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# BACK TO THE FUTURE: Palliative Care in the 21<sup>st</sup> Century

## Section 3: Hospice 101



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**That's more than healthcare. That's smartcare.**

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***“I’m not afraid of death; I just don’t want to be there when it happens.”***

**-Woody Allen**



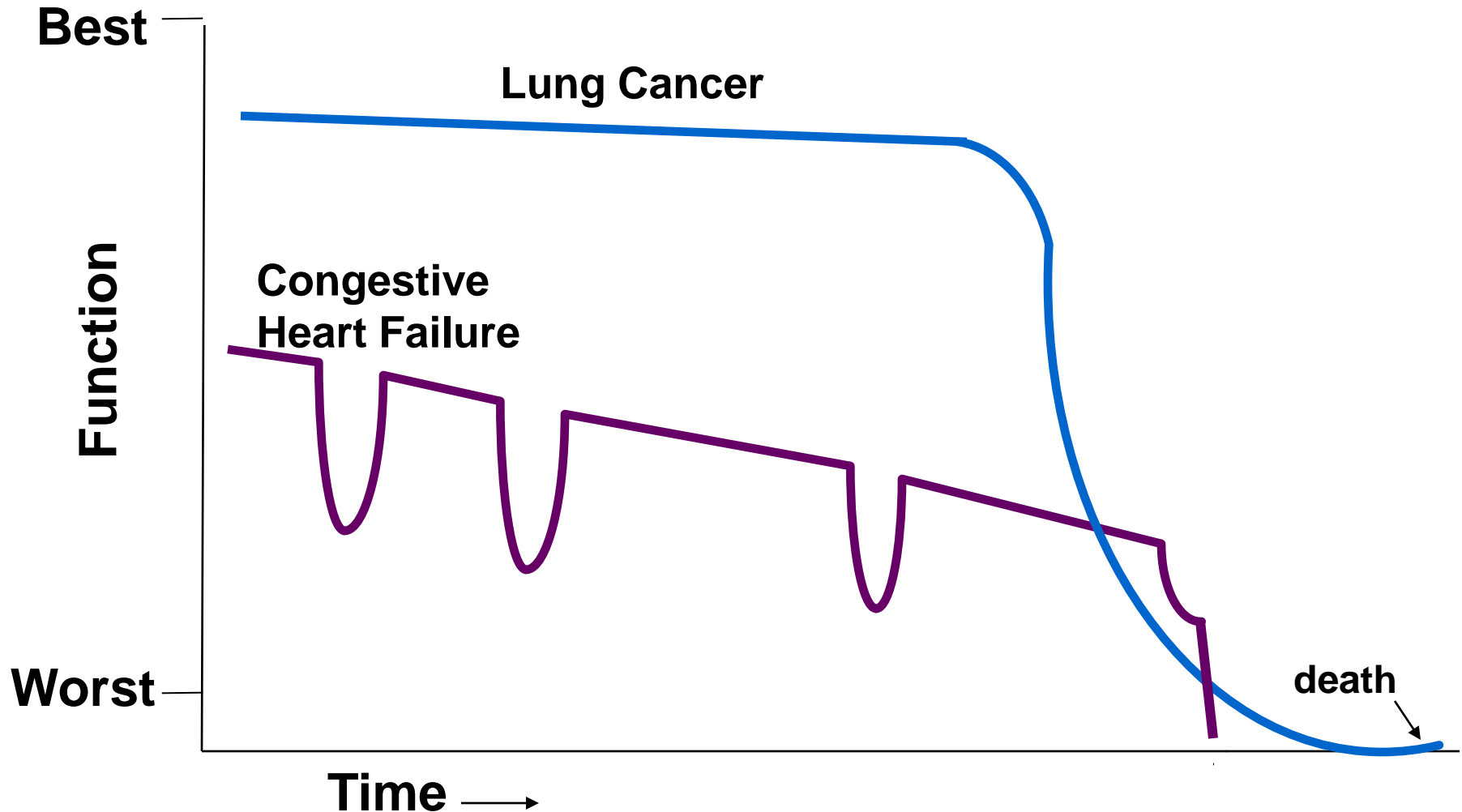
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**That's more than healthcare. That's smartcare.**

