HOSPICE NEWS NETWORK

What the Media Said about End-of-Life Care This Week

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JAMA COMMENTARY CALLS FOR RETHINKING OF HOSPICE ELIGIBILITY CRITERIA

Dr. David Casarett, of the Center for Bioethics and the Leonard Davis Institute of Health Economics at the University of Pennsylvania, has written "Rethinking Hospice Eligibility Criteria, in the current *JAMA*. Casarett **says that the rules of a six-month prognosis and no life-sustaining treatment relating to the primary diagnosis were "meant to make the benefit budget neutral by ensuring that any incremental costs of hospice would be offset by reduced expenditures on life-sustaining treatment." The evidence, however, is that hospice decreases costs of care, especially when the patient has cancer.**

The article cites three ways in which the current hospice eligibility criteria create barriers to hospice care: 1) They create delays in hospice enrollment; 2) They are not based on needs for care; 3) They may reduce access for some groups more than for others, such as for black patients, who are less likely to use hospice than whites.

The Affordable Care Act of 2010 requires CMS to implement a demonstration project of concurrent care, in which patients can receive curative as well as hospice care. While this modification of the eligibility rules could improve access to hospice, Casarett writes, the project "will only guide changes to the Medicare hospice benefit if it is designed to measure the right outcomes."

Casarett asserts that "at a minimum, the demonstration project must measure the effect of concurrent care on costs. Specifically, it should determine whether additional treatment costs will be offset by decreased acute care utilization compared with usual care. … **An evaluation of costs of concurrent care relative to typical hospice care is essential** because the legislation requires budget neutrality. However **it is possible that concurrent care may increase costs**. Even the most robust cost savings may be insufficient to offset the increased cost of aggressive treatment in the concurrent care group."

Additionally, the costs of concurrent and usual care should be compared, and the calculation of net costs will be essential, the article says. "If concurrent care is less expensive than typical hospice care but more expensive than usual care, the net cost savings of concurrent care will depend on whether patients receiving concurrent care would have used typical hospice care or usual care."

Casarett also writes that the evaluation should include measures other than costs. Measures of access should be incorporated, including whether patients enroll sooner in concurrent care programs, and whether racial and ethic disparities are reduced.

Second, effects on quality should be measured, including "assessments of symptoms and quality of life, measures of the degree to which patients and families feel that treatment was consistent with their preferences," and prospective and retrospective measures of patients' and families' perceptions of the quality of care received.

Third, the concurrent care project should "evaluate the impact of concurrent care on patients' survival." While life-prolonging treatments may increase survival compared to typical hospice care, and palliative care may extend it even further, survival may also be shortened by complications of aggressive treatment.

Casarett concludes, "Ultimately, the concurrent care model should not be judged solely on its ability to reduce costs. In addition, a comprehensive evaluation should include measures of access, quality, and survival. More broadly, any hospice eligibility criteria should be judged by how well those criteria can ensure that the right patients receive the right services at the right time." (*JAMA*, 2011,305(10):1031-1032, dx.doi.org/10.1001/jama.2011.271; *HealthCanal.com*, 3/10, www.healthcanal.com/geriatrics-aging/15174-Penn-Medicine-Expert-Rethinking-Medicare-Hospice-Eligibility-Criteria.html)

PALLIATIVE CARE CUTS MEDICAID HOSPITAL COSTS

A study of Medicaid patients at four New York State hospitals from 2004-2007 found that the hospital costs for patients who received palliative care were $6,900 less than that for a matched set of patients who did not receive palliative care. Costs per admission for palliative care patients who were discharged alive were $4,098 less and. for those who died while they were in the hospital, costs were $7,563 less.

The palliative care patients also spent less time in intensive care than non-PC patients, were less likely to die while in intensive care units, and were more likely to be referred to hospice.

