Three major studies paint a grim picture of the experience of dying:

Field & Cassel, 1997; Last Acts, 2002; SUPPORT, 1995

Highlights of studies:
- Shortcomings in care of seriously ill hospitalized patients
- Lack of knowledge by health care professionals in pain & symptom management
- Communication barriers regarding goals of care
- Frequent use of aggressive curative treatment in advanced disease
- Average length of stay in hospice less than one week (NHPCO, 2009)
Death and Dying in America (cont.)

- Disparity between the way people die/the way they want to die
- Patient/family perspective

Egan & Lusyak, 2006; Field & Cassel, 1997

The Need for Improved Palliative Care

- Late 1800’s
- Early to mid 1900’s

Field & Cassel, 1997; Saunders 2004

Cause of Death, Demographic and Social Trends

<table>
<thead>
<tr>
<th>Medicine’s Focus</th>
<th>Early 1900s</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause of Death</td>
<td>Infectious Diseases, Communicable Diseases</td>
<td>Chronic Illnesses</td>
</tr>
<tr>
<td>Death Rate</td>
<td>17.20 per 100,000 (1900)</td>
<td>8.00 per 100,000 (2004)</td>
</tr>
<tr>
<td>Average Life Expectancy</td>
<td>50</td>
<td>78</td>
</tr>
<tr>
<td>Site of Death</td>
<td>Home</td>
<td>Institutions</td>
</tr>
<tr>
<td>Caregiver</td>
<td>Family</td>
<td>Stranger/Health Care Provider</td>
</tr>
<tr>
<td>Disease/Dying Trajectory</td>
<td>Relatively Short</td>
<td>Prolonged</td>
</tr>
</tbody>
</table>

Administration on Aging, 2010; Kochanek et al., 2011; Minino et al., 2009
Differences in Cause of Death

- Age
- Race
- Ethnic origin
- Disparities

Field & Cassel, 1997; Yabroff et al., 2004

Illness/Dying Trajectories
Sudden Death, Unexpected Cause

< 10% (MI, accident, etc.)

Field & Cassel, 1997

Illness/Dying Trajectories
Steady Decline, Short Terminal Phase

Field & Cassel, 1997
Illness/Dying Trajectories
Slow Decline, Periodic Crises, Death

Health Status
Decline
Crisis
Death
Time

Field & Cassel, 1997

Illness/Dying Trajectories
Lingering, Expected Death

Health Status
Frailty
Death
Time

Lunney et al., 2003

What is Palliative Care?

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any stage and at any age in a serious illness, and can be provided together with curative treatment.

History
General Principles of Palliative Care

- Patient and family as unit of care
- Attention to physical, psychological, social and spiritual needs
- Interdisciplinary team approach

www.nationalconsensusproject.org

General Principles (cont.)

- Education and support of patient and family
- Extends across illnesses and settings
- Bereavement/grief support for families and staff

Panke & Ferrell, 2010; Corless, 2010

Quality Care Barriers at the End of Life

- Failure to acknowledge the limits of medicine
- Lack of training for healthcare providers
- Hospice/palliative care services are poorly understood
- Rules and regulations
- Denial of death

Glare et al., 2003; NHPCO, 2005
Continuum of Care

- Disease-Modifying Treatment
- Palliative Care
- Hospice Care
- Bereavement Support

Martha’s Story

- Video from National Cancer Institute EPEC-O (Education in Palliative and End-of-Life Care for Oncology)

Quality-of-Life Model

- Physical Well-Being
- Psychological Well-Being
- Social Well-Being
- Spiritual Well-Being

Ferrell et al., 1991
Maintaining Hope in the Midst of Death

- Experiential processes
- Spiritual processes
- Relational processes
- Rational thought processes

Ersek, 2006

Potential Goals of Care

- Cure of disease
- Maintain or improve function
- Prolong life
- Relief of suffering
- Quality of life
- Reconciliation with others
- Staying in control
- Complete unfinished business
- Staying out of hospital
- Support for family and loved ones
- A peaceful death
How Do Hospice and Palliative Care Differ:

- **Palliative Care**
  - May be combined with curative care
  - Any time during illness
  - No prognostic requirements
  - Independent of payor

- **Hospice**
  - Must forgo curative care
  - Prognosis of < 6 mons of life as certified by 2 MDs
  - Convert from standard insurance to Medicare Hospice Benefit

Role of the Nurse in Improving Palliative Care

- Some things cannot be "fixed"
- Use of therapeutic presence
- Maintaining a realistic perspective

Extending Palliative Care Across Settings

- Nurses as the constant
- Expanding the concept of healing
- Becoming educated
- JCAHO Advanced Certification in Palliative Care
Why Care….

Palliative Care:
Mission Possible

Mission Possible… Home Care Role

- Provide quality in an environment of patient shuffle
- Provide continuity and compassion for patients
- Contribution to lowering health care costs
- Survival strategy for emerging health care law

Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

<table>
<thead>
<tr>
<th>Category</th>
<th>NON-PCU</th>
<th>PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and chemotherapy</td>
<td>$2,267</td>
<td>$511</td>
</tr>
<tr>
<td>Lab</td>
<td>1,134</td>
<td>56</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>615</td>
<td>29</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>1,821</td>
<td>731</td>
</tr>
<tr>
<td>Room &amp; nursing</td>
<td>4,330</td>
<td>3,708</td>
</tr>
<tr>
<td>Other</td>
<td>2,152</td>
<td>278</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$12,319</strong></td>
<td><strong>$5,313</strong></td>
</tr>
</tbody>
</table>

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002. Source: Virginia Commonwealth University medical center
### Mission Possible...

<table>
<thead>
<tr>
<th>Causes of Healthcare waste (JAMA: Berwick and Hackbarth)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failures of care delivery:</td>
<td>$102 B - $154 B</td>
</tr>
<tr>
<td>Failures of coordinated care:</td>
<td>25 B - 45 B</td>
</tr>
<tr>
<td>Over treatment:</td>
<td>158 B - 226 B</td>
</tr>
<tr>
<td>Administrative complexity</td>
<td>107 B - 389 B</td>
</tr>
<tr>
<td>Pricing Failures</td>
<td>84 B - 178 B</td>
</tr>
<tr>
<td>Fraud &amp; Abuse</td>
<td>82 B - 272 B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$558 B - $1254 B</strong></td>
</tr>
</tbody>
</table>

### Objectives:

Identify and Describe benefits from a multidisciplinary palliative care program in a hospital based system

A. Patient benefits

B. Physician benefits

C. Business benefits
   - Hospital
   - Home Health Care
   - Hospice

### Service Design Options

**Inpatient Unit**  
**Inpatient Consult Service**  
**Outpatient Specialty Clinics**  
**Provider Home Visits**  
**SNF Consult Service**  
**Outpatient PCP Clinics**  
**Cancer Center**
Mission Possible... Patient benefits

1. Clear communication with patients about their disease process
2. Patient driven goals for care defined
3. Services coordinated to address patient needs within the patient's goals for care

Mission Possible... Patient benefits

<table>
<thead>
<tr>
<th>Shared Philosophy</th>
<th>Home Health</th>
<th>Hospice</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Mission Possible... Physician Benefits

Provide resources to physicians for the burden of carrying out lengthy, complex and sometime multiple discussions that focus on prognosis, goals of care and treatment options.

FACTS about Primary Care Physicians
- Competing demands for time
- Not all medical programs offer special training in palliative medicine
- Skills to assess emotional, psychological and existential suffering are difficult to assess and manage
Mission Possible... Hospital benefits

- Decrease Hospital readmissions
- Decrease Hospital supply costs
- Decrease Hospital length of stay
- Decrease Hospital mortality and morbidity rates
- Decrease Hospital cost reduction through direct costs including, Rx, Lab, Diagnostic Imaging

Mission Possible... Outpatient benefits

- Increase Outpatient Volumes
- Increase outpatient encounters
- Increase outpatient charges including referred services

Mission Possible... Home Health benefits

- Increase volumes
- Decrease re-admission rates (studies show palliative care patients choose to stay at home)
- Provide added value to hospital system
- Provide smooth transitions through collaboration within hospital systems...
Mission Possible… Hospice benefits

- Palliative Care exists within the Hospice continuum of care
- Increase volumes
- Increase Hospice length of stay - median
- Provide value added to hospital system

Mission Possible… Palliative Care

- Video from National Cancer Institute EPEC-O (Education in Palliative and End-of-Life Care for Oncology)

Why Care… About Palliative Care?

"It's the right thing to do... for the patient, for the physician and for our hospital system." It is a mission possible!