Palliative Care and Patient Demographics

Palliative Care and End of Life Patient Population: Any person of any age diagnosed with a serious medical illness. This serious medical illness could be terminal or one that requires long term treatment. The most Common Illnesses include: Cancer, Heart disease, Stroke, Renal disease, Diabetes, Parkinson’s/Alzheimer’s, COPD, AIDS and ALS

• Palliative care is the treatment of a patient with serious medical illness and their family to relieve symptoms and stress related to the illness or the treatment of the illness. The goal of Palliative Care is to improve the Quality of Life (QOL) of the patient and their family by focusing on physical, emotional and spiritual needs.

• Palliative Care is covered by most insurances, including Medicare and Medicaid. Palliative Care can begin at diagnosis and doesn’t depend on prognosis.

• In addition to increasing patient’s QOL, Palliative Care has been shown to increase survival time in patients with some diseases (lung cancer) when initiated early in the disease process.

A Palliative Care Team should be Interdisciplinary and be made up of: A Physician, NP/PA, Pharmacist, Social Worker, Nurses and many times a Chaplain and Music therapist.

On average in the U.S. 67% of hospitals (with 50 beds or more) have a palliative care team, this number is growing nationally.

Economics of End of Life Care

The U.S. population continues to get older on average due to aging of the baby boomers as well as increased life expectancy; therefore, the need to continue to expand palliative present. Palliative care is associated with significantly lower costs compared to inpatient treatment.

• Ciemens et al. analyzed data collected at one large academic medical center and found average daily costs were reduced by 33% and average length of stay was reduced by 30%. Ciemens estimated that these figures resulted in an annual savings of $2.2 million.

• Morrison et al. found that patients who had palliative care had $6,900 less overall in hospital costs compared to usual care patients.

• Patients who received palliative care on average spent less time in ICU, had a lower chance of dying in ICU, and were able to get hospice referrals at higher rates than usual care patients.4

• In addition to lower costs, there is evidence that palliative care is associated with higher satisfaction of care as well as lower ER visits

• Generally speaking, palliative care is covered under Medicare Part B as well as most private insurance companies.

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Palliative Care and End of Life Population Health Clerkship Leaders: Jena Adams and Joanne Calista

Advisors: Jena Adams and Joanne Calista

MOLST and End of Life Discussions

A MOLST form is a medical order documenting a patient’s choices about end of life and the potential use of life sustaining treatments. It is intended to be used when clinicians suspect that a patient may face end of life within the next year. It is important for providers to initiate conversations with patients about goals of care early in the disease process. The MOLST form is intended to be used as a final step in these end of life discussions, once the patient has had time to consider their goals and values, rather than as a tool to initiate or guide such conversations.

While various members of the interdisciplinary care team may engage in end of life discussions with patients, a physician, nurse practitioner or physician assistant must complete and sign the MOLST form with the patient. Once MOLST forms are completed, patient’s choices should be honored in any healthcare setting and by emergency medical services assuming the MOLST form is properly displayed. It is important for patients to understand that they may make changes to the MOLST form at any time.

Disparities, Challenges, and How to Improve

Disparities:

• Lower quality of Palliative Care for minorities across multiple domains: satisfaction, communication, and pain management. As well as access to Palliative Care

• Conversations between physicians and patients are less likely to result in care consistent with patient preferences for minorities

• Studies consistently document lower rates of hospice use in minorities across all diagnosis, geographic areas and settings of care (Overall: 46% Caucasians, 34% of African Americans)

Challenges:

• Disproportionate gap in knowledge about Palliative Care and distrust of health care system among minorities. Misunderstandings about the correct usage and intention of MOLST forms

• Conflicts with spiritual and cultural beliefs regarding end of life care

Ways to Improve:

1. Communication: Open communication between providers and patients. Providers taking responsibility to have these conversations.

2. Education: Physician training on how to approach conversations with patients and patient education on what Palliative Care and Hospice is. Education as to the proper use of MOLST

Hospice Care and Patient Demographics

The goal of hospice is to provide quality compassionate care and symptom relief for seriously ill patients nearing the end of their life. Patients that have a life expectancy of 6 months or less are eligible for hospice care. Hospice care is utilized to ease patient suffering and avoid hospitalizations near the end of life. A hospice care team is interdisciplinary and must consist of at least a physician, nursing staff, social work staff, a chaplain, and volunteer staff.

Hospice care provides: Pain and other symptom management, medication and other medical supplies, emotional and spiritual care, social and grief counseling.

Hospice care is available at home or in an accredited hospice facility. Hospice services are covered by Medicare.

Hospice Care Data from 2015:

• Enrolled Patients: Nearly 1.4 million Medicare beneficiaries were enrolled in hospice care in 2015.

• Age of Patients: 65% of enrolled patients were over the age of 80, 30% between the age of 60 and 65, and 5% were under the age of 65.

• Length of Hospice Stay: A significant number of patients (close to 30%) enrolled for 7 days or less before death.

• Patient Race: A substantial majority of patients enrolled were Caucasian (87%)

Patient Resources

Many non-medical caregivers provide support throughout and after end of life care

• Chaplains: Can be of any faith. Provide emotional, spiritual, and religious support to patients and families. Encouraged to be "board-certified"

• Social Workers: Patient advocates. Provide emotional, social, psychological support to patients and families. Assist the health care team in treating the whole patient, not just the illness.

• Community Support: Many patients and families find support through the community.

• Bereavement Groups: Relating to specific types of lost loved ones (children, cancer patients, etc.)

• Bereavement support often offered for over a year.

Key Takeaways and Next Steps

1. Need to educate the general public about options for end of life care and the best practices for use of MOLST forms

2. Need for education, tools and guidelines for health care providers about how to have end of life conversations

3. Need to empower clinicians to initiate these conversations and develop goals of care as part of providing quality care for patients

References


Hospice Care and Patient Demographics

Palliative and End of Life Care Clerkship Advisors: Jena Adams and Joanne Calista

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