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## Hospice Care Report: Median and Average Lengths of Service Continue to Drop

At 1.58 million, the number of patients accessing hospice services remained relatively stable in 2010, rising slightly from the 1.56 million served in 2009. However, the continuing trend towards shorter lengths of stay presents a cause for concern, according to the National Hospice and Palliative Care Organization (NHPCO), which released its most current annual report in January 2012.

“What’s important to recognize here is that half of hospice patients received care for less than 20 days,” said J. Donald Schumacher, PsyD, NHPCO president and CEO. “With drops in both the median and average length of service, there is concern that hospice providers are not reaching the patients and family caregivers who need hospice support in a timely manner.”

### KEY FINDINGS INCLUDE:

- Median length of hospice service declined to 19.7 days in 2010 from 21.1 days in 2009.
- Average length of stay dropped to 67.4 days from 69.0 days.
- The proportion of patients remaining in hospice for longer than 180 days was the same for both years, at 11.8%.
- 62.3% of hospice patients received care for fewer than 30 days.
- 35.3% died within 7 days of admission.

“It’s very difficult for patients and families to take full advantage of the range of services hospice offers when they are under care for only a few days,” Schumacher pointed out. “We must be careful about focusing too intently on long-stay patients while turning a blind eye to the large number of patients dying in less than a week.”

### HEART DISEASE PATIENTS ENTERING HOSPICE IN INCREASING NUMBERS

Although when it began in the U.S. in the 1970s, hospice care was viewed as a service primarily for patients with terminal cancer, less than 25% of U.S. deaths are currently caused by this disease, and cancer diagnoses now account for just 35.6% of hospice admissions, notes the report. The leading non-cancer admission diagnosis in 2010 was heart disease, at 14.3% of admissions (up from 11.5% in 2009).

New additions to this year’s report, entitled “Facts and Figures: Hospice Care in America,” include appendices with data sources and methodologies, and sections addressing hospice care in the nursing home and within the Medicare population.

“While Medicare’s coverage of hospice has risen in the past decade, this represents appropriate care of dying Americans,” noted Schumacher. “We don’t want appropriate access of hospice care to drop — particularly with our aging population, where more people are dying with complex, multiple illnesses. There are no better providers more skilled at providing palliative care at the end of life than hospice professionals, and the dying deserve the best care that our society can offer.”

**For more information visit  
[www.nhpc.org](http://www.nhpc.org).**

# Oncologists Offered Approach to Integrating ACP Discussions into Routine Care, Based on Advice from Clinical Experts

Initiating candid discussions about advance care planning (ACP) and the range of palliative options available to patients with advanced cancer can be daunting, but by incorporating strategies used by experts into routine practice, clinicians can make these encounters “as painless as possible,” according to an article published in the *Journal of Oncology Practice*, a peer-reviewed journal of the American Society of Clinical Oncology (ASCO).

“Conversations about end-of-life care are tough — for the provider, the patient, and the family,” says lead author Dean H. Gesme, MD, a practicing oncologist with Minnesota Oncology, Minneapolis. “But research shows, and patients agree, that advance care planning can improve quality and length of life.”

Despite evidence of the benefits of ACP and the urging of professional guidelines, fewer than half of patients with advanced cancer have ACP discussions with their oncology team, notes Gesme. Further, data collected by ASCO in 2011 revealed that more than half of cancer patients were enrolled in hospice for less than one week.

## CHALLENGES FOR PHYSICIANS CAN INCLUDE:

- The feeling that having to discuss non-curative options denotes therapeutic failure
- Fear of taking away hope or adversely affecting outcomes
- The belief that patients just do not want to talk about ACP
- A lack of training in holding advance care planning discussions
- Reimbursement policies that favor intervention over conversation

To help clinicians address such hurdles, Gesme offers strategies and resources gathered from “those who do it routinely,” that is, experts in hospice and palliative medicine. **“Physicians certified in hospice and palliative medicine have training in eight domains, including psychological, social, spiritual, and cultural aspects of clinical palliative**

**care,”** explains Gesme. He draws upon the wisdom of several such experts to outline guidance for ACP discussions.

## ‘START EARLY, FOCUS ON GOALS, HAVE ONGOING DISCUSSIONS’

Experts advise introducing the topic of ACP early in the treatment process, notes Gesme. Although in-depth discussion of options such as hospice can wait until later in the disease progression, it is important to identify the patient’s surrogate decision maker and to elicit the patient’s goals for both the present and the future as soon as possible.

As care continues, the appropriateness of anticancer therapy in the context of the patient’s goals and disease status should be regularly revisited. “In the absence of these conversations, the ‘default care plan’ is often further, and potentially futile, systemic therapy,” warns Gesme.

