

HOSPICE Management Advisor™

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Collaboration — and coordination of care — is the future of health care

Hospices use innovative approaches to work with others

The current focus in federal health policy on coordinating patients' health care throughout the entire continuum of care has resulted in promotion of Accountable Care Organizations (ACO), Medical Homes, and Integrated Delivery Networks. Although no one can predict what the final rule from the Centers for Medicare and Medicaid Services (CMS) governing ACOs will look like, everyone agrees that improved coordination and communication among providers is a good thing for patients.

"Hospice providers will play an important part in ACOs and we are aligning ourselves with other providers who are likely to be key drivers in ACOs," says **Flint Besecker**, chief executive officer of the Center for Hospice and Palliative Care in Cheektowaga, NY. His organization was a winner of the American Hospital Association's 2011 Circle of Life

ExECut IVE SummARy

Collaboration and coordination of care across different settings is recognized as the best way to improve health care. Hospice providers can play a key part in partnerships designed to meet the needs of patients in different settings and at different stages of their illness. Partnerships with physicians as well as long-term care facilities enable hospices such as the Center for Hospice and Palliative Care in Cheektowaga, NY, and Gilchrist Hospice in Hunt Valley, MD, to reach patients earlier in their disease process.

- Palliative care, as well as other hospice services, such as psychosocial services or end-of-life counseling, are available to patients to help them make decisions about the right time to enter hospice.
- Communications, including care conferences, between providers is improved when there is a formal relationship.
- Patients have more time to make a gradual transition to hospice care.

Award®, presented for innovation in end-of-life care. A key reason for the hospice's award is a history of collaboration with other providers and people in the community (see **story on community efforts page 123**) to expand services to a wider range of patients.

There is a natural psychological barrier for patients and families when considering a decision to choose hospice, points out Besecker. Although his organization went through several years of presenting itself as a "symptom management" organization to make hospice seem less threatening, people still think of hospice as a place to die if you don't have an opportunity to educate them, he adds. "We've found the best strategy is to recognize the psychological barrier and find ways to reach patients before you are talking to them

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Editorial Questions
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about hospice," he says.

By partnering with physician practices that provide oncology, nephrology, and cardiology services, Besecker's staff can provide palliative care services to manage symptoms that are not directly related to the disease for which the patient is being treated. "A great benefit to the physician and the patient is the availability of our palliative care nurse practitioner or physician to make house calls to evaluate the patient's pain, shortness of breath, or other symptoms outside office hours," he points out. "Typically, a patient who calls to complain of pain in the evening or on weekends is sent to the emergency department," he explains. The additional support of a clinician, who can make house calls, enables the patient to stay home in most cases.

"We also offer psychosocial services that the physician does not have to offer patients," says Besecker. "Physicians see us as a value-added service for their practices and we get an opportunity to educate patients as their disease progresses," he says. By establishing a relationship with patients while they are receiving treatment, staff members can introduce the concept of hospice when appropriate, he says. "Our staff is comfortable having these tough conversations and can help patients and their families evaluate their options," he says. Because patients have a relationship with the hospice staff member who has provided palliative care, they are often receptive to the conversation and will often enter hospice care earlier than they might have before, he points out. "If we can get patients into hospice earlier rather than the last 7 to 14 days of life, we can positively impact their comfort and quality of life for them and their families," he adds.

In addition to the physician practices with which his hospice currently partners, they are working on agreements with a geriatrics practice, among others, says Besecker. The key to his hospice's success is that they've recognized that not all physicians see the value of palliative care, he points out. "We talk with a physician to see if we are a fit for each other," he says. "We don't want to impose our philosophy on a physician's practice but we do want to work with physicians who share our goals of providing the best care for patients," he adds. If a physician seems reticent or unsure, don't waste your time trying to talk him or her into a partnership, he recommends. "Spend your time where you are wanted."

Gilchrist Hospice Care in Hunt Valley, MD, another winner of the 2011 Circle of Life Award,

also was recognized for its patient-centered care that coordinates and provides patient care in multiple settings. The hospice, an affiliate of Greater Baltimore Medical Center, was opened in 1994 and over the years the hospital system added palliative care, geriatric medicine, and senior services. Although the different services communicated with each other to coordinate care, they were all combined into Gilchrist Greater Living in 2010.

“We have staff members providing services in acute inpatient settings, the patients’ homes, assisted-living and long-term care facilities,” says **Cathy Hamel**, vice president of post acute care services for the hospital system and executive director of the hospice. “Our field staff specializes in different areas because each setting requires us to do our work a little differently,” she explains. Even though hospice and palliative care staff members may focus only on one setting, the continuity of care is there because everyone uses the same practice guidelines and standards of care, she says. “We’ve also standardized our handoffs to include two-way conversations rather than one-way methods of communicating, such as written

notes or voicemails,” she adds. “Also, each of our staff members has access to all electronic medical records.” This gives staff members the opportunity to see the patients’ records from all care received in different settings of the health care system. “Long-term care facilities’ records are usually not automated and we work with facilities that are not part of the same system so staff members in those settings need to work with the facility staff to review the patients’ records when necessary,” she adds.

Care conferences, which are routine and expected as a Medicare Condition of Participation for hospices, are utilized in all settings, even long-term care facilities, points out Hamel. “These conferences are well received by the long-term care staff,” she says. “They appreciate the effort to bring people together to discuss a patient’s care.” The interdisciplinary conferences can differ from setting to setting, she points out. “If we have several patients in one facility, we’ll gather in a meeting room to discuss all of the patients, but if we only have one patient in the facility, we may hold the conference bedside,” she explains. The most important focus is improving communication

Reach out to the community

Talk to groups whenever possible

Successful partnerships in health care occur when both organizations have the same high standards of care and philosophy. It is also important to stay in touch with your community and understand what information they want and need to make good decisions about care, points out **Flint Besecker**, chief executive officer of the Center for Hospice and Palliative Care in Cheektowaga, NY.

To make sure the hospice and its efforts to work in a wide variety of settings stays top-of-mind for the local community, his organization uses a variety of formal and informal methods to stay in touch with local leaders and community members.

“We do schedule formal educational sessions that are open to the community to discuss different topics related to end of life,” explains Besecker. “Speakers include social workers, physicians, attorneys, and other staff members.”

Although the hospice staff designs the schedule for the formal educational sessions, there are many other speaking opportunities at churches, local clubs, or neighborhood groups, Besecker points out. “We encourage all of our employees to let us know if a group uses speakers at meetings,” he says. By offering to talk to people at their group meetings, the hospice staff can reach a wide range of people, he adds.

In addition to staying in touch with the local community, **Cathy Hamel**, vice president of post acute care services for the Greater Baltimore Medical Center and executive director of Gilchrist Hospice in Hunt Valley, MD, also is looking at a way to expand the hospice’s ability to attract clinical personnel. “We are fortunate that we have very little turnover throughout our hospice, but as we expand our services, we are seeing that there is a shortage of palliative care nurse practitioners,” she explains. One strategy she is evaluating for the future is the creation of a training program for palliative care nurse practitioners. “Not only would we be able to grow our own nurse practitioner staff, but we would offer a program that can increase the number of nurse practitioners certified for palliative care.” ■

between all members of the patient's care team, she adds.

Gilchrist Hospice also offers Expanded Services, which is a program that provides services that are not part of the hospice benefit but are requested by the family or patient, says Hamel. "These are families who need a little more time to make the decision to stop curative treatment and enter hospice," she says. "For example, a patient may be receiving nutritional support but wants to enter hospice," she says. Because the Medicare hospice benefit does not cover nutritional support, Hamel's staff may agree to provide the service as the staff counsels the patient and family. "This provides a more gradual passage to hospice," she explains.

Although Medicare does not cover services such as nutritional support for hospice patients, some third party payers do cover some expanded services, says Hamel. "Hospice fundraising covers the non-covered expenses," she adds.

Hamel's organization is interested in the proposed Concurrent Care Demonstration Project that is included in Patient Protection and Affordable Care Act. "By offering expanded services now, we are positioned to participate in the project when it is announced," says Hamel. "Offering patients a more gradual transition to hospice will result in more people entering hospice sooner and being able to die with dignity."

With the movement toward more collaborative care across the health care continuum, Hamel believes that hospices are well positioned to be an important part of the new focus on communication. "We are already good at working with a variety of clinicians, patients, families, and settings, and we have a lot of experience to bring to the table," she explains. "This is a very exciting time for hospice providers to reach out and collaborate with other providers." ■

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Expand the reach of your marketing with public relations

Media coverage enhances image

[Editor's note: This is the first of a two-part series that looks at effective media relations. This month, we look at proven strategies that result in media coverage of hospice events, services, and announcements. Next month, tips and strategies for handling media relations during a crisis are described.]