# A Century of Change

	<u>1900</u>	<u>2000</u>
<b>Age at death</b>	<b>46 years</b>	<b>78 years</b>
<b>Causes</b>	<b>Infection Accident Childbirth</b>	<b>Cancer Heart Disease Stroke/Dementia</b>
<b>Disability</b>	<b>Not much</b>	<b>Median &gt;4 years before death</b>
<b>Financing</b>	<b>Private, modest</b>	<b>Public and substantial- 75% in Medicare ~1/3 of Medicare</b>

# Trajectory for Dying of Lung Cancer Cancer or Congestive Heart Failure



# Short Term Predictions Are Difficult

- We've gotten better at keeping people alive for a longer with their (eventual) fatal illness
- Physicians tend to underestimate  
(By months) survival for heart and lung disease
- We tend to overestimate (by weeks to months) for cancer

## Successful resuscitation after cardiac arrest:

- 85% according to the lay public
- 67% on television
- 30% overall
- 0-5% in the elderly, debilitated, chronically ill



- **90% of respondents to NHO Gallup survey want to die at home**
- **Death in institutions**
  - 1949 – 50% of deaths
  - 1958 – 61%
  - 1980 to present – 74%
    - 57% hospitals, 17% nursing homes, 20% home, 6% other (1992)

# Shift in focus...

- Shift in *location* of dying had an impact on the *nature* of dying
- Increased focus on science, technology & cure
- Marked shift in values
  - “death denying”
  - Increased value on productivity, youth, & independence
- Fragmentation of care
- Minimal psychosocial and spiritual support



# Perverse Incentives: How We Finance Health Care

- **We like things that are NEW**
  - **A 2% increase in survival with a 2000% increase in cost is all that is needed for a new treatment to become the “standard of care”**
- **We like PROCEDURES**
  - **Much, much easier to get a hip replacement or bypass than to get someone to help Mrs. Jones with a bath**

# The Tradeoff:

- **No money left for basic care**
  - Home care
  - Aides
  - Simple medicines to provide comfort
  - Simple equipment in the home
- **Our medical-industrial complex is much more in love with high tech solutions**

# Poor Communication About Death and Dying

- We do not share our fears and desires with our loved ones or our doctors
- No real agenda for discussion
- Advance directives are inadequate in Ohio
  - Living wills
  - Durable power of attorney for healthcare
  - New “portable” DNR form

# Results of Denial and Poor Communication:

- **Lost opportunities:**
  - Goodbyes
  - Reconciliation
  - Affairs not in order
- **Inappropriate care**
- **Spiritual concerns not addressed**

# Other Issues...

- **Social Isolation & Fragmentation**
- **Caregiving**
- **Financial Pressures**