Patients selected for the study had to have Medicaid as their sole insurer, hospital stays between 6-44 days, and at least one of several advanced diseases, including metastatic solid tumors, malignancies of the central nervous system, melanoma, advanced head and neck cancer, advanced pancreatic cancer, HIV/AIDS with a secondary diagnosis, CHF or COPD, or advanced liver disease with cirrhosis.

The authors estimate that if every 150+ bed hospital in New York State had a fully operational palliative care unit, Medicaid could eventually save between $84 million and $252 million annually, depending on how many Medicaid patients received palliative care.

Dr. R. Sean Morrison, one of the co-authors of the study, said that the savings come from matching treatments to patient goals. Palliative care teams "listen to what patients want to achieve from the health-care system, listen to their goals and what they want to accomplish, then match their treatment to those goals. In the setting of this very complex, very sick population, you're eliminating misutilization." (*Health Affairs*, 2011,30(3):454-463, dx.doi.org/10.1377/hlthaff.2010.0929; *Wall Street Journal*, 3/8, blogs.wsj.com/health/2011/03/08/study-palliative-care-for-medicaid-patients-reduces-their-hospital-costs/; *Geripal*, 3/8, www.geripal.org/2011/03/palliative-care-consulations-answer-to.html)

RESEARCH & RESOURCE NOTES

A recent survey by the *National Journal* and the Regence Foundation found that "roughly 3 out of 4 Americans, 78 percent, said that palliative care and end-of-life treatment should be part of the public discourse, and 93 percent said they believe such decisions should be a top priority for the U.S. health care system." More than 70% of the respondents agreed with this statement: "It is more important to enhance the quality of life for seriously ill patients, even if it means a shorter life." Twenty-three percent said "it was more important to extend life through every medical intervention possible." (*National Journal*, 3/8, www.nationaljournal.com/healthcare/no-death-panels-please-but-poll-shows-americans-can-handle-end-of-life-chat-20110308; *PR Newswire*, 3/8, www.prnewswire.com/news-releases/new-poll-americans-choose-quality-over-quantity-at-the-end-of-life-crave-deeper-public-discussion-of-care-options-117575453.html)

A survey of parents of children in a Florida pediatric palliative care program used the Functional Assessment of Chronic Illness Therapy-Spiritual Well-being (FACIT-Sp) to measure parents' spirituality. The researchers conclude, "Our results suggest that non-white parents have greater faith-based and overall spirituality than white parents." (*Journal of Palliative Medicine*, 2011,3/8,www.ncbi.nlm.nih.gov/pubmed/21385082)

"**Design and Implementation of an Online Course on Research Methods in Palliative Care: Lessons Learned" says that palliative physicians receive little or no formal research training and that more education is needed to increase palliative care research capacity**. Foundations of Palliative Care Research is a 12-week online course that offers palliative care physicians a foundation in research. (*Journal of Palliative Medicine*, 2011,14(4), www.liebertonline.com/doi/pdfplus/10.1089/jpm.2010.0374)

PUBLIC POLICY NOTES

A Rwandan immigrant in Maryland, Rachel Nyirahabiyambere, had her feeding tube removed because her court-appointed guardian thought she was "profoundly vegetative" and would not recover. Her children disagreed, but "felt powerless to save her." The Alliance Defense Fund petitioned the Alexandria Circuit Court on behalf of the children, and the judge ordered the tube reinstated while the court considered the legal issues. Nyirahabiyambere, 59, had suffered a stroke. (*The New York Times*, 3/11, www.nytimes.com/2011/03/12/us/12brfs-JUDGEORDERSN_BRF.html)

