

Palliative Care Center Now Open

Mark M Murray, President & CEO

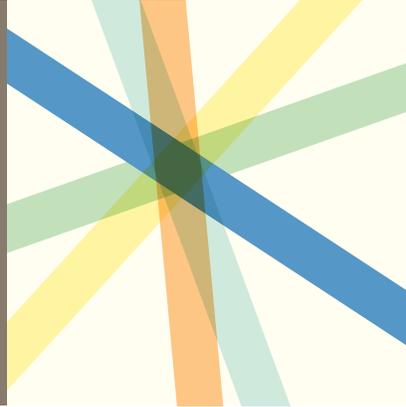
As the first and most experienced hospice program in the region, Center for Hospice Care (CHC) has been the preferred choice for area families and referral sources for more than 30 years. A longtime proponent for interdisciplinary care across the spectrum of needs for those with life-limiting illnesses, we provide palliative care, hospice care, grief / bereavement intervention services, and educational programming for the entire community. Our mission is to improve the quality of living. Everything we do is intended to enlighten patients and families to the choices available for them to make the most of life.

At CHC, palliative care is provided primarily in the residential home setting under our home health license for patients with advanced progressive illness who are continuing to pursue curative, life-prolonging treatments. The goal of CHC palliative care services is to help patients and their families improve the rest of their lives by improving the prevention and relief of suffering. This is accomplished by early and repeated assessments and treatment of their pain and other physical, psychological, and spiritual needs. Palliative Care is the "quality add-on" to the patient's regular medical care and does not replace it. We work closely with the attending physician to monitor progress while attempting to decrease repeat hospitalizations.

CHC, committed to expanding its palliative care services, recently opened the Palliative Care Center at Edison Lakes in Mishawaka. This new space is for palliative care consultations where our board certified hospice and palliative care physicians are available to assist attending physicians as we address the goals and concerns of individuals with life-limiting illnesses. We also support the patient's relationship with the attending physician. The consultation offers the patient and family an opportunity to talk about priorities regarding care. With specialized training in the clinical, emotional, and spiritual dimensions of pain and symptom management, CHC staff is uniquely qualified to offer valuable assistance around end-of-life care decision making.

CHC palliative care consultations provide options and choices for appropriate palliative treatment plans. This may be accomplished by medical history, physical examination, obtaining and interpretation of health data, the recommendation of appropriate medications, and routine and diagnostic studies. We inform the referring physician of services provided, treatments recommended, and provide a written

hospice & physician
team
newsletter



newsletter



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President & CEO*

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choices to make the most of life

Prelude to Palliative

Dr. Gregory Gifford, MD JD, AMBS



Gregory Gifford, MD JD, AMBS Board Certified in Palliative Medicine, Chief Medical Officer, Center for Hospice Care

Gregory Gifford is board certified in both hospice and palliative medicine and in emergency medicine. After earning an undergraduate and medical degree from Indiana University, he completed a rotating internship at St. Joseph Medical Center in Denver, CO and an emergency medical residency at Michigan State University, where he was chief resident. An interest in law led him to earn a law degree during the day while working nights at the Ingham Medical Center in Lansing, MI. After that, he became Chief of Staff and Bioethics Committee Chair at the Castle Medical Center in Ulikaiki, HI. While working in emergency medicine, he became interested in hospice and palliative care and became board certified through AAHPM in 2001. Dr. Gifford's principal interests today are improving end-of-life care for patients and families along with addressing medical as well as ethical and legal issues.

"Palliative Care (PC) Extends Life, Study Finds," New York Times, 8/18/10 and, "Study: Advanced Cancer Patients Receiving Early Palliative Care Lived Longer," Wall Street Journal, 8/18/10.

The headlines above resulted from a recently-published New England Journal of Medicine study, "Early Palliative Care of Patients with Metastatic Non-Small-Cell Lung Cancer," (NEJM: 2010; 363:733-742.) This was a randomized controlled three-year study at Massachusetts General Hospital on 151 patients with newly diagnosed Stage IV non-small cell lung cancer.

