HOSPICE NEWS NETWORK

Recent News On End-of-Life Care

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STUDY CONCLUDES THAT MENTAL HEALTH IS A MAJOR CONCERN FOR HOSPICE STAFF

***The Journal of Palliative Medicine* has published a study by hospice researchers in Minneapolis.** The study explores the impact that "stress, burnout, compassion fatigue," and other mental health issues can have on hospice care staff members. While the study's authors write that "working in hospice care is a highly... rewarding profession," they note that "the challenges of working with dying patients and their families can overwhelm even the most highly dedicated professional, leading to burnout, compassion fatigue and depression." In light of these serious challenges facing many hospice workers, the authors urge more attention be given to these issues.

The study was conducted in 2008 and 2009 "through a private, not-for-profit research institute affiliated with a large Midwestern health plan." **Data was collected by researchers in the form of a "cross-sectional survey of hospice staff from across Minnesota," surveying 547 hospice staff members with questions that gauged overall mental health, including stress levels, indicators of burnout and compassion fatigue.** The survey also asked questions to help assess how staff members dealt with these challenges.

Over the course of the study, "hospice staff reported high levels of stress, with a small but significant portion reporting moderate-to-severe symptoms of depression, anxiety, compassion fatigue and burnout." Staff members reported that they brought these symptoms under control in a variety of ways, including exercise and social support networks. They suggested that "more opportunities to connect with coworkers and to exercise could help decrease staff burnout."

The study highlights mental health issues as serious and in need of attention if staff members are to be sustained in their work. **The authors conclude, "Poor mental health places staff at risk of burnout and likely contributes to staff leaving hospice care." Researches say that this is becoming a more serious issue "as the profession attempts to attract new staff to meet the expanding demands for hospice care."** With end-of-life care projected to grow by leaps and bounds in the coming decades, **hospice care organizations will need to work to meet the mental health needs of their staff members if they hope to develop a sustainable working environment in this highly demanding field**. (*The Journal of Palliative Medicine*, 12/10, online.liebertpub.com/doi/abs/10.1089/jpm.2013.0202)

PALLIATIVE CARE HAS AN IDENTITY PROBLEM

"Palliative care suffers from an identity problem," write Ravi B. Parikh, and others, in *The New England Journal of Medicine*. More than two-thirds of Americans describe themselves as "not at all knowledgeable" about palliative care, while most health care professionals still believe that palliative medicine is synonymous with end-of-life care. To make matters even more confusing, this perception is not so far from the reality of current medical practice. According to the article, it is indeed the case that specialty palliative care, offered by palliative care specialists, is mostly offered through hospice care, or in situations where life-prolonging treatment has failed. Yet, "limiting specialty palliative care to those enrolled in hospice or admitted to the hospital ignores the majority of patients facing serious illness." The authors "believe that palliative care should be initiated alongside standard medical care for patients with serious illness."

In order to elaborate on their perspective, Parikh and colleagues make an argument for a more deeply integrated palliative care model. They provide a variety of angles from which the issue can be approached, each one of which commends a practice of palliative care that is more integral to medicine as a whole, and less tied to end-of-life and hospice care contexts. In making a case for this shift in palliative medicine, the authors present the matter from three perspectives: the clinical, economic and political.

Clinically, Parikh and colleagues observe that multiple studies demonstrate the effectiveness of palliative care. