

## MEDICAL DIRECTOR

Geoffrey Coleman, MD

## TEAM PHYSICIANS

Grace Brooke Huffman, MD

Jayant Patankar, MD

Gary Wilks, 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

Debrah Miller, CRNP

Anna Moretti, CRNP

Nancy Palker, CRNP

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

## Contents

Patients with Advanced Heart  
Failure Need Earlier Discussion  
of Hospice Care.....Page 1

Patient Preferences Have Little  
Influence on Receipt of Chemo-  
therapy, National Study Finds...  
.....Page 2

Elderly Patients Found to Use  
Medicare Skilled Nursing Facility  
Benefit Rather Than Hospice at  
the End of Life.....Page 3

Racial Disparities in Hospice  
Use Persist among Patients  
with Cancer.....Page 4

## Patients with Advanced Heart Failure Need Earlier Discussion of Hospice Care

Elderly patients in the advanced stages of heart failure and their physicians face particular challenges unique to this disease, and these challenges make it difficult to determine when to discuss the initiation of palliative and hospice care, according to an invited review article published in the journal *Cardiology in Review*.

“The terminal stages of heart failure present challenges to both the patient and the clinician that are the equal of terminal cancer, but with facets that are unique to cardiovascular disease,” writes cardiologist John Arthur McClung, MD, professor of Clinical Medicine and Public Health, New York Medical College, Valhalla, New York.

Challenges faced by clinicians caring for these patients include:

- Prognostic uncertainty
- Episodes of acute decompensation that are often followed by relatively rapid improvement
- Increasing frequency of device therapy

McClung discusses the management of common symptoms such as dyspnea, pain, and fatigue, as well as the importance of treating comorbidities. Identifying psychosocial problems experienced by patients with advanced disease is also important, he notes. Physicians can elicit these problems by asking, “What are your three most troublesome problems?”

The article also addresses clinical and ethical issues surrounding such topics as the deactivation of device therapy, resuscitation status, and palliative sedation. But the focus of McClung’s review is on the importance of timely discussion of palliative care, followed by its implementation.

“Palliative intervention for patients with heart failure, including hospice, is clini-

cally indicated for patients presenting with progressively increasing pump failure,” states McClung. “What seems clear from the experience of many is that palliative care needs to be considered much earlier in the course of the disease process than is currently the case.”

Triggers for a discussion of palliative intervention include:

- A physician’s answer of “no” to the “surprise” question (“Would I be surprised if this patient died in the next 12 months?”)
- The occurrence of an acute exacerbation
- A lack of response to angiotensin converting enzyme inhibition
- The initial discharge of an automatic in-dwelling cardioverter defibrillator

“[P]atients dying of heart failure either do so suddenly, suffer a chronic, slow deterioration punctuated by acute episodes, or both,” McClung points out. “In either case, the physician will miss many opportunities to explore patient preferences in this population unless these preferences are addressed early in the course of the disease.”

Source: “End-of-Life Care in the Treatment of Advanced Heart Failure in the Elderly,” *Cardiology in Review*; Epub ahead of print, August 7, 2012; DOI: 10.1097/CRD.0b013e31826d23ea. McClung JA; Department of Medicine, Division of Cardiology, New York Medical College/Westchester Medical Center, Valhalla, New York.

# Patient Treatment Preferences Have Little Influence on Receipt of Chemotherapy, National Study Finds

*Experts from across the U.S. call for greater emphasis on shared decision making between patient and physician*

Most patients with metastatic colorectal cancer who preferred comfort-oriented care stated they believed that chemotherapy would not extend their lives or help them with cancer-related problems. Nevertheless, these patients did receive chemotherapy, suggesting a need for more emphasis on shared decision making between patient and physician, according to the authors of a report published in the journal *Cancer*.

“The majority of patients received chemotherapy even if they expressed negative or marginal preferences or beliefs regarding chemotherapy,” write the authors, led by S. Yousef Zafar, MD, MHS, of the Duke Cancer Institute in Durham, NC. In addition, “patient preferences and beliefs were not associated with the intensity or number of chemotherapy regimens.

“Although chemotherapy for patients with advanced colorectal cancer can modestly extend survival, such treatment is associated with the risk of significant toxicity. This balance between possible benefit versus probable risk necessitates a patient-centered approach to treatment decision making,” observe the authors.

Investigators conducted a prospective cohort study of 702 patients with stage IV colorectal cancer who were enrolled nationwide by the Cancer Care Outcomes Research and Surveillance (CanCORS) Consortium. Patients were adults (aged 21 years or older) enrolled within three months of diagnosis from 2003 to 2006 and followed for 15 months. Data were collected from patient medical records and by telephone interview with patients or surrogates familiar with patients’ cancer care.