Are you tired of reading about other hospices or health care providers in your local paper or seeing their special events featured on television news? Their events, their expert speakers, and their services are probably not bigger and better than yours, but they are handling media relations the right way.

"The most common mistake people make in media relations is not understanding the difference between public relations, which includes media relations, and advertising," says **Merrily Orsini**, MSSW, managing director of Corecubed, an integrated marketing, design, and public relations company based in Louisville, KY. They can both be used to promote a product, service, or event, but advertising space is purchased while public relations space is obtained by offering a newsworthy item to the media to generate coverage, she explains. This "free" publicity is an effective tool to enhance your overall marketing efforts, she adds.

Although your event or announcement may be significant to your employees, board members, and patients, the fact that it is planned may not appear newsworthy to media, points out Orsini. In these cases, look for ways to demonstrate newsworthiness, she suggests. Prominent community leaders who are personally connected to your hospice through volunteer work or have experience with your hospice providing care to a family member can serve as masters of ceremonies, hosts, or introductory speakers, she says. The public standing of the person can make the event newsworthy, she adds.

Other tips to enhance the likelihood that the media will cover your event include:

- **Show impact of hospice**

"Use statistics to demonstrate why hospice is important," says Orsini. "If your message is to

encourage people to consider hospice earlier in the trajectory of their disease, support the message with statistics that show that patients and families benefit from the extra time on hospice,” she suggests.

- **Relate hospice to current trends**

“The cost of health care is a topic that everyone discusses today,” says Orsini. “There are studies that compare costs of providing health care at the end-of-life in hospitals versus hospice so use this information to educate reporters about the newsworthiness of hospice care.”

- **Demonstrate expertise**

If your event has a speaker who is a recognized expert on a topic, promote the expertise, recommends Orsini. Provide information about the speaker that demonstrates his or her expertise, and offer reporters a chance for an interview prior to or after the event. “This is especially important if your speaker is a physician or researcher from outside your hospice who talks about cutting-edge practices,” she adds.

- **Describe visual opportunities**

Both television and newspaper editors are more likely to cover an event that provides exciting visuals to accompany the story, says Orsini. “Butterfly releases are wonderful visuals and when you pair that with a creative name, such as “Monarchs to Heaven,” you will catch someone’s attention,” she says. Open houses also can provide good visuals if you’ve recently renovated or opened a new facility, she says.

When you “pitch” or present your story to the media, it is not enough to say, “We’re wonderful,” says **Stephanie Smith**, director of communications at Hosparus in Louisville, KY. “You have to present something that is interesting, unique, or of great interest to the community,” she explains.

Three years ago Smith’s organization underwent a name change. The previous name was The Alliance of Community Hospices and Palliative Care Services. “Research showed us that people perceived all hospices to be the same and the idea of hospice scared them,” says Smith. The organization’s name change to Hosparus was accompanied by paid advertising with print ads, billboards, and television, but public relations efforts also resulted in good coverage by news staffs as well, she says. “We had a very clear message that explained how we help people gain control over their care at the end of life,” she says.

Although not all events are as significant as an organization’s name change, even smaller stories will be covered if presented correctly. “One of our stories that received very good coverage was a grief group for men,” says Smith. Because men don’t share stories of grief as often as women, the health editor of a local paper liked the idea of presenting a different perspective on grief. “I was able to easily point out why this story was different and how it could appeal to the local audience,” she adds.

How you make the pitch is as important as what you pitch, points out Smith. “A few years ago I surveyed editors and reporters to find out how they wanted me to contact them and what information they wanted to receive,” she says. “I found out that I was sending too much information in my first contact.” Most editors and reporters prefer e-mail messages but they don’t want attachments, they want the key information in the body of the e-mail, she says. (See page 126 for more tips on pitching a story.)

Be sure your press release contains the essential information such as day, time, and location of an event along with other information such as potential visuals or an opportunity to interview experts or families one-on-one, suggests Orsini. “If you have a photograph of a previous event, such as a balloon or butterfly release, include that with the press release as an example of what they’ll be able to use.”

