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Quality Measures for Palliative and End-of-Life Care Endorsed

To help advance the quality of care delivered to seriously ill patients and to those nearing the end of life, the National Quality Forum (NQF) has announced its endorsement of 14 quality measures addressing areas of concern in palliative and end-of-life care. The measures are designed to be applicable across a range of providers and clinical settings, including acute care facilities, intensive care units, and hospices.

“As the number of older adults in this country continues to grow, palliative and end-of-life care services are needed more than ever,” says NQF president and CEO Janet Corrigan, PhD, MBA. “This set of measures will help promote the type of high-quality care older people and acutely ill patients deserve.”

THE PERFORMANCE MEASURES ADDRESS CARE CONCERNS SUCH AS:

- Assessment and management of pain and other symptoms
- Patient- and family-centered care, with a focus on psychosocial needs and care transitions
- Patient, caregiver, and family experiences of care

Although the number of palliative and end-of-life care programs has increased rapidly in recent years, notes the NQF, their services remain underutilized. It is estimated, for example, that more than one million people in the United States die annually of chronic and debilitating illnesses without receiving the benefits hospice services could have provided them.

“Despite the evidence for and support around palliative and end-of-life care, these services are still underused,” states the NQF. “Studies have found that palliative care programs across

the trajectory of a patient’s illness, including end-of-life care, can result in improved quality of care.”

BENEFITS OF PALLIATIVE AND HOSPICE CARE INCLUDE:

- Higher patient satisfaction
- Improved communication
- Fewer emergency department visits
- Fewer admissions to acute care hospitals and intensive care units
- More referrals to hospice
- Reduced costs

“Measuring palliative and end-of-life care quality is relatively new territory,” notes the report, and “it is critical that providers have the right measurement tools to help ensure patients receive safe, high-quality, and compassionate care.”

The current project was undertaken by NQF at the request of the U.S. Department of Health and Human Services. A panel of health care stakeholders, which included providers, measurement experts, and consumer representatives, evaluated 22 measures against the NQF endorsement criteria, then selected 14 as suitable for accountability and quality improvement.

**For more information, visit:
www.qualityforum.org.**

COPD Patients Who Have End-of-Life Discussions More Likely to Give High Ratings for Quality of Care

But only 15% of patients report having such discussions, study finds

Patients with chronic obstructive pulmonary disease (COPD) who report having discussed end-of-life care planning with their clinicians have higher perceived quality of medical care and higher satisfaction with their physicians than do those reporting no such discussions, according to a study published in *Chest*, the official journal of the American College of Chest Physicians.

“These results suggest that clinicians should not be reticent to have end-of-life discussions,” write the authors. “The idea that patients with COPD may in fact desire end-of-life discussions is not new; however, the relationship between having had end-of-life care discussions and overall perception of quality and satisfaction with care is novel.”

Researchers analyzed questionnaire responses of 376 predominantly older white men with COPD treated at the Veterans Affairs health care system in Seattle and Tacoma, WA. Respondents had been enrolled between 2004 and 2007 in a randomized trial designed to improve end-of-life care communication.

KEY FINDINGS:

- 67.7% of patients with COPD indicated a desire for end-of-life planning discussions.
- Only 14.6% reported having had such discussions with their clinicians.
- Patients who had end-of-life discussions were more than twice as likely to rate their care as the “best imaginable” (adjusted odds ratio [AOR], 2.07; 95% confidence interval [CI], 1.05 to 4.09).
- Those reporting end-of-life discussions were nearly twice as likely to be “very satisfied” with their medical care (AOR, 1.98; 95% CI, 1.10 to 3.55).
- Patients who discussed end-of-life care were more likely to believe that their provider knew the treatments they wanted (AOR, 7.69; 95% CI, 2.83 to 20.94) and to report that their physician had provided an excellent or very good explanation of their breathing problems (AOR, 4.48; 95% CI, 1.85 to 10.81).
- Discussions were more likely to have occurred among patients with worse overall health status, as indicated by higher scores on the St. George’s Respiratory Questionnaire, than among those with more advanced COPD.
- No association of discussion occurrence was found with COPD disease severity as assessed by predicted value of FEV1 (Forced Expiratory Volume in 1 Second).