## OVERALL FINDINGS

- 91% of patients consulted a medical oncologist.
- Among those treated by an oncologist, 82% of patients received chemotherapy.
- 63% received more than one therapeutic agent as their first line of therapy.

## DECEDENT CHARACTERISTICS

- 90% of patients who expressed a preference for comfort-oriented care were given chemotherapy.
- 90% of those who felt chemotherapy would not extend their lives received chemotherapy.
- 89% of patients who thought chemotherapy was unlikely to help them with cancer-related problems were nevertheless given chemotherapy.
- Virtually all patients who reported a preference for extend-

*“Physicians may believe it is easier to offer chemotherapy to the patient with advanced cancer rather than engaging in challenging end-of-life discussions.”*

— Zafar et al, *Cancer*

ing life or who believed chemotherapy would extend their lives or help them with cancer-related problems did receive chemotherapy (99%, 99%, and 100%, respectively).

No association was found with the intensity or number of chemotherapy regimens received by patients and their expressed preferences, beliefs, concerns about treatment, actual and preferred roles in decision making, or the quality of communication with their physicians.

Patients with less likelihood of visiting an oncologist included those who were aged 65 to 75 years, those aged 75 years or older, and those whose surveys were completed by a surrogate because they were too sick to respond. Patients with less likelihood of receiving chemotherapy included those aged 75 years or older with moderate or severe comorbidity, and those too sick to complete their own survey.

“Taken together, these data suggest that concerns regarding the potential underuse of chemotherapy in patients with metastatic colorectal cancer largely may be put to rest,” comment the authors.

“Patient preferences should be emphasized particularly in the setting of advanced cancer, in which the treatment is palliative,” the authors state. “These findings shed new light on the patient experience and decision making in the use of palliative chemotherapy, and can shift the focus of health services research in advanced cancer from investigating underuse of treatment to the inclusion of patient preferences in decision making.”

*Source: “Chemotherapy Use and Patient Treatment Preferences in Advanced Colorectal Cancer,” Cancer; Epub ahead of print, September 12, 2012; Zafar SY, Malin JL, Grambow SC, Abbott DH, Kolimaga JT, Zulig LL, Weeks JC, Ayanian JZ, Kahn KL, Ganz PA, Catalano PJ, West DW, Provenzale D, for the Cancer Care Outcomes Research & Surveillance (CanCORS) Consortium; Duke Cancer Institute, Durham, North Carolina; Center for Health Services Research in Primary Care, Durham Veterans Affairs Medical Center, Durham; Greater Los Angeles Veterans Affairs Healthcare System, Los Angeles; Division of Hematology and Medical Oncology, Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles; Department of Biostatistics and Bioinformatics, Duke University Medical Center, Durham; Dana-Farber Cancer Institute, Boston; and Division of Gastroenterology, Department of Medicine, Duke University Medical Center, Durham.*

# Elderly Patients Found to Use Medicare Skilled Nursing Facility Benefit Rather Than Hospice at End of Life

Nearly one-third of Medicare beneficiaries used the Medicare skilled nursing facility (SNF) benefit in the last six months of life, with one in 11 elders dying while enrolled in the SNF benefit, according to a report published in the *Archives of Internal Medicine*.

“Our finding that Medicare decedents commonly used SNF care at the end of life suggests a need to better understand who is using the SNF benefit and whether they are receiving care that matches their goals,” write lead author Katherine Aragon, MD, of the Department of Medicine at the University of California, San Francisco, and colleagues.

Researchers analyzed data from the Health and Retirement Study, a nationally representative, longitudinal survey of older adults, linked to Medicare claims on individuals who died from 1994 to 2007 (n = 5163; mean age, 82.8 years). They examined the prevalence of the use of the SNF benefit in the last six months of life by decedents whose residence prior to the last six months was either in a nursing home or in the community.

## KEY FINDINGS

- 30.5% of Medicare beneficiaries used the SNF benefit in the last six months of life.
- 9.2% of elders died while enrolled in the SNF benefit, most during the first 30 days of admission following hospitalization.
- 42.5% of the 1081 community-dwelling decedents who used the SNF benefit died in a nursing home; 53.5% of these died while enrolled in the SNF benefit, while only 19.3% died under the hospice benefit.
- In contrast, only 5.3% of community dwellers who had not used the SNF benefit in the last six months of life died in a nursing home, and 44.5% of these died with hospice care.

The finding that more than half of these community dwellers who died in a nursing home were enrolled in SNF at the time of death “suggests that patients are being discharged from hospitals to nursing homes under the Medicare SNF benefit for end-of-life care,” point out the authors. Under Medicare, patients can be enrolled in both the SNF and hospice benefits concurrently, but not for the same diagnosis. In this study, only 0.5% of decedents were enrolled in both programs simultaneously.

## REHABILITATION VS END-OF-LIFE TRAJECTORY

The two strongest predictors of SNF benefit use were the expectation of the patient’s death by their next of kin (adjusted relative risk [ARR], 1.46; 95% confidence interval [CI], 1.30 to 1.63) and the use of home health services among community

dwellers before the last six months of life (ARR, 1.24; 95% CI, 1.09 to 1.40).

It is likely that individuals referred to SNF care are those who are seen as having a potential for recovery. However, note the authors, it is also possible for physicians to overlook that a decline during hospitalization may reflect a health condition that will continue to deteriorate despite rehabilitation.

“In fact, the needs that necessitate SNF use are the same indicators of an end-of-life trajectory seen in frail elders,” they point out. “Honest and frank discussions about goals of care not only in the hospital, but once they are admitted to a SNF may allow an earlier introduction to palliative care.”

Those who used the SNF benefit had greater disability and required more home health and nursing home care than those who did not use the benefit. Patients transferring to SNF often have high care needs and can be medically complex.

“Incorporating a palliative care focus into SNF-level care may allow earlier recognition of when hospice referral is appropriate,” suggest the authors. “While rehabilitation is an important aspect of elder care, other issues near the end of life (e.g., symptom management or discussions about goals of care) may not be addressed when a patient is enrolled in the SNF benefit.”

## FINANCIAL INCENTIVES FOR USE OF THE SKILLED NURSING FACILITY BENEFIT

Nursing homes receive higher reimbursement for patients enrolled in the SNF benefit compared with long-term care reimbursement through Medicaid, giving these facilities a financial incentive to hospitalize patients who will then be enrolled in the SNF benefit upon discharge, the authors observe.

Elderly patients living in the community may be hospitalized when their symptoms and functional decline can no longer be managed at home, then admitted to a nursing home under the SNF benefit rather than hospice. Unlike SNF, the hospice benefit does not cover room and board, which must be paid for either out of pocket or through Medicaid.

“Families often face an uncomfortable choice: either they pay for room and board out of pocket to have access to hospice services, or they continue under the Medicare SNF benefit, relying on nursing home services for palliative and end-of-life services,” note the authors.

*Source: “Use of the Medicare Posthospitalization Skilled Nursing Benefit in the Last Six Months of Life,” Archives of Internal Medicine; Epub ahead of print, October 1, 2012; DOI: 10.1001/archinternmed.212.4451. Aragon K, Covinsky K, Miao Y, Boscardin WJ, Flint L, Smith AK; Divisions of Palliative Care and Geriatrics, Department of Medicine, and Division of Biostatistics, Department of Epidemiology and Biostatistics, University of California, and San Francisco Veterans Affairs Medical Center, San Francisco.*



## 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



## Racial Disparities in Hospice Use Persist among Patients with Cancer

The lower rate of hospice enrollment among African-American patients compared with Caucasian patients has been well documented. A recent review of the literature has found these disparities exist also within the population of patients with advanced cancer, according to a report published in the *American Journal of Hospice & Palliative Medicine*.

“Despite the potential benefits of hospice...this review indicated that the most broadly based studies found that racial disparities in hospice use between Caucasian and African-American patients persist when focusing specifically on patients with cancer,” write the authors.

Researchers conducted a literature review of studies published since 1983 — the year the Medicare Hospice Benefit was enacted — on the use of hospice among African-American patients with cancer, and the factors influencing this utilization. Although the use of hospice by patients with noncancer diagnoses has grown considerably in recent years, the authors note, cancer still represents the most prevalent admitting diagnosis.

Overall, the largest studies found that African-American patients with cancer use hospice at a lower rate than do Caucasian patients. Hospice use among African Americans is influenced by:

- **Age:** African Americans who use hospice are more likely than their Caucasian counterparts to be younger than 65 years.
- **Gender:** African-American women with cancer enroll at a higher rate than do African-American men.
- **Preferences:** African-American patients are more likely to pursue aggressive care at the end of life, thus curtailing their use of hospice under the Medicare benefit.
- **Knowledge:** African-American patients with cancer are less likely than Caucasians to be informed about hospice programs.

### **BARRIERS TO HOSPICE USE BY AFRICAN AMERICANS WITH ADVANCED CANCER INCLUDE:**

- Religious beliefs / religious coping
- Misunderstanding or lack of information about hospice
- Mistrust of the health care system

“Future studies...are necessary to ensure that every patient has the opportunity to access this valuable end-of-life program if they so desire,” conclude the investigators.

Source: “Disparity in Hospice Utilization by African-American Patients with Cancer,” *American Journal of Hospice & Palliative Medicine*; July 19, 2012; 29(5):346-354. Ramey SJ and Chin SH; Department of Medicine, Medical University of South Carolina, Charleston.