ($P = 0.03$).

Discharge to home with support services was more likely overall among those receiving the PC intervention. Home-based services included visiting nurse or home attendant (32% PC intervention vs 19% control) or home hospice (25% vs 8%). Patients in the intervention group were also more likely to be enrolled in inpatient hospice (11% vs 6%) and less likely to be discharged to subacute rehabilitation facilities (3% vs 13%).

Just last year, note the authors, the Centers for Medicare & Medicaid Services launched its Oncology Care Model, a value-based payment program that rewards practices that can demonstrate improved quality of care in the following areas:

- Reducing hospitalizations
- Enhancing prognostic communication
- Facilitating earlier referral to hospice

“[H]ospitalization for symptoms and disease progression in patients with advanced cancer heralds the end of life,” point out the authors. “This intervention was highly successful at improving multiple quality measures in hospitalized patients. However, if PC is to have the greatest impact on overall care received, it needs to begin earlier in the disease trajectory, while patients are still in the ambulatory setting.”

Source: “Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream HealthCare Use,” *Journal of Oncology Practice*; Epub ahead of print, March 17, 2017; DOI: 10.1200/JOP.2016.016808. Adelson K, Paris J, Horton JR, Hernandez-Tellez L, Ricks D, Morrison RS, Smith C; Yale University School of Medicine, New Haven, Connecticut; New York University, and Icahn School of Medicine at Mount Sinai, both in New York City; and Brigham and Women’s Hospital, Boston.

Emergency Medicine (from Page 2)

In 2014, the ACEP developed and released a two-page Palliative Care Toolkit (available at www.acep.org/palliativesection). Components of the toolkit include a table on palliating refractory symptoms in the ED (reproduced in Wang’s article), a sample template for providing palliative care information to patients, and a pathway to disposition of patients to palliative care consultation or early hospice referral.

DISPOSITION OPTIONS INCLUDE:

- Early outpatient palliative care referral
- Inpatient palliative care consult
- Direct ED-to-hospice discharge
- Inpatient hospice bed, if available, for patients whose symptoms may not be

adequately controlled at home

- Short-stay private room for imminently dying, comfort-care patients

“Palliative care begins in the ED and bridges into inpatient and outpatient services,” concludes Wang. “Current momentum hinges on greater education and research. Historically, emergency physicians have prided themselves on being first-movers. Now is the time to own the change.”

Source: “Beyond Code Status: Palliative Care Begins in the Emergency Department,” *Annals of Emergency Medicine*; April 2017; 69(4):437–443. Wang DH; Department of Emergency Medicine, Stanford University, Stanford, California; and Division of Palliative Medicine, University of California-San Francisco, San Francisco.

Montgomery HOSPICE



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



Many Late Hospice Referrals, Wide Variation Found among Practices of Oncology Divisions and Physicians

Although late referral to hospice has been identified as a marker for poor-quality care at the end of life, nearly one-third of patients with end-stage cancer had a hospice length of service (LOS) of one week or less. Further, hospice referral practices varied widely, both among different oncology departments and among individual physicians, according to a report published in the *Journal of Oncology Practice*, a journal of the American Society of Clinical Oncology (ASCO).

“These data call for a need to review hospice referral practices and inconsistencies, as well as a need to further inform patients and physicians alike,” write the authors. “ASCO recommends a hospice information visit during the six months before death, as triggered by a change in treatment regimen or performance status.”

Investigators conducted a retrospective chart review of patients with advanced cancer (n = 452) referred to hospice from an urban comprehensive cancer center from 2013 to 2015, analyzing patient LOS and percentage of short LOS (≤ 7 days) among eight divisions of oncology subspecialties and by individual physician.

Overall, median LOS was 14.5 days, with 32.5% of patients referred to hospice ≤ 7 days before death, including 5.1% who died before reaching hospice services.

INTERDIVISIONAL VARIATION

- The divisions of head and neck malignancies and neuro-oncology had the longest LOS (median, 37 days and 33.5 days, respectively).
- Shortest LOS was found in hematology (median, 7 days) and melanoma and sarcoma (median, 8 days).
- Neuro-oncology had the lowest percentage of LOS ≤ 7 days (12.5%), while hematology had the highest (54.1%).

PHYSICIAN VARIATION

- Median hospice LOS by referring physician ranged from 0 to 157.5 days (from 4 to 88 days for physicians with five or more patients).
- LOS varied among physicians within the same division (e.g., thoracic malignancies, which ranged from 4 to 33 days), despite the similarities in the patient population.
- The percentage of LOS ≤ 7 days ranged by physician from 0% to 100%, regardless of number of patients cared for.

Source: “Variations among Physicians in Hospice Referrals of Patients with Advanced Cancer,” *Journal of Oncology Practice*; Epub ahead of print, February 21, 2017; DOI: 10.1200/JOP.2016.018093. Wang X et al; The Johns Hopkins University School of Medicine and Johns Hopkins Sidney Kimmel Comprehensive Cancer Center, Baltimore.