After sending your press release, call the editor or reporter a few days later to make sure the press release was received and ask if there is any other information you can provide, suggests Orsini. If someone indicates an interest in attending the event, or following up on the story idea, offer to help meet the deadline by providing the information, setting up interviews, or providing visuals. “If they don’t indicate any interest in the idea, don’t push,” she says.

Another way to generate interest in your story ideas or special events is to make sure you use a variety of media to publicize them, says Orsini. “Use on-line media, such as Facebook, to promote events to generate interest throughout the general community and to show reporters that the event will be well-attended,” she says. “Research on-line event directories for your area and make sure your event shows up in them so reporters researching activities in the community will see them.”

The most difficult part of handling public relations is the expectation of other people in your organization, admits Smith. “People get very excited about their activities and believe that if I

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• **Stephanie Smith**, Director of Communications, Hosparus, 3532 Ephraim McDowell Dr., Louisville KY 40205. Tel: (502) 719-8925; e-mail: ssmith@hosparus.org.

send a press release, they will get media coverage,” she says. “I try to be honest and explain that I will send the press release but the award or presentation may not be considered newsworthy,” she says. “I try to set realistic expectations for what the press release might achieve.”

Even if you receive positive feedback and reporters plan to attend your event, be aware that things change, says Orsini. “Expect to be bumped from the reporter’s schedule by a more newsworthy event and have a backup plan,” she says. Have your own photographer or videographer on site to get visuals you can send to the media following the event. Along with the visuals, send statistics on how many people attended, how much money was raised, or how many butterflies were released, she says. “A backup plan gives you a second chance to get coverage.” ■

How to make the perfect pitch

Tailor messages to specific editors

Although there are many different ways to present information to reporters and editors to obtain media coverage, the key to each of them is to know your audience, according to experts interviewed by *Hospice Management Advisor*.

The results of a survey of local reporters and editors gave **Stephanie Smith**, director of communications for Hosparus in Louisville, KY, valuable information about what story ideas caught their attention. “Know what different reporters cover and what they might be working on at the moment,” she explains. For example, if a reporter writes a column on special events in the community, only send information on events to that

reporter, she says.

Be sure your press release is concise and complete, as well as well written, says Smith. “Get an AP [Associated Press] Stylebook and use it for guidance,” she suggests. “Proofread the release and have three other sets of eyes review it to make sure you’ve included all of the facts and that conveys the message you want,” she adds.

Finding out what reporters are covering can be accomplished by watching television news, reading local newspapers and magazines, and asking them what interests them, suggests Smith. Another good way to increase the chances that a newspaper will pick up a story is to make it personal, she suggests. “Put a face on the story and be sure you appeal to the audience most likely to respond to the idea,” she says.

When the hospice newsletter featured an article about a patient who was a WWII veteran, Smith was able to expand the audience for the article by contacting the newspaper that covered the county in which the patient had lived. “Smaller, community papers want stories about people who live in the community,” she explains.

Press conferences should only be used for significant announcements, suggests Smith. “We held a press conference to announce a series of events that occurred throughout the week, but the key attraction was a collection of Princess Diana’s dresses on display for one of the events,” she says. “I created a media packet with fact sheets and information about the events to distribute to those who attended the press conference as well as reporters who could not attend.”

When inviting reporters to cover an event, offer something special, such as an opportunity to enter before the public so the reporter can conduct a private interview or photographers can get visuals, suggests **Merrily Orsini**, MSSW, managing director of Corecubed, an integrated marketing, design, and public relations company based in Louisville, KY. “Also, be prepared with family members, board members, physicians, or other people who are prepared to give interviews.”

Also, be sure you have people at the event to greet reporters and help them get what they need for their story, says Smith. “At our Hike for Hosparus we have between 400 and 500 people so I make sure the reporters have my cell phone number and I make sure hospice employees know how to reach me to let me know a reporter is present,” she says.

After the event, remember your manners, says Smith. “After we’ve received coverage in any

media outlet, I send a handwritten thank you note,” she says. Even though covering the event and writing the story may be part of the reporter’s job, she says the note of appreciation strengthens the relationship between the reporter and Hosparus.

Finally, don’t be discouraged when you don’t receive the amount of coverage you believe you should, says Smith. “It’s not about you or your organization, it’s about limited resources on a news staff, other breaking, more newsworthy events, or no room left in the broadcast or publication. Just keep trying and build good relationships.” ■



Hospice improves care for dementia patients and their families

Quality of dying reported improved as well

Hospice services substantially improved the provision of care and support for nursing home patients dying of dementia and their families, according to an analysis of survey responses from hundreds of bereaved family members. The research comes as hospice funding has received particular scrutiny in the debate over Medicare spending.

