

Medical Association of Georgia
Journal
Building A Better State of Health Since 1849

2010, Vol. 99, Issue 4

The Issues that Matter in 2011

Insurance reform, tort reform, Medicaid...
and coming to grips with the
new health care law

**MAG Unveils New
Five-Year Strategy**

Funding Trauma Care

**Constitutional Challenges
to the Affordable Care Act**

**Accountable Care Organizations:
Are They Relevant?**

**Case Report:
Cyanosis in an Infant**

Prescription for Life

Palliative and hospice care in metro Atlanta today

By Torey Clark, M.D.



Torey Clark, M.D.

The field of palliative care has grown dramatically over the last two decades and is now recognized as an accredited specialty of the American Board of Internal Medicine. Palliative care, in the simplest sense, utilizes technologic modalities to achieve relief of suffering and can therefore be implemented throughout the course of illness, from diagnosis to treatment to the terminal phases, when the disease is no longer considered curable. It naturally overlaps the scope of care traditionally associated with hospice care, but it is by no means synonymous with hospice.

Parallel philosophies include the use of a collaborative interdisciplinary team, focus on patient-defined goals of care, and relief of “total pain” and suffering. Both strive to identify and address the physical, psychological, spiritual, social and philosophical aspects of the human condition. Thus, the field of palliative medicine arose as a result of the hospice movement – but seeks to fill the void of care when medicine can no longer cure, but death is not imminent.

The concept of hospice is derived from the use of a “resting place for pilgrims and travelers” dating as far back as the Middle Ages. By the end of the 19th century, hospices were established in Ireland and England as havens for the terminally ill. Our current model of hospice care comes from St. Christopher’s Hospice in London, established under the direction of Dame Cicely Saunders in 1967, and it is widely recognized as the first hospice to link compassionate care, education and clinical research. The basic principles of humanitarian care include symptom control (during course of illness as well as in active death), psychosocial care for the patient and extended to family/caregivers, nursing care, bereavement, and respite care.

There are two general criteria for hospice care eligibility in the U.S: 1) the individual has a terminal illness and 2) the individual has an estimated prognosis of six months or less if the condition follows the expected course. These criteria were derived from the fact that the most frequently encountered diagnoses for hospice care involved cancer patients in the final stages of their illness. Outcomes were predictable as the cancers progressed through the natural stages. Identifying the final stages of other chronic advanced diseases such as heart failure or liver disease proved more difficult. The National Hospice and Palliative Care Organization (NHPCO) has

published general guidelines for admission criteria and determining prognosis for selected non-cancer diagnoses.

Hospice provides home services under the direction of the multidisciplinary team, but the primary responsibility for care falls on the family member or primary caregiver. When home care is neither feasible nor desired, in-patient hospice care is available, usually for the more functionally-dependent or cognitively-impaired individual.

The many advantages of hospice care have been explored over the last two decades, and the Hospice Medicare benefit, established in 1983, reflects the preference for home care and the emphasis on comfort measures. It requires election of hospice care – therefore foregoing curative measures, with treatment goals directed toward relief of symptoms, rather than cure of the underlying disease – and certification of the life-limiting illness and six month prognosis. It provides a fixed sum of money, paid on a per diem basis, from which all medical care provided to care for that diagnosis must be paid.

Herein lies what is perceived to be the major disadvantage to hospice and, therefore, end-of-life care: Hospice election implicitly restricts access to other aspects of treatment, which may be considered life-prolonging. By choosing ongoing “curative” care, there is significant underutilization of appropriate end-of-life services, resulting in late hospice referrals, short length of stays, and no reduction in the cost of health care since “everything has already been tried” – chemotherapy, emergency room visits, ICU admissions, and acute care hospitalizations.

Palliative medicine incorporates the hospice philosophy and applies them in the traditional medical system – thus bridging the desire for use of available treatments, regardless of the chance for recovery or cure, with effective communication, decision making in advanced disease, symptom and complication management, psychosocial care of the patient and family, and coordinating care of the dying.

The implementation of palliative care programs has progressed rapidly since the mid-90s with numerous institutions setting up palliative care services that incorporate the interdisciplinary team model. More than 70 percent of large hospitals (200 beds or more) reported the presence of a palliative care program in the American Hospital Association’s 2006 annual hospital

survey. In most hospitals, the interdisciplinary palliative care consultation service provides evaluations for patients with an acute or chronic life-threatening or life-limiting condition – in both cancer and non-cancer diseases – and it communicates the findings and recommendations to the primary team.

