hospice & physician

team

newsletter

newsletter

Mark M Murray
President & CEO

Patients with an advanced serious illness affecting their quality of life or causing them significant discomfort may benefit from a palliative care consultation.

Outpatient Palliative Care Clinic Now Accepting Referrals

Mark M Murray, President & CEO

Center for Hospice Care is pleased to announce the region's first freestanding, independent palliative care outpatient clinic is now open and accepting patients. The Center for Palliative Care is now accepting appointments via physician referrals for palliative care consultations. The consultation program is specifically developed to address the complex symptom management needs of your patients with advanced serious illnesses. The program is staffed by Nurse Practitioners in collaboration with our own physician medical directors, two of which are board certified in hospice and palliative medicine.

The palliative care consultation program is structured to enhance the care provided by area primary care providers and specialists to offer expert evaluation of a patient's needs along with suggestions to assist referring physicians in managing those needs. Following a consultation, we report back to the referring physician with our observations and recommendations. They continue managing the patient's care.

Benefits of Palliative Care Consultation

Center for Palliative Care's consultation program is beneficial for patients who:

- Require specialized management of uncontrolled symptoms caused by advanced serious illness or the side effects of treatment
- Have co-morbidities that are challenging to address during a short office visit
- Frequently call the office with recurring concerns that are difficult for your staff to sort through and address
- Often go to the ER or are hospitalized due to uncontrolled pain or other symptoms
- Have been released from the hospital or a rehabilitation facility and are having difficulty managing their condition at home
- Under-report the severity of their condition, or the difficulty of their living situation, when visiting the doctor's office
- Have caregivers who are struggling to understand or manage the patient's illness
- Are likely on an eventual trajectory toward hospice care within the next two years
- Want to explore their goals of care or make their end-of-life care wishes known

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Center for Hospice Care

choices to make the most of life™

On Point for Palliative Care

by Brian Moloney, M.D.

Let us start with three brief case histories.

1) 81 year-old man with known metastatic lung cancer who had a unilateral pneumonectomy. Shockingly, he had to be re-admitted shortly after discharge, was intubated that same day, and lived for three months on a ventilator until the family decided to stop.

2) A man in his 80s with chronic renal failure, oxygen dependent end-stage COPD, class IV congestive heart failure, and multiple myeloma who was being hospitalized once or twice per month for the previous year with various complications. During the hospitalization that I knew about, he had a feeding gastrostomy tube inserted because he could not swallow well enough to meet his caloric needs. Because he insisted on trying to eat, he aspirated a chunk of meat, arrested, and was intubated. He eventually did go home to be re-admitted again.

3) 82 year old man with oxygen dependent end stage COPD, inoperable lung cancer (although he had not had the benefit of meeting the surgeon from case #1), colon cancer, and atrial fibrillation treated with warfarin despite two upper gastrointestinal bleeds related to alcoholism. Less than a few weeks before his death, his oncologist started him on a new chemotherapy regimen.

The first was a patient I learned about because he was an ACO re-admission. The second was a patient I encountered supervising the residents on staff medicine. The third was my father.

When one considers these three cases, there are a number of aspects that could be discussed. I am going to choose two.

The first is informed consent. This really occurs in many spheres of life – for example getting an estimate from a roofer, a plumber, or a mechanic. In addition to the price, you want to know everything else associated with the transaction – time frame, inconvenience, warranty, the cost of replacement instead of repair, and so forth. You get angry if there are any surprises. Informed consent has a special meaning in medicine. Too often it is only looked at as a medical-legal protection. Actually it is a comprehensive, easily understood contract, written or implied, through which the patient is able to judge the risks and benefits of a procedure, treatment, or medication as well as the risk and benefit of alternatives including doing nothing at all. CMS includes several specific questions about this in their CAHPS survey. Just as no care giver would ever want to endure the protracted deaths occurring daily in our hospitals, any medical person would insist on knowing every fact, statistic, and nuance before making a critical health care decision. I can only speculate on the depth and breadth of the informed consent with the first two patients. With my father, it would be better characterized as "misinformed consent."

The other area of concern is treating organ systems instead of people. Too often in our medical system, a complaint is addressed by the appropriate specialist without considering the human host in total. This is exacerbated now with most of the inpatient care being given by hospitalists who neither know the patient, the family, and the social situation nor have the "ownership" acquired through a longitudinal relationship. The specialists do not have easy access to the primary care provider who can supply that important history and can help with true informed consent.

When it comes to end of life decisions, we should provide the information and opportunity to have a death with dignity. Our current system actually rewards financially and protects medico-legally the practice of "treating organ systems" without true informed consent. Think of those three cases. It is often salesmanship rather than a dispassionate presentation of options. As my father's oncologist said, "If we do nothing, you're going to die. If we try this, who knows?"

There needs to be a paradigm shift in the way the country views the end of life. Too many patients seem to think with good medical care, death is optional. There needs to be an enormous raising of consciousness about the importance of planning for a painless death with dignity. Social media can help this. Palliative care needs to be taught in medical and nursing schools. Palliative care programs need to be at the forefront of every hospital. Studies show that the influence of the palliative care team inversely correlates with the number of empty beds. Palliative care is concurrent with standard medical care. This is not an either/or question. The real questions are "What are your goals? How can we work together to achieve them?" The term hospice care needs to be "managed up." Physicians and patients need to realize that hospice is a concept, not a location. In our society, people often do not avail themselves of the many benefits of hospice until it is too late. Typically patients are in hospice for three days. They were in ICU for a lot longer.

The unknown is always scary. Try walking down an unfamiliar dark big-city street and see how you feel. Add light and you feel better. Palliative care can shed that light on an inevitable but unknown situation, easing the anxiety and the pain. This will decrease the desperate cries for help which lead to ER visits, tests, and futile therapy. Many medical students tend to follow the money, which is why so few go into primary care and almost none into palliative care. This also needs to change. There are specific CPT codes for palliative care, but much more can be done to make palliative care the standard and not a fall-back.

Dr. Moloney was a family practitioner for 35 years and is now the Medical Director of Select Health Network.

Outpatient Palliative Care Clinic Now Accepting Referrals (cont.)

Palliative care is a holistic approach to caring for patients with potentially life-limiting illnesses. We can help improve the quality of life for patients and their families by addressing the discomforts and stressors commonly associated with serious illness. Patients with an advanced serious illness affecting their quality of life or causing them significant discomfort may benefit from a palliative care consultation.

The Center for Palliative Care opened in late September.

When should a Palliative Care Consultation Be Considered?

These are some of the clinical indicators that would trigger a palliative care consultation:

Advanced Disease Processes:

Advanced CHF (NYHA III – IV)
Advanced COPD
Advanced neurodegenerative disease (dementia, Parkinson's, ALS)
Cancer (active, metastatic, recurrent)
Cardio-respiratory arrest with cerebral hypoxia, anoxia
ESLD
ESRD
Shock with MODS
Stroke with at least 50% decreased functional ability

Exacerbating Factors:

Bed-bound, dysphagia, functional decline, weight loss, pressure ulcers
Complex medical decision making, family disagreements, conflicts about care
Hemodialysis
Liver Disease
Moderate CHF, CAD to severe valvular disease, cardiomyopathy
Pulmonary hypertension
Renal disease

Other Patient Circumstances to Consider:

A life-limiting illness
Frequent visits to the ER for symptom management
More than one hospital admission for the same diagnosis within the last 30 days
Unacceptable level of pain >24 hours
Uncontrolled symptoms (dyspnea, nausea, vomiting, anxiety, agitation)
Patient and Family Decision-Making Support:
Advance care planning
PEG tube for artificial nutrition
Tracheostomy for prolonged mechanical ventilation
Withdrawal of ventilatory support

Center for Palliative Care Contact Information and Location

Office Hours:

Flexible and by physician referral and appointment only

Office Location:

211 North Cedar Street • Mishawaka, IN 46545

Telephone:

(574) 367-2476

Website:

www.cfhcare.org/cpc

An Open House was held at the Center for Palliative Care on September 13th. Center for Hospice Care staff were on hand to give tours and answer questions about the purpose of the new facility.