“People whose loved ones received hospice care reported an improved quality of care, and had a perception that the quality of dying was improved as well,” said **Joan Teno, MD**, a Brown University gerontologist and the lead author of the study published on-line in the *Journal of the American Geriatrics Society*. “This is one of just a few studies out there that has examined dying with dementia where the predominant site of care is a nursing home and can report the benefits of hospice services. As just one example, for nursing home patients not in hospice, one in five family members reported an unmet need for shortness of breath while that was only 6.1 percent for people in hospice.”

Hospice care was a great comfort to **Bartley**

Block, of Providence, when he lost his wife, Janet, to dementia in October 2010. He and Janet received service from Home and Hospice Care of Rhode Island on and off for about a year as her condition wavered, and then ultimately declined. Block said that even after his wife began struggling to eat, she still would get up and walk. Hospice workers would help the couple take walks at the nearby Tockwotton Nursing Home and patiently feed her food that they’d puree.

“It meant a great deal to her and to me,” Block said. “It not only was able to calm her, but it was calming to me. There were spiritual sessions for me. They did so much for her to make her life easier.”

That kind of experience is reflected in the responses of hundreds of families in the survey. In all, Teno’s team asked 538 family members of nursing home patients who died of dementia to reflect on the care and support they experienced and observed at their loved one’s end of life. Of that group, 260 received hospice care and 278 did not. Among the report’s key findings:

- Family members of hospice recipients were 51% less likely to report unmet needs and concerns with quality of care.
- They were 49% less likely to report an unmet need for management of pain.
- They were 50% less likely to have wanted more emotional support before their loved one’s death.
- They rated the peacefulness of dying and the quality of dying more positively than families whose loved ones did not receive hospice care.

The survey also found that people who felt their loved one received hospice care “too late” had stronger concerns about care and support in almost every one of the survey’s many measures. They felt worse off than people who had no hospice care at all.

“These are people who get slammed around the health care system in the last days of life,” Teno said. “These are people with transitions who go from an acute care hospital to a nursing home in the last 24 hours. They are reacting to a set of circumstances that shouldn’t have occurred.”

Dementia is a particularly important area to study, Teno said, because the untreatable condition has only recently gained recognition as being a terminal illness. The unpredictability of its progress, however, has led to a large number of dementia patients staying in hospice for longer than people with other conditions. That has made dementia a focus for scrutiny in discussions of cost.

But the study provides new evidence that hospice provides a meaningful benefit to nursing home patients with dementia and their families, such as the Blocks, Teno said. Therefore, policymakers should factor in that evidence as they discuss the future of Medicare funding.

“It is a terminal illness,” Teno said. “As we do payment reform we should preserve access and quality of care for those persons dying of dementia.” ■

Advance directives for palliative care use lower medicare EOL spending

Results vary by region, amount of spending

Advan­ce di­rec­tives do have an im­pact on health care at the end of life, espe­cially in re­gions of the coun­try with high spend­ing on end-of-life care, ac­cord­ing to a Uni­ver­sity of Michi­gan study.

Peo­ple who had com­pleted ad­vance di­rec­tives stat­ing their pref­er­ences for care were less likely to die in a hos­pi­tal and more likely to re­ceive pal­lia­tive hos­pice care than sim­i­lar de­cedents with­out ad­vance di­rec­tives.

“Ad­vance di­rec­tives may help pa­tients get the care they want if they prefer less ag­gres­sive care at the end of life, while also pro­viding cost sav­ings to the Me­dicare pro­gram, par­ticu­larly in higher-spend­ing re­gions of the coun­try,” said **Lauren Hersch Nicholas**, a Uni­ver­sity of Michi­gan health econ­omist who is the lead au­thor of the study.

The study is in the Oct. 5, 2011, issue of the *Journal of the American Medical Association*.

“Ac­com­panying greater use of pal­lia­tive care, we found that Me­dicare ex­pen­di­tures for those with ad­vance di­rec­tives were sig­nifi­cantly lower than for those with­out, but only in those re­gions that spent more than av­erage per per­son on end-of-life care,” she said. In con­trast, ad­vance di­rec­tives seemed to have lit­tle ef­fect on care re­ceived by peo­ple liv­ing in re­gions of the coun­try that have lower lev­els of med­ical spend­ing at the end of life.