It is important in all discussions to “empower the patient,” emphasizing that the patient’s goals and desires are predominant. **“Communicate to the patient and family that the advance care planning process is intended to give patients control of what happens; it is not ceding the management of their care to others,”** advises Gesme.

Patients should be encouraged to ask questions, and to seek further information from such online resources as ASCO’s cancer.net. [See *Suggested Resources, right.*]

## IMPLEMENT A SYSTEMATIC, CONSISTENT APPROACH

Clinicians are encouraged to develop a systematic approach to goal and end-of-life care discussions that works for them, and then to use it consistently. Beginning with diagnosis, certain markers — such as relapse or hospitalization — could be used to prompt revisiting and revising the patient’s care plan and goals of treatment.

The multidisciplinary team approach is considered the best model for end-of-life care planning. Although more challenging to implement in smaller community practices, it is nonetheless possible to use the patient’s physician, nurse prac-

## Tips for Facilitating ACP Discussions

- Incorporate resources and strategies from practicing experts
- Develop and implement a disciplined, systematic approach
- Direct patients and families to specific online resources

— Gesme and Wiseman,  
*Journal of Oncology Practice*

itioner, nurse, and office administrator as a team to explain options, provide supportive material, help complete an advance directive, and coordinate referrals to hospice or specialized palliative care. “Establish procedures with hospice resources in your community, and if possible use a palliative care physician for patient consultation in your office,” suggests Gesme.

He concludes, “These conversations will never be easy, but every patient deserves an individualized assessment of needs, goals, and preferences throughout the continuum of care.”

## SUGGESTED RESOURCES:

- **For patients and families:** “Advanced Care Planning,” a free, 24-page booklet from ASCO, which explains advance directives and care options, including palliative and hospice care. Download the booklet at [www.cancer.net/patient/Coping/Advanced+Cancer+Care+Planning](http://www.cancer.net/patient/Coping/Advanced+Cancer+Care+Planning).
- **For physicians:** Respecting Choices, an evidence-based program designed to help busy clinicians integrate ACP as an ongoing process into their practice routine. Available at [www.respectingchoices.com](http://www.respectingchoices.com)

Source: “Advance Care Planning with Your Patients,” *Journal of Oncology Practice*; Epub DOI: 10.1200/jop.2011.000442; November 2011; 7(6):e42-e44. Gesme DH, Wiseman M; *Minnesota Oncology, Minneapolis; Wiseman Communications, Washington, DC.*

## Improved Access to Hospice for Patients with Advanced Dementia Identified as Top Priority

Advanced dementia is a leading cause of death in the U.S., yet has remained largely underrecognized as a terminal illness. Thus, although research has contributed much to our understanding of the disease, initiatives aimed at improving the experience of demented patients have lagged behind those designed for persons dying of more recognized diseases.

That is according to an article published in *Annals of Internal Medicine*, in which a national team of investigators reviews the current understanding of advanced dementia, and identifies the most pressing areas for future research needed to develop interventions and strategies for improving care.

Although most proxies for patients with advanced dementia identify comfort as the primary goal of care, the patients often receive treatments inconsistent with this goal in the last months or even weeks of life — such as hospital transfers, feeding tube placement, and antimicrobial use for infections.

### **MODIFIABLE FACTORS ASSOCIATED WITH IMPROVED CARE INCLUDE:**

- Completion of an advance directive
- Effective counseling of health care proxies
- Residence in a special-care dementia unit
- On-site presence of nurse practitioners in a nursing home
- Utilization of hospice services

Hospice care is of proven benefit for these patients. “Patients dying with dementia who received hospice care have better symptom management, fewer terminal hospitalizations, and greater family satisfaction with care than those not receiving hospice care,” report the authors. But hospice services are underutilized, often because of prognostication difficulties.

“The difficulty of estimating six-month survival in advanced dementia suggests that access to palliative care for these patients should be guided not by their

prognosis, but rather by their preference to focus care on maximizing comfort and quality of life,” state the authors.

Health policy research could focus on ways to expand access to the Medicare hospice benefit as well as to broad-based palliative care programs, the authors suggest. “For example, prior work clearly shows that the six-month hospice eligibility guidelines are problematic,” they write. “Thus, research that explores novel approaches to enroll dementia patients into hospice is warranted.”

*Source: “Advanced Dementia: State of the Art and Priorities for the Next Decade,” Annals of Internal Medicine; January 3, 2012; 156(1):45-51. Mitchell SL, et al; Hebrew SeniorLife, Institute for Aging Research, Boston; Johns Hopkins University School of Medicine and Berman Institute of Bioethics, Baltimore; School of Nursing, University of Pennsylvania, Philadelphia; Center for Aging and Health, University of North Carolina, Chapel Hill; and Brown University Program in Public Health and Alpert Medical School at Brown University, Providence, Rhode Island.*

## Surgical Intervention Common among Medicare Patients in the Final Year of Life

Nearly one-third of elderly Americans undergo inpatient surgery in the last year of life, with most of these procedures occurring within a month before death, a team of Boston researchers has found. In addition, substantial variation was identified in the intensity of end-of-life (EOL) surgery across local regions.

“For clinicians, these data should prompt careful consideration of a patient’s goals when assessing the need for surgical intervention at the end of life,” write the authors of a report published in *The Lancet*. “Furthermore, such wide regional variation in surgical intensity suggests room for change in policies and guidelines regarding the care offered at the end of life.”

The team conducted a retrospective cohort study of 1.8 million fee-for-service

Medicare beneficiaries who died in 2008. While the likelihood of undergoing surgery was highest for those aged 65 years (38.4%), and declined slightly for those aged 80 years (35.3%), the rates dropped by one-third (23.6%) for beneficiaries aged 81 to 90 years.

### **KEY FINDINGS:**

- 31.9% of Medicare decedents underwent inpatient surgery in the last year of life, compared with 13.9% of the 35.2 million survivors during the same year.
- 25.1% of decedents had surgery in the last three months of life.
- 18.3% had surgery in their last month of life.
- 8.0% had a surgical procedure during the last week of life.

Substantial regional variations were found, with the rate of EOL surgical intensity measuring three times higher in the highest intensity region (Munster, IN) compared with the lowest (Honolulu, HI). Hospital referral regions with high surgical intensity had a 40% higher number of hospital beds per capita, and significantly higher overall Medicare spending compared with low-intensity areas.

*Source: “The Intensity and Variation of Surgical Care at the End of Life: A Retrospective Cohort Study,” The Lancet; October 15, 2011; 378(9800):1408-1413. Kwok AC, Semel ME, Lipsitz SR, Bader AM, Barnato AE, Gawande AA, and Jha AK; Department of Health Policy and Management, Harvard School of Public Health, Boston; Center for Surgery and Public Health and Division of General Medicine, Brigham and Women’s Hospital, Boston; VA Boston Healthcare System, Boston; and Division of General Medicine, University of Pittsburgh Medical Center, Pittsburgh.*



## 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 **heart disease** or **CHF**, look for the following indicators:

- NYHA Class IV; discomfort with physical activity
- Symptomatic despite maximal medical management with diuretics and vasodilators
- Arrhythmias resistant to treatment
- Ejection fraction < 20%

Call us any time, any day.

**Geoffrey Coleman, MD,**  
Medical Director,  
Montgomery Hospice



## Heart Failure Patients and Their Families Desire Earlier Palliative Care Centered on Both Patients and Caregivers

Patients with chronic heart failure (HF) and their family caregivers want their clinicians to provide more symptom control and psychosocial support earlier in the disease, and to include caregivers sooner in the planning and coordination of collaborative care, according to a report published in the *Journal of Palliative Medicine*.

“Overall, patients with HF and their family caregivers desired early help adjusting to the limitations and future course of illness, relief of a diverse number of symptoms, and the involvement of family caregivers using a team approach,” write the authors.

**“A diverse group of participants desired these elements of palliative care early in illness — prior to Stage D HF or at the end of life — concurrent with their disease-specific care.”**

The team analyzed the responses of 33 adult outpatients with symptomatic HF (median age, 64 years; women, 30.3%) and 20 of their family caregivers from one-on-one, in-depth interviews conducted from 2007 through 2008. Rather than using such terms as “palliative care,” or “advance care planning,” interviewers asked participants what was most difficult or important to them, and about their thoughts and concerns regarding the future.

### **IMPORTANT CARE NEEDS INCLUDED:**

- Early support in adjusting to the limitations and the future course of the illness
- Alleviation of a number of symptoms, but especially of fatigue and shortness of breath
- Providers who were familiar with the patient’s heart condition, and with the patient as a person
- Involvement of family caregivers, using a team approach

Caregivers in particular wanted providers to acknowledge their involvement in patients’ care, and to work with them towards better communication, coordination, and continuity of care.

“Palliative care needs in chronic HF are evident from the substantial physical and psychosocial burdens that patients and families experience with this highly morbid and life-limiting illness,” the authors point out.

*Source: “Giving Voice to Patients’ and Family Caregivers’ Needs in Chronic HF: Implications for Palliative Care Programs,” Journal of Palliative Medicine, December 2011; 14(12):1317-1324. Bekelman DB, et al; Research and Genetics Sections, Department of Veterans Affairs Medical Center, Denver; Division of General Internal Medicine and Division of Cardiology, Department of Medicine, University of Colorado School of Medicine, Aurora; Colorado Cardiovascular Outcomes Research, Denver.*