# Summary of the Challenges We Face:

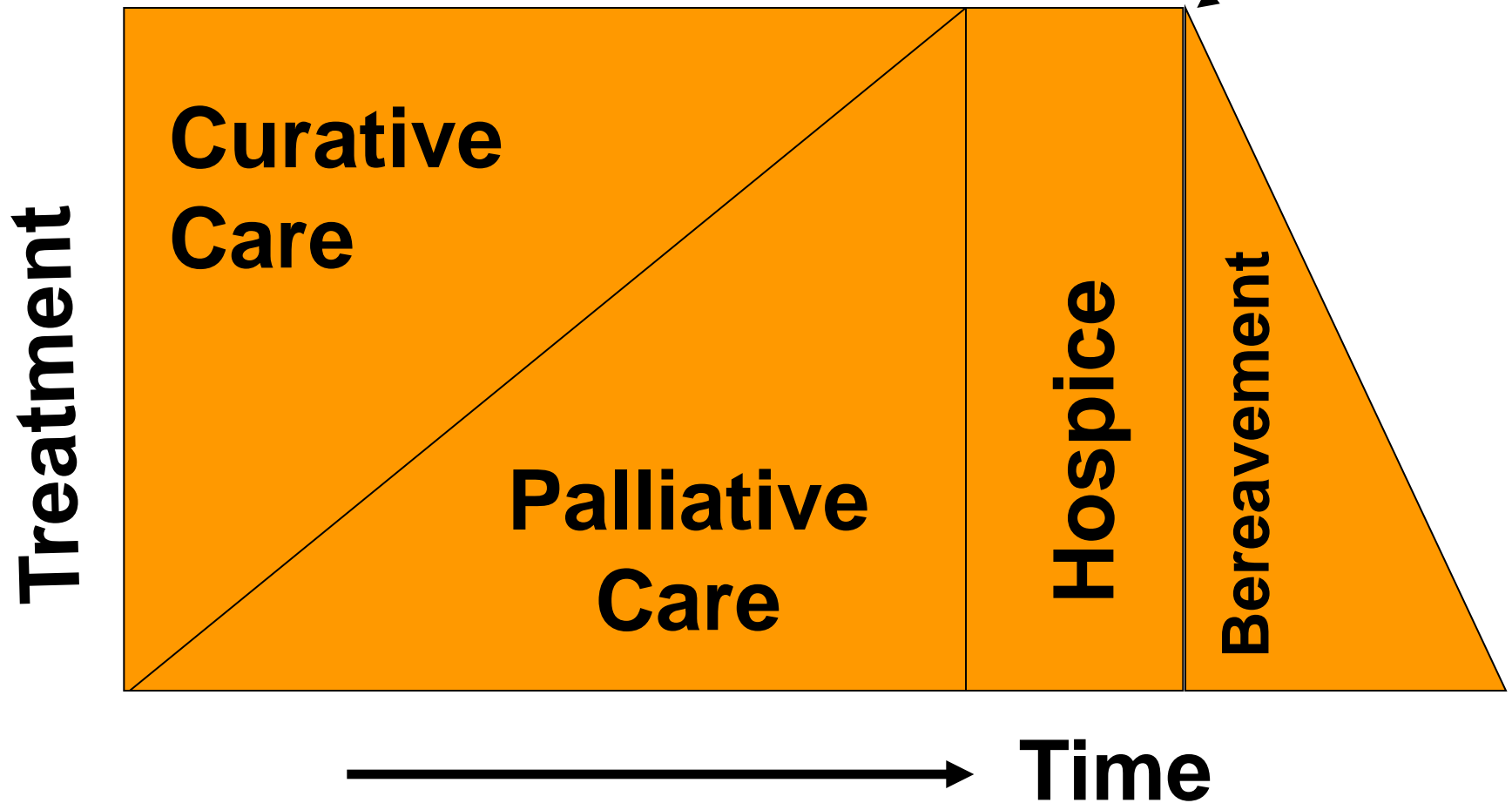
- **Living longer with chronic illness**
- **Aging, isolation, caregiver issues**
- **Denial of death**
- **Communication inadequate (poor tools)**
- **Financing of care/medical-industrial complex**
- **Lack of education**

# Current: Cure vs. Care Model



# Proposed: Integrated Model

Death







**“End-stage chronically ill patients do NOT need intensive care...”**



**“...they need intensive *caring*”**

# What is Hospice?

- **A system of care for terminally ill patients who meet Medicare's criteria of a six-month or less (approximate) prognosis. Care is holistic and is delivered by an interdisciplinary team.**
- **The majority of care is delivered in the patient's place of residence.**
- **ALL hospice care is palliative care**

# What Is Palliative Care?

- **Comprehensive management of a patient's physical, psychological, social, and spiritual needs. It can be part of the treatment of any person with a serious or life-threatening condition for which a patient-centered approach, pain and symptom control and compassionate care is needed.**
- **Palliative care is available for any patient who needs and desires it at *any* course in their illness**
- **NOT all palliative care is hospice**

# Palliative Care vs. Hospice



	<b>Palliative Care</b>	<b>Hospice</b>
<b>Place</b>	Hospital/ECF	Home (> 90%)
<b>Timing</b>	No time restrictions	Within 6 mos of death
<b>Payment</b>	Regular medical insurance Specialist visit	Medicare Hospice Benefit 100% covered Private Insurance – Varies
<b>Treatment</b>	Comfort-oriented Curative treatment allowed	Comfort-oriented Curative treatment not allowed

*In other words...*

**All Hospice is  
Palliative Care,  
but not all  
Palliative Care  
is Hospice**



# History of Hospice

- **Today's hospice grew out of a movement, which began in England during the 1960's.**
- **During this time, medicine was rapidly changing with many cures and vaccinations being found; thus treatments and research focused on cures.**
- **Dame Cicely Saunders, a British physician, noticed dying patients were put at the end of the hall and hospital staff did not know how to care for their medical, spiritual, emotional and psychosocial needs.**
- **Dr. Saunders founded the Modern Hospice movement.**

# History of Hospice

- **1963 – Dr. Saunders introduced the idea of specialized care for the dying to the United States.**
- **1965 – Florence Wald, then Dean of the Yale School of Nursing, invites Saunders to become a visiting faculty member of the school.**
- **1967 – The first modern hospice, St. Christopher’s was founded in England.**
- **1969 – Elizabeth Kubler-Ross, wrote “On Death and Dying” and gave impetus to the movement in the U.S.**
- **1974 – The first hospice in the United States began in New Haven, Connecticut.**
- **1983 – Medicare began offering a hospice benefit.**
- **1986 – Hospice benefit offered to terminally ill patients in Nursing Homes.**



# Some Hospice Stats...

- **90% of Americans want to die at home.**
- **Of the 2.4 million Americans who die each year, less than 25% die at home.**
- **Of the 930,000 patients who receive hospice care, over 70% die at home.**
- **4 out of 5 hospice patients are age 65 or older – and more than 1/3 of all hospice patients are 85 years or older. 16.5% are 35 – 64 years.**

# Some Hospice Stats...

- **Hospice care may prolong the lives of some terminally ill patients.**
  - Mean survival was 29 days longer for hospice patients than non-hospice patients.
  - A longer length of survival between hospice and non-hospice patients was observed in congestive heart failure (81 days), lung cancer (39 days), pancreatic cancer (21 days) and colon cancer (33 days).
- **41.3% of hospice admissions are for cancer and 58.7% are for non-cancer diagnoses; with top four being: heart disease, debility-unspecified, dementia-including Alzheimer's Disease and Lung Disease.**

# Hospice Philosophy

- **Hospice is a concept of care, not a place**
- **Hospice neither hastens nor postpones death**
- **Patient and family are the unit of care**
- **Care is holistic**
- **Hospice affirms life**

# Medicare Hospice Benefit Interdisciplinary Team (IDT)



- Patient's MD/DO
- Hospice Physician
- RN Case Manager
- Hospice Aide
- Social Work
- Spiritual Care
- Massage Therapy
- Volunteer Services
- PT, OT, ST, RT, as appropriate

# Medicare Hospice Benefit

## Levels of Care

- **Routine Home Care**
- **Continuous Home Care** - crisis management of acute symptoms; a minimum of 8 hours of nursing care in the home each day
- **General Inpatient Care** - pain and symptom management in an in-patient hospice or in contracted hospital beds
- **Respite Care** - for up to five days at a time in an in-patient unit or extended care facility

# Medicare Hospice Benefit

- **Patient may revoke the benefit at any time**
- **May resume at any time with recertification**
- **Currently recertified regularly while on the benefit**
- **Most private insurers now offering some form of hospice benefit**