The study, which is among the first to have na­tional data link­ing end-of-life spend­ing, treat­ments, and pa­tients’ ad­vance di­rec­tives, is based on a sam­ple of 3,302 Me­dicare ben­e­fi­ciaries from the Health and Re­ti­re­ment Study, a na­tionally rep-

re­sen­ta­tive lon­gi­tu­di­nal study of more than 30,000 older Amer­i­cans con­ducted by the Uni­ver­sity of Michi­gan In­sti­tute for So­cial Re­search (ISR). The study is funded by the Na­tional In­sti­tute on Aging (NIA), part of the Na­tional In­sti­tutes of Health, and by the So­cial Se­cu­rity Ad­min­is­tra­tion.

The Uni­ver­sity of Michi­gan re­search team ana­lyzed data on Health and Re­ti­re­ment Study par­tic­i­pants who died be­tween 1998 and 2007. Their re­cords were linked to Me­dicare claims and the Na­tional Death In­dex. The study con­ducted in­ter­views with next-of-kin af­ter the sur­vey re­spon­dent’s death, dur­ing which they asked about the de­cedent’s end-of-life ex­pe­ri­ence, in­clud­ing the na­ture and type of their ad­vance di­rec­tives.

“The unique de­sign of the Health and Re­ti­re­ment Study makes it the ideal ve­hicle for this type of ana­lysis,” said **Richard Suzman**, di­rec­tor of the NIA’s Di­vi­sion of Be­havioral and So­cial Re­search, which has funded the study for more than 20 years. “The com­bi­na­tion of in­di­vid­ual in­ter­views and links to ad­min­is­tra­tive data such as Me­dicare pro­vides a rich data re­source that can be used for ana­lyses. Mov­ing for­ward, we ex­pect the study will be used to more fully ex­plore qual­ity-of-life is­sues at the end of life.”

“The most ex­citing thing about this study is that it pro­vides some clear ad­vice for real peo­ple, the kind of peo­ple who give of their time to par­tic­i­pate in re­search,” said **David Weir**, an econ­omist and re­search pro­fessor at ISR, the se­nior au­thor of the pa­per and di­rec­tor of the Health and Re­ti­re­ment Study. “If you care about what may hap­pen to you in your final days, take some time to com­plete an ad­vance di­rec­tive, and talk it over with those closest to you. It can make a big dif­fer­ence.”

Dis­cussing and docu­menting the type of care that you want at the end of life — ei­ther with your fam­ily or your phy­si­cian — can be stress­ful and dif­fi­cult, said co-au­thor **Theodore Iwashyna**. “But our study sug­gests these dis­cus­sions may be very im­por­tant for get­ting the type of end-of-life care you want, espe­cially if you live in a re­gion of the coun­try where more ag­gres­sive care is the norm.”

Nicholas and col­leagues em­ployed a unique ana­lytic strat­egy. “Ad­vance di­rec­tives can only in­flu­ence care when the pa­tient wants some­thing dif­fer­ent from what the local health care system would oth­er­wise pro­vide,” Nicholas said. “Given the wide vari­a­tion in end-of-life Me­dicare ex­pen­di­tures across U.S. geo­graphic re­gions, there are likely de­fault lev­els of care that also vary re­gionally. So we ex­amined the re­la­tion­ship of ad­vance di­rec­tives with the cost and ag­gres­sive­ness of

end-of-life care in geographic regions with high, medium, and low average expenditures for this type of care and found that advance directives made the biggest difference for patients living in regions with higher average levels of spending.”

Specifically, they found major differences between geographic regions in the relationship between advance directives and end-of-life spending. In high-spending regions, adjusted spending on patients with treatment-limiting advance directives was \$33,933, while spending for patients without these directives was \$39,518. There was no difference in spending for patients with and without advanced directives in medium- and low-spending regions, which had average expenditure levels of approximately \$26,000 and \$21,000, respectively.

In addition to regional differences in the economic impact, the study also found significant differences in the type of end-of-life care received by those with treatment-limiting advance directives. “Patients with these advance directives were less likely to die in hospitals and more likely to receive palliative hospice care in both high- and medium-spending regions, where patients are most likely to receive aggressive care at the end of their lives,” said **Kenneth Langa**, co-author of the study. “This has important implications for the comfort and quality of patients’ last months of life, as well as the well-being of family and close friends. Increasing evidence suggests that focusing on palliative, rather than curative, care for appropriate patients near the end-of life leads to much better outcomes for patients and their families.”