Our new outpatient clinic, Center for Palliative Care, is the first step toward the realization of a comprehensive suite of palliative care services. We plan on providing a well-developed, community-based palliative care program during the second half of 2017. To make this possible, we are currently in the process of ramping up our clinical team and adding additional members.

Center for Hospice Care

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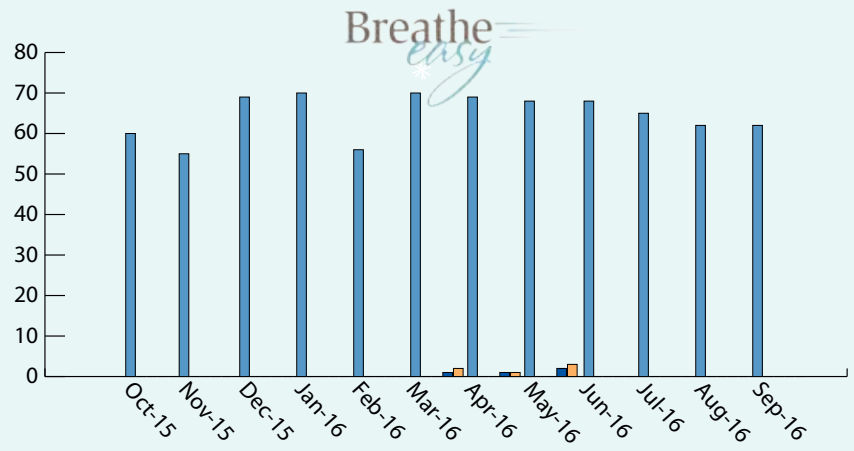
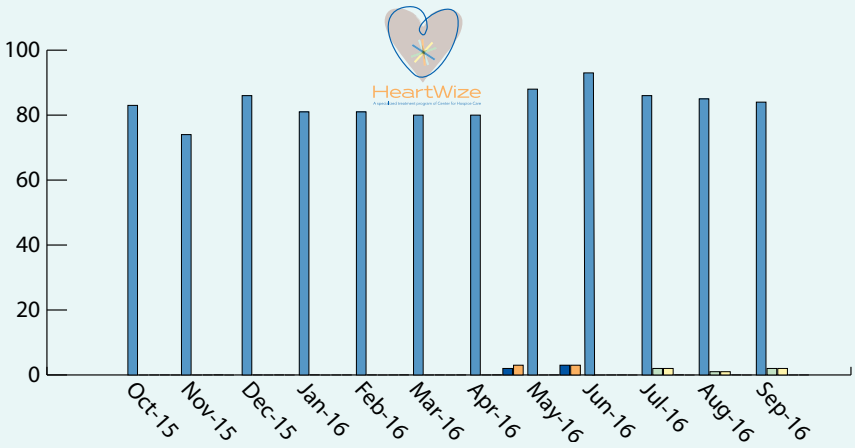
111 Sunnybrook Court
South Bend, IN 46637

Avoid Hospital Readmissions with CHC's Exclusive Programs





Center for Hospice Care has developed innovative programs to help meet the needs of our patients, including HeartWize for advanced heart disease and BreatheEasy for COPD. Each program addresses the unique needs of patients affected by these diseases. Diseases of the heart and lungs now comprise 38% of the diagnoses for the more than 2,000 patients seen by CHC each year. Our specialty programs take an interdisciplinary approach and include the use of emotional and spiritual support for the patient and family.

CHC has seen great success with both programs, particularly BreathEasy for COPD and HeartWize for CHF, particularly in the area of reducing hospital readmissions. Now, we have a year's worth data to prove it and we're pleased to present it here.

- Number of patients in the program
- Number of patients who sought breathing/heart related care in the Emergency Room
- % of patients who sought breathing/heart related care in the Emergency Room
- Number of patients who were hospitalized related to breating/heart difficulties
- % of patients who were hospitalized related to breathing/heart difficulties