The most frequent issues involve pain and symptom management, goal-of-care discussions and decision-making, prognostication, hospice eligibility assessment, patient family support, and withdrawal of life-sustaining interventions. Much less frequent are requests for transfer of care to the palliative care physician or to an inpatient palliative care unit are made – primarily due to the lack of this valuable resource. Several studies have shown the positive financial impact of cost savings when utilizing a dedicated palliative care unit.

Hospital-based palliative care programs care for seriously ill and dying patients. Unlike traditional hospice programs, palliative medicine is not restricted by the Medicare hospice benefit in terms of reimbursement for medical interventions. Therefore, palliative care units can provide a wide range of clinical services related to end-of-life care provided in the acute care setting, and limit use of inappropriate or uncomfortable procedures. Early referral to hospice is still desired for an inevitably fatal illness, and many of these programs are linked to local hospices.

According to the Georgia Hospice and Palliative Care Organization (GHPCO), there are approximately 140 licensed hospices and palliative care programs serving throughout the state of Georgia – some 40 in the metro Atlanta area. Several metro Atlanta hospitals have thriving palliative care programs; the earliest were established in 2005. They are all hospital-based consultative services comprised of interdisciplinary teams, with board certified palliative care physicians and advanced level nurse practitioners coordinating the care. Many have affiliations with local hospice companies, including contracted in-hospital designated hospice beds and free standing in-patient hospice facilities. None, however, have inpatient palliative care units, nor do they function as primary subspecialty admitting services.

The Georgia Alliance for Palliative Care is an interdisciplinary forum that provides journal club review of relevant current articles in health care, ethics, pain management and end-of-life care.

From 1996 to 2006, board certification for physicians practicing hospice and palliative medicine was administered by the American Board of Hospice and Palliative Medicine (ABHPM). More than 2,100 physicians obtained certification from ABHPM. In September 2006, the American Board of Medical Specialties (ABMS) approved the creation of Hospice and Palliative Medicine (HPM) as a subspecialty of 10 participating boards, and the first ABMS-recognized examination was administered in 2008.

Starting in 2013, only applicants who have completed a 12-month ACGME-accredited hospice and palliative medicine fellowship program will be eligible to take the certification exam. Physicians who already hold ABHPM certification will need to take the new ABMS certification examination before the grandfathering period ends in 2012. Currently, there are approximately 25 board-certified hospice and palliative care physicians in the state.

Unlike hospice, palliative care is not limited to the last months of life and can be provided simultaneously with curative measures, allowing physicians, patients and families maximum flexibility in tailoring care to each individual. All patients with any life-limiting disease and complex medical needs should have access to specialist-level palliative care.

Developing dedicated hospital-based palliative care units, with goals of cost control and enhancing patient-clinician communication, affords the opportunity to offer Medicare covered medical interventions as well as the psychosocial interventions traditionally available through the hospice benefit. In this vein, alternatives to costly, unrealistic or unwanted treatments can be offered without precluding attempts to pursue cure. Similarly, outpatient access to specialist-level care for those who are not hospice-eligible or do not desire those services need to be established, and several models are evolving across the country.

A recent *New England Journal of Medicine* study of patients with advanced lung cancer at Massachusetts General Hospital showed quality of life and overall survival improvement in patients offered early palliative care at the outset of cancer chemotherapy.

Even more encouraging is the recent Centers for Medicare and Medicaid Services (CMS) implementation of the Affordable Care Act, allowing pediatric patients with life limiting illnesses access to hospice services without forgoing curative treatment for the terminal disease. Future blending of curative and palliative services will increase utilization of hospice services as patients and families are no longer forced to make a choice to forego life-prolonging therapies.

Approximately 60 percent of the nearly 2.5 million people who die each year in the U.S. die in a hospital setting. Many suffer in those final days – without access to end-of-life care. Palliative care is an emerging field of medicine, dedicated to relieving the pain and suffering of patients facing a chronic or life-limiting illness, enhancing the quality of life. Satisfying these goals will not cure, but this certainly can no longer be viewed as a failure in the quest to heal. Evidence-based clinical outcomes repeatedly show improved symptom control, as well as overall patient and family satisfaction with care.

Torey Clark, M.D., is the owner and medical director of Harbor Grace Hospice in Atlanta.