The Washington State Department of Health released the *2010 Death With Dignity Act Report.* In 2010, 68 physicians wrote 87 prescriptions which were filled by 40 different pharmacists. Of the 87 who received prescriptions, 51 died after ingesting the medication, 15 died without ingesting it, and the ingestion status of the other six is unknown. Their ages ranged from 52 to 99, 78% had cancer and 10% had a neuro-degenerative disease. Ninety percent of those who ingested the medication were at home, and 84% were enrolled in hospice. The After Death Reporting forms received for 67 participants indicated that 90% worried about loss of autonomy, 64% about loss of dignity, and 87% about inability to participate in activities they enjoyed. (*Washington State Department of Health 2010 Death with Dignity Act Report*, www.doh.wa.gov/dwda/forms/DWDA2010.pdf)

A Canadian toddler was taken by his parents from an Ontario hospital where doctors wanted to take him off assisted breathing, saying he was in a permanent vegetative state. The parents of Joseph Maraachli brought him to Cardinal Glennon Children's Hospital in St. Louis after an Ontario court ruled that the breathing tube could be removed. The Maraachli family lost another toddler to the same progressively degenerative neurological condition several years ago, and wanted a tracheotomy for Joseph so that his life could be extended for several months and he could die at home. **The article cites Rebecca Dresser, professor of law and medical ethics at Washington University in St. Louis, as saying that US courts generally support families who want to continue life-supporting treatment, even when it is seemingly hopeless.** (*Yahoo! News*, 3/14, news.yahoo.com/s/ap/20110314/ap_on_re_us/us_canadian_boy_end_of_life_dispute)

OTHER NOTES

Teresa Lin, director of the Asian Home Care Program at the Visiting Nurse Service of New York (VNSNY), suggested that her father do "something tantamount to breaking a millennia-old cultural taboo." When he was admitted to the hospital with a life-threatening illness, she "put on her professional hat" and helped him commit his end-of-life wishes to paper. In Chinatown, "where thousands of seniors are aging alone at home," VNSNY offers an outreach program at the Chinatown Community Center about living wills, healthcare proxies, and DNR orders. In the year that the program has been in operation, more than 100 Chinese residents have signed advance directives. (*The Huffington Post*, 3/9, www.huffingtonpost.com/jeanne-dennis/end-of-life-care_b_831474.html)

Oral Diclofenac potassium liquid-filled capsules, with ProSorb dispersion technology, are for treatment of mild to moderate acute pain. A review of oral says that the major advantage of its use "as a first-line therapy is that peak effect is achieved rapidly with minimal variability between patients, potentially speeding the time to patient pain relief." (*Pain Medicine News*, 3/2011, www.painmedicinenews.com/download/SR1031xanodyne_WM.pdf)

Richard Heffner, host of "The Open Mind," recently interviewed Dr. Diane Meier, director of the Center to Advance Palliative Care. Heffner and Meier discussed the differences between hospice and palliative care. **Meier says that palliative care "is a social change process and a diffusion of innovation process." She adds that "80% of large hospitals in the United States have a Palliative Care Program, but it is still a work in progress because … having a hospital palliative care program is not the same thing as you being able to access palliative care when you're living at home, for example.** And we have a ways to go to make palliative care available across the continuum and in all settings." (*WNET Website*, 2/26, www.thirteen.org/openmind/health/palliative-medicine-care-versus-cure/2038/)

Ohio's Stein Hospice has opened a 22-bed unit at the Ohio Veterans Home in Georgetown. According to the website, "The Georgetown home is the first Veterans Home in the country to offer hospice services in a designated in-house unit. Stein was selected to enter into this partnership with the state because of its track record at the Ohio Veterans Home in Sandusky." (*Stein Hospice Website*, www.steinhospice.org/news.html)

An art exhibit at the Pain Management Center of New Jersey's Overlook Hospital is a "long-term teaching display" created by patients whose art submissions tell others "about their pain experience." Rosemary Smith, clinical coordinator of the Pain Management Center team, "believes that through art, people can increase awareness of self and others, cope with symptoms, stress and traumatic experiences. (*NJToday.net*, 3/7, njtoday.net/2011/03/07/art-exhibit-focuses-on-living-with-pain-depicted-by-those-who-experience-it/)

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