Interestingly, the researchers found a weaker relationship between treatment-limiting advance directives and the receipt of aggressive life-sustaining end-of-life treatments such as intubation and mechanical ventilation. “This may suggest that treatment-limiting advance directives still permit trials of intensive care, but that they also may make it easier to stop these aggressive and expensive interventions if they are not working,” Iwashyna said.

The researchers also found substantial geographic diversity in the use of treatment-limiting advance directives, with 42% of decedents in low-spending regions having these directives, compared to only 36% of those in high-spending regions. Even after adjusting for a variety of demographic and socioeconomic characteristics, as well as cause of death, the researchers found that decedents in high-spending regions were less likely to have treatment-limiting advance directives. “This means

that advance directives are currently being used the least where they seem to have the biggest impact,” said Nicholas, “indicating a real opportunity for public policy to help these patients get the kind of care they really want while potentially reducing Medicare spending.”

The mean age at death for the sample was 82.8 years, and 70% of decedents had been hospitalized at least once in the last 6 months of their lives. The researchers also found that 41% died in a hospital; 61% had either a living will or a written Durable Power of Attorney, giving another person the right to make end-of-life treatment decisions for them if they were no longer competent to do so; and 39% had a written advance directive limiting the treatment they wished to receive at the end of life. Those with advance directives were more likely to be white, affluent, and highly educated.

The authors noted that the clinical impact of advance directives is critically dependent on the context in which patients receive end-of-life care. “For those who prefer less aggressive care at the end of life, but who are patients in health systems characterized by high intensity of care, advance directives may be especially important for ensuring care consistent with patients’ preferences,” they wrote.

This work was supported by funding from the National Institutes of Health and the Michigan Institute for Clinical and Health Research. The Health and Retirement Study is conducted at the Survey Research Center, Institute for Social Research, University of Michigan. Nicholas is also affiliated with the University of Michigan Center for Healthcare Outcomes and Policy. Co-authors Kenneth Langa and Theodore Iwashyna are affiliated with the University of Michigan Medical School, the Ann Arbor Veterans Affairs Health System, and ISR. ■

Data show palliative care saves medicaid money, improves care

Less time in ICU, more hospice referrals

Medicaid patients facing serious or life-threatening illnesses incurred \$6,900 less in hospital costs if they received palliative care, compared with a similar group of patients who received usual care, according to a

new study.¹ Palliative care recipients also spent less time in intensive care units (ICUs), and were more likely to receive hospice referrals.

Based on these findings, the researchers estimate that the Medicaid hospital spending in New York state could be reduced by \$84 million annually, if every hospital with 150 or more beds had a fully operational palliative care consultation team.

“Over the past ten years, we have seen the rapid growth and development of palliative care teams in hospitals. They are focused on improving the quality of life for persons with serious illness and their families,” says **R. Sean Morrison**, MD, one of the study’s authors and a professor of geriatrics and palliative medicine at Mount Sinai School of Medicine in New York City.

Given the fact that palliative care teams are focused on the most complex, seriously ill patients, which are the 10% of the population that accounts for 50% to 60% of total Medicaid costs, the researchers wondered if this would result in cost savings to hospitals, says Morrison. They decided to focus on Medicaid beneficiaries because of the rapid growth in Medicaid spending, he explains, and because Medicaid covers a vulnerable patient population.

“If you can improve quality and lower costs for Medicaid patients, this would have significant benefits for other populations served by those hospitals,” says Dr. Morrison.

The researchers selected four New York hospitals with mature palliative care programs, and found significant reductions in overall hospital costs, ICU expenditures, and ICU deaths, and increases in referrals to hospices.

These findings, combined with other studies that have looked at cost savings of palliative care, show that care of this population can be improved in a cost-effective manner, says Dr. Morrison.

Better quality, less cost

“Palliative care programs essentially shift care of complex, seriously ill patients back into the community, which is where most patients want to be and where they tend to be much safer,” says **Diane E. Meier**, MD, FACP, director of the Center to Advance Palliative Care at the Mount Sinai School of Medicine in New York City. “They make sure they get the services and support they need to remain at home.”

The quality of care improves and costs are reduced, says Meier, because the hospital is by

far the most expensive and high-risk setting for patients with serious illness. “Most of the reason they end up in hospitals is because there is simply no alternative safety net in the community,” she explains.

Most admissions to the hospital occur through the ED, she says, and patients often turn to the ED because there is nowhere else for them to get care. “Our health care system is overbalanced on the hospital side, and underbalanced on the community side,” says Meier.

Palliative care teams mobilize existing resources in the community to meet the needs of these typically very complex patients, she says, and the needs of family caregivers who are often exhausted and overwhelmed themselves.

“The result of that, not surprisingly, is that many crises are averted. Patients do not end up having to go back to the hospital,” says Meier. ■

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Chatting about faith boosts patient approval

Whom they speak to makes no difference

Hospitalized patients who had conversations about religion and spirituality with the health care team were the most satisfied with their overall care. However, 20% of patients who would have valued these discussions say their desires went unmet, according to a new study by **Joshua Williams** from the University of Chicago and his colleagues.¹ Their work appears on-line in the *Journal of General Internal Medicine*.

Religious and spiritual concerns are particularly prominent during times of illness, suffering, and death. Some medical leaders and policymakers in the United States have urged health care systems and providers to give due attention to patients’ spiritual concerns. However, there is disagreement about which members of the health care team should ask about and address these concerns. According to hospitalized patients in this study, whom they speak to makes no difference. The important factor appears to be that they have these discussions.

Williams and team analyzed data collected between January 2006 and June 2009 on 3,141 patients enrolled in the University of Chicago Hospitalist Study. In particular, the authors were interested in whether patients wanted to have their religious or spiritual concerns addressed in the hospital, whether anyone talked to them about religious and spiritual issues, and which member of the health care team spoke with them about these issues. They also looked at patient-satisfaction ratings for overall hospital care.

They found that 41% of patients wanted to discuss religious or spiritual concerns with someone while in the hospital, and 32% of all patients said some discussion did occur. Among those who had taken part in discussions, 61% spoke with a chaplain, 12% with a member of their own religious community, 8% with a physician, and 12% with someone else.

Half of the patients who wanted a discussion did not have one (20% of patients overall), and one in four who did not want a conversation about spiritual issues had one anyway. "It did not appear to matter if patients said they wanted such a conversation," said the study's senior author, **Farr Curlin**, MD, associate professor of medicine at the University of Chicago. "Even patients who did not want the conversation had higher rates on all four of the study's patient-satisfaction measures." Those measures were: satisfaction with the doctors' care, always had confidence and trust in doctors, excellent teamwork among doctors and nurses, and overall care was excellent.

The authors also found that older patients, African Americans, women, those who were less educated, and those in severe pain were more likely to have discussed their religious and spiritual concerns with someone in the hospital.

The authors conclude: "Many more inpatients desire conversations about religious and spiritual concerns than actually experience such conversations. Our findings suggest that physicians, nurses, health care organizations, and pastoral care departments may address an unmet need and simultaneously improve patient satisfaction by talking to patients about religious and spiritual concerns in the inpatient setting." ■

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Survival rates unaffected by end-of-life discussions

Results support clinicians who initiate discussions

Discussing and documenting patients' preferences for care at the end of life does not cause them any harm, contrary to recent claims. A new study published in the *Journal of Hospital Medicine* found that patients who talk with their physicians about end-of-life care and have an advance directive in their medical record have similar survival rates as patients who do not have these discussions and documents.

The study included 356 patients admitted at three different hospitals who had low or medium risks of dying within 1 year. Patients were followed from 2003 to 2009. During the study, there were no differences in survival for patients who had end-of-life discussions and those who did not; there also were no survival differences for those who had a living will in their medical record and those who did not.

"Our findings are reassuring. They support health care providers, who can initiate these discussions, and policy makers, who seek to reimburse these time-consuming discussions," said lead researcher **Stacy M. Fischer**, MD, of the University of Colorado School of Medicine. "Most importantly, our findings are reassuring for patients and families who desire these discussions with their health care providers.

"The term 'death panels' has sparked considerable controversy recently. It has undermined the efforts of clinicians who provide end-of-life care by scaring patients into thinking that their lives may be cut short for their families' or society's best interest," added Fischer. "We hope our study provides data to help inform the national debate about advance directives for key stakeholders, health care providers, policy makers, and patients and families." ■

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