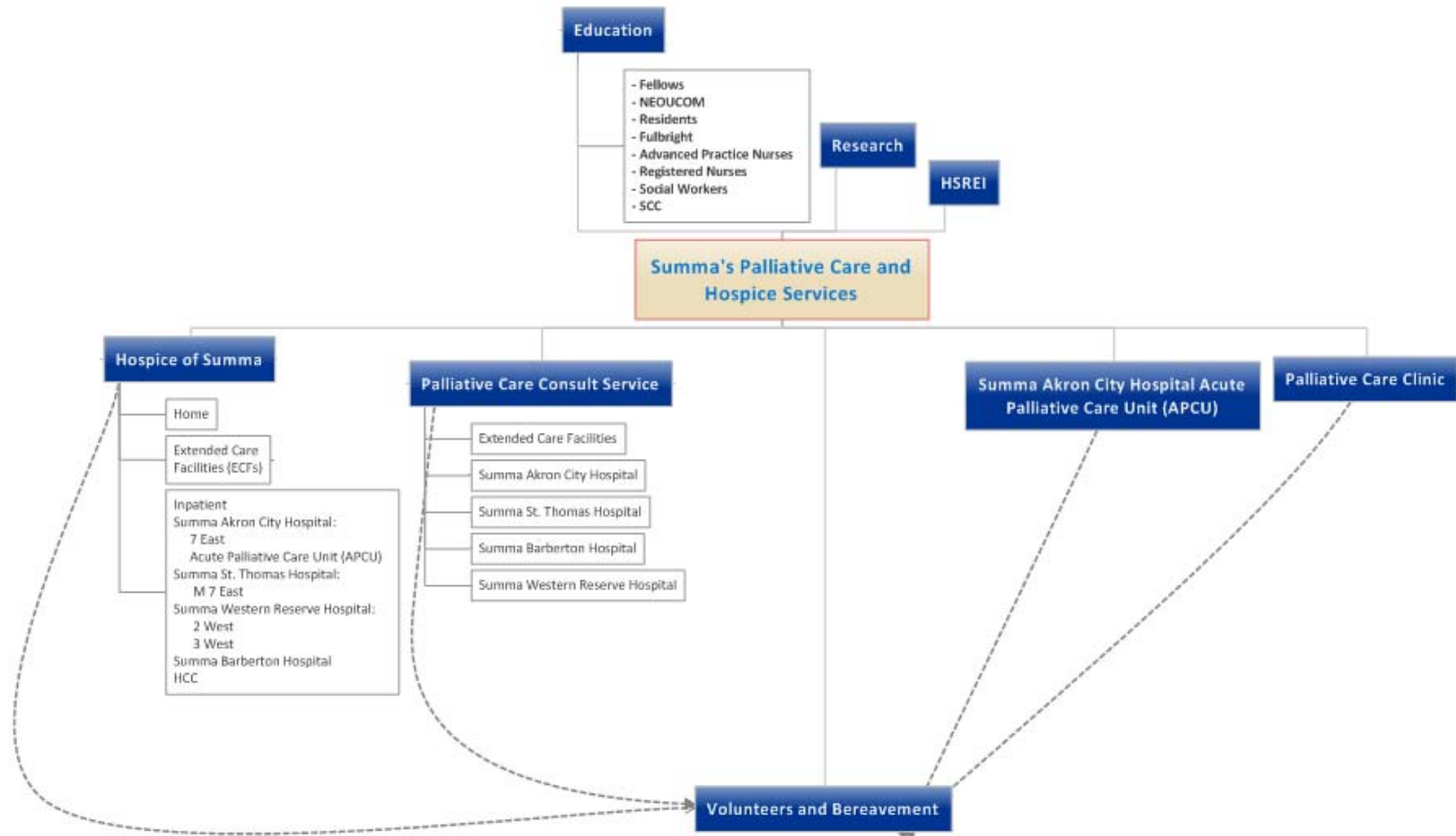
# Admission Diagnoses

- **Cancer**
- **Cardiovascular Diseases**
- **Congestive Heart Failure**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Renal Disease**
- **Dementia or Alzheimer's Disease**
- **Neurological Disease (Parkinson's, ALS, etc.)**
- **Acquired Immune Deficiency Syndrome (AIDS)**
- **Liver Disease**

# Hospice of Summa History

- **In October, 1998 program development started.**
- **In July, 1999, the program was Medicare-certified and JCAHO-accredited.**
- **In December 2002, Summa's Palliative Care Consult Service was established.**
- **In August, 2006, new Acute Palliative Care Unit at Akron City Hospital opened.**
- **Hospice of Summa is under the umbrella of "Summa's Palliative Care and Hospice Services"**





## VISION

**To be the premiere regional provider of  
Palliative Care & Hospice Services**

## VALUES

- **Uncompromising, interdisciplinary, team-based, quality care is provided to our patients and those who love and care for them.**
- **Supportive services are delivered through cost-effective means promoting comfort, dignity and the opportunity to live each day to the fullest.**
- **Education and support are provided to team members and other professionals in recognition of the challenging and unique nature of this work.**

# Acute Palliative Care Unit (APCU)

## **12 Bed Inpatient Unit- Akron City Hospital**

- **Rooms all private**
- **24-hr visitation**
- **Family rooms**
- **Kitchen and shower for family**

## **Patients Served:**

- **Patients with progressive neurologic, renal, cardiac, respiratory and oncologic illness**
- **Actively dying patients**
- **Hospice in-patients for pain and symptom management**

**“You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die”**

**Dame Cicely Saunders  
1918-2005**