Half of the patients (the Palliative Care group) received early-onset scheduled consultative PC visits by a team of Board-Certified Palliative Care physicians and APRNs. The other half (the control group) had a PC visit only at the oncologist's request (14% of the control group patients did receive a requested PC evaluation). The two groups had similar demographic, prognostic, and disease-specific factors (including EGFR cancer status) and QOL & mood determinations.

Periodic measurements of quality of life and psychological morbidity demonstrated that early-onset Palliative Care increased both QOL and psychological well-being of patients and their families/caregivers. What was *not* expected was that the PC group of patients lived on average 2.7 months longer than the control group. From the article:

"Despite receiving less aggressive end-of-life care, patients in the palliative care group had significantly longer survival than those in the standard care group (median survival, 11.6 vs. 8.9 months; P=0.02)."

The PC group of patients also had a trend toward decreased chemotherapy utilization, decreased hospitalization, decreased ER visits, and increased rates of hospice utilization and deaths at home on in an inpatient hospice facility.

This study is of particular meaning to us at Center for Hospice Care (CHC) because we now have a separate Palliative Care Center and consultation service, staffed by the only two ABMS Board Certified Palliative Care physicians in North Central Indiana.

We weren't too surprised by the increased longevity of the PC group because we've noticed that people tend to "do" better when their most troublesome symptoms are optimally treated. Knowing they have doctors and nurses whose only goal is to help them *feel* better can actually help them "be" better.

Primary providers or oncologists may feel that they themselves already address these palliative issues. The control group oncologists in this study probably felt that way, too. However, the perspective/point of view of the Palliative Care physician is *different* from that of the oncologist. The real lesson here probably is that *both* their perspectives definitely add value, and perhaps even longevity, to the cancer patient.

Please think of our Palliative Care Center availability and this study when you first diagnose a patient's cancer, when you order consultations, and make referrals.

palliativecarecenter

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Phone: 574.243.3712

Hospice Stats at a Glance

How long do most patients receive care?

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay). Length of service can be influenced by a number of factors including disease course, timing of referral, and access to care.

The median (50th percentile) length of service in 2008 was 21.3 days, an increase from 20.0 in 2007. This means that half of hospice patients received care for less than three weeks and half received care for more than three weeks. The average length of service increased to 69.5 days (from 67.4 in 2007) (see chart).¹

Short and Long Lengths of Service

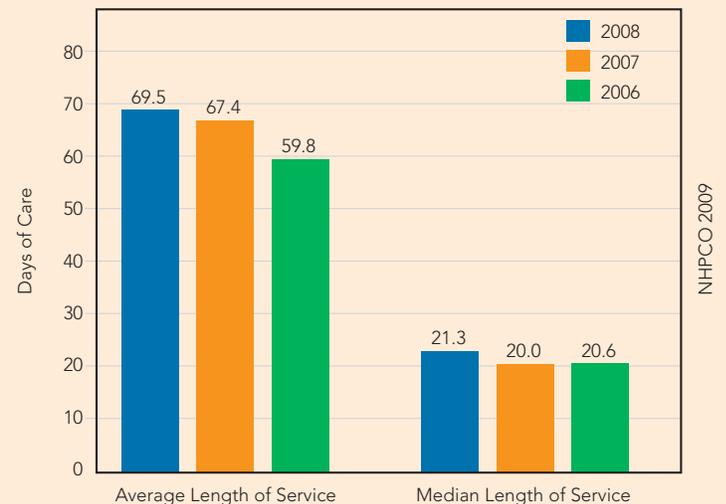
In 2008, approximately 35.4% of those served by hospice died or were discharged in seven days or less, and 12.1% died or were discharged in 180 days or more.

Impact of Hospice Care on Survival

Hospice care may prolong the lives of some terminally ill patients. In a recent study, the mean survival was 29 days longer for hospice patients than for non-hospice patients.² In other words, patients who chose hospice care lived an average of one month longer than similar patients who did not choose hospice care. Researchers selected 4,493 terminally ill patients with either congestive heart failure or cancer of the breast, colon, lung, pancreas, or prostate. They then analyzed the difference in survival periods between those who received hospice care and those who did not.