A 2004 guideline from the American Thoracic Society (ATS) recommends that end-of-life care be integrated into routine COPD therapy, but this has yet to be translated into clinical

“This study demonstrated that having end-of-life discussions is associated with higher ratings of patient satisfaction with and quality of medical care. The paucity of these conversations at even the most advanced stages of disease, however, suggests that significant additional effort will be needed to facilitate these discussions.”

— Leung et al, *Chest*

practice, note the authors.

“As a result, patients with COPD are more likely than those with lung cancer to receive treatment consistent with preservation of life at the end of life. Moreover, palliative care resources often made available to cancer patients are less likely to be offered to patients with COPD.”

Physicians may feel that it is not appropriate to initiate discussions of end-of-life care preferences until patients reach very advanced stages of COPD, observe the authors. “For these patients, discussions may occur only after an acute deterioration in symptoms, when patients and family are already under significant emotional and functional stress, and where careful reflection about preferences cannot be fully considered.”

But because patients often have opinions — even in the absence of a physician-directed discussion — on such topics as life support, symptom relief, and preferred location for their final months, eliciting these opinions early in the disease process provides them with the opportunity to more fully consider their values and to discuss their preferences with family and providers.

Although the ATS recommendations focus on end-of-life care specifically for patients with severe COPD, the authors suggest that the spectrum of disease severity complicated by comorbid conditions demonstrated in their study cohort “may make discussions about preferences for end-of-life care appropriate regardless of the markers of COPD severity.”

Source: “The Effect of End-of-Life Discussions on Perceived Quality of Care and Health Status among Patients with COPD,” Chest; Epub ahead of print, January 2012; DOI: 10.1378/chest.11-2222. Leung JM, Udris EM, Uman J, Au DH; Critical Care Medicine Department, National Institutes of Health, Bethesda, Maryland; Department of Medicine, Division of Pulmonary and Critical Care Medicine, University of Washington, Seattle; and Health Services Research and Development, VA Puget Sound Health Care System, Seattle.

Aggressive Care at End of Life Is Common Among Cancer Patients, But Varies Both Across and Within Types of Hospitals

'The majority of patients prefer comfort over curative care and would rather die at home'

The overall amount of care delivered by facilities to terminally ill cancer patients nationwide is high, yet no hospital characteristic reliably predicts a specific pattern of care, and no type of hospital was found to excel in the delivery of high-quality end-of-life care, a team of Dartmouth researchers reports in a study published in *Health Affairs*.

"Our study revealed a relatively high intensity of care in the last weeks of life," write the authors. "At the same time, there was more than a twofold variation within hospital groups with common features. These results indicate a need for a broad re-examination of end-of-life cancer care and whether it meets the needs and wants of patients."

Researchers analyzed data on 215,311 patients with poor-prognosis cancer (i.e., patients likely to die in less than one year) who were Medicare beneficiaries during the last six months of life, and were cared for at one of 4444 hospitals nationwide between 2003 and 2007.

The hospitals were categorized into one of the following groups: members of the National Comprehensive Cancer Network (NCCN); designated National Cancer Institute (NCI) centers; academic medical centers not in NCCN or designated by NCI; or community hospitals.

To determine the quality of end-of-life care provided, the team used standards endorsed by the National Quality Forum (NQF). These included: lower rates of intensive care unit (ICU) use in the last month of life, reduced use of chemotherapy in the last 14 days of life, fewer deaths occurring in hospital, and fewer late referrals to hospice ("late" being defined as within three or fewer days of death). **"Such late hospice use has been aptly described as 'using hospice to manage death rather than palliate disease,'" comment the authors.**

DIFFERENCES IN NATIONAL QUALITY FORUM QUALITY MEASURES ACROSS HOSPITAL TYPES

- Compared to NCCN hospitals, "late" hospice initiation was 29% higher in community hospitals, 19% higher in academic hospitals, and 13% higher in NCI hospitals.
- ICU use in the last month of life, when compared to NCCN hospitals, was 11% to 15% higher in the other three types of hospitals.
- The use of chemotherapy in the last 14 days of life was about 30% higher in community hospitals than in the other three hospital groups.

- Use of potentially life-prolonging procedures in the last month of life was about 30% higher in NCI centers and academic hospitals than in community or NCCN hospitals.

Patients cared for in large (more than 300 beds) and medium size (150 to 300 beds) hospitals received more aggressive care by almost every measure than did patients in small (fewer than 150 beds) hospitals. Patients in for-profit hospitals received more aggressive care than those in not-for-profit facilities, although the use of hospice services was similar in both types.

VARIATION WITHIN HOSPITAL GROUPS

Although modest differences in intensity of end-of-life cancer care were observed across hospital types and hospital characteristics, these trends were "dwarfed" by the variation in care intensity found within hospital groups sharing common characteristics — even groups with a specific clinical focus on cancer care, such as NCCN hospitals or those designated as NCI centers, note the authors.

"Generally, more than a twofold variation was noted within the hospital groups with common features," report the authors. "We found that these hospital characteristics explained little of the observed variation in intensity of end-of-life cancer care and that none reliably predicted a specific pattern of care."

PATIENT PREFERENCES

Such a variation in intensity of care for chronically ill patients in the last six months of life is not likely to be a reflection of patient preferences, suggest the authors. "The majority of patients prefer comfort over curative care and would rather die at home than in the hospital," they state. "The fundamental question is whether the care received by these patients is the care that they and their families wanted.

"These findings raise questions about what factors may be contributing to this variation," the authors continue. "They also suggest that best practices in end-of-life cancer care can be found in many settings and that efforts to improve the quality of end-of-life care should include every hospital category."

Source: "End-of-Life Care for Medicare Beneficiaries with Cancer Is Highly Intensive Overall and Varies Widely," Health Affairs; April 2012; 31(4):786-796. Morden NE, Chang CH, Jacobson JO, Berke EM, Bynum JP, Murray KM, Goodman DC; Dartmouth Medical School and Dartmouth Institute for Health Policy and Clinical Practice, Hanover, New Hampshire; Cancer Control Research Program, Dartmouth-Hitchcock Norris Cotton Cancer Center, Lebanon, New Hampshire; Dana-Farber Cancer Institute, Boston; and Center for Outcomes Research and Evaluation, Maine Medical Center Research Institute, Portland.



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 pneumonia or UTI, sepsis or decubiti within the past 12 months

Call us any time, any day.

Geoffrey Coleman, MD
Medical Director
Montgomery Hospice



Relationships Between Caregivers and Hospice Patients Found to Vary Among Racial/Ethnic Groups

As the overall number of patients enrolling in hospice care continues to increase annually, the proportions of hospice users among ethnic and racial minorities remains low. An understanding of the caregiver relationships found among different racial/ethnic groups may help providers to better explain the benefits of hospice care, according to a report published in the *American Journal of Hospice & Palliative Medicine*.

Investigators examined the characteristics of 22,936 patients (White, 80.6%; African American, 9.6%; Hispanic, 9.3%; Asian American/Pacific Islander, 0.5%) enrolled at a hospice in the central part of Florida from 2002 to 2006. Overall findings:

- Hospitals were the most common referral sources across all groups, followed by primary care physicians. Whites were referred from long-term care facilities about twice as frequently as all other groups.
- Length of stay did not differ significantly across the groups.
- While the total number of hospice users increased from 3622 to 6124 over the four-year period, proportions by race/ethnicity varied only minimally.

Different caregiver relationships were found among the four groups:

- Spouse caregivers were most common among Whites and Asians/Pacific Islanders (35.1% and 36.2%, respectively). For these two groups, the second most common caregivers were daughters for Whites (27.1%), and sons for Asians/Pacific Islanders (24.8%).
- Daughters were most often the caregivers for Hispanics (32.6%), followed by spouses (30.2%).
- Caregivers for African Americans were most frequently listed as “other” than spouse or adult child (40.9%), followed by daughters (27.1%).

“Caregiver relationships are a key finding in this study, since many hospice organizations require patients to have a caregiver,” comment the authors. They suggest that referring physicians and hospices make careful identification of patients’ caregivers and ensure that discussions of hospice referral are culturally specific and scheduled to give working-age caregivers adequate time to consider and understand their recommendations.

Source: “Hospice Use Among African Americans, Asians, Hispanics, and Whites: Implications for Practice,” *American Journal of Hospice and Palliative Medicine*; March 2012; 29(2):116-121. Carrion IV, Park NS, Lee BS; School of Social Work, University of South Florida, Tampa.