Longer lengths of survival were found in four of the six disease categories studied. The largest difference in survival between the hospice and non-hospice cohorts was observed in congestive heart failure patients where the mean survival period jumped from 321 days to 402 days. The mean survival period also was significantly longer for the hospice patients with lung cancer (39 days) and pancreatic cancer (21 days), while marginally significant for colon cancer (33 days).

Length of Service by Year



¹ Length of service can be reported as both an average and a median. The median, however, is considered a more meaningful measure for understanding the experience of the typical patient since it is not influenced by outliers (extreme values).

² Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within a three-year window. *J Pain Symptom Manage.* 2007 Mar;33(3):238-46.

(Continued from cover)

report. In partnership with the attending physician, a palliative care consultation may include evaluation of the patient care plan and the suggestion of potential revisions to that plan based upon the patient's response. Because of our mission, we pledge to treat all patients and families with respect and compassion, involve them in the care planning process, and support their social and spiritual needs. When appropriate, CHC will also explain and assist with the determination of palliative care eligibility in the home setting as well as provide information on all end-of-life care options and choices.

Patients of any age who are facing a progressive life-limiting illness are eligible for a palliative care consult. This includes patients who may be receiving curative treatments, chemotherapy, radiation, or dialysis. Patients with a prognosis of greater than six months, and when hospice care is not appropriate, are eligible. In fact, this patient population is ideal for palliative care consults. Because this is an addition to the care they are currently receiving, nothing needs to be discontinued to qualify for a visit to our Palliative Care Center. Consultations are covered by Medicare, Medicaid,

commercial insurance, and self-pay. Patients with limited resources may qualify for discounted services.

Currently in the U.S. there are a limited number of physicians who are Board Certified in Palliative Medicine. Nationwide, just 1,271 passed the exam by the American Board of Medical Specialties during its most recent offering of the boards in 2008. Two of them are available for palliative care consultations at the new Palliative Care Center. They are, CHC Chief Medical Officer, Gregory C. Gifford, MD, JD, Diplomate ABEM, Board Certified in Hospice and Palliative Medicine, and, Jon B. Kubley, MD, Diplomate ABFM, Board Certified in Hospice and Palliative Medicine.

Initially, the Palliative Care Center is accepting appointments Tuesdays and Thursdays from 2 - 4 PM. This is a physician referral only and a by appointment only service. To refer a patient to the Palliative Care Center, call 574-243-3712. Or, for more information contact our Chief Medical Officer, Gregory C. Gifford MD, JD, by calling 800-413-9083.

National Survey Finds 'Dire Need' for Palliative Care Training of Neurology Resident Physicians

Palliative care and symptom management play a central role in the care of patients with neurologic disease...

Current literature shows that only 52% of neurology residency programs offer a didactic experience in palliative and/or end-of-life care and fewer than 8% of programs provide residents with clinical rotations.

That is according to the authors of a study designed to assess the basic palliative care knowledge of neurology residents. Their preliminary findings are published in the *Archives of Neurology*.

The authors write, "Palliative care and symptom management play a central role in the care of patients with neurologic disease...It is, therefore, surprising that such a pervasive theme is inadequately addressed during neurology residency training."

One-third of neurology residency programs (n=34) agreed to participate in the survey, with one-fifth of residents nationwide (n=338) completing questionnaires.

Residents were asked questions about several main components of palliative care. Key findings include:

- **Commonly used medications:** 14.6% of residents were able to correctly answer a question about the half-life of the commonly used intravenous medication lorazepam in patients who are not in organ failure.

- **Hospice and Medicare:** 24.1% of respondents correctly answered a question regarding Medicare reimbursement for patients enrolled in hospice.
- **Medical decision-making capacity:** 55% of residents correctly identified requirements for determining whether a patient is capable of making his or her own medical decisions.
- **Advance directives:** 77.7% of respondents correctly answered a question regarding validity and changes to advance directives.

"The results of this preliminary study support earlier studies and confirm the dire need to enhance palliative care education of neurology resident physicians, who play a vital role in the care of patients faced with a life-threatening, life-limiting, and/or life-changing disease," the authors conclude.

Source: "Are Neurology Residents Prepared to Deal with Dying Patients?" *Archives of Neurology*; November 2009; 166(11): 1427-1428. Creutzfeldt CJ, et al; Department of Neurology, University of Washington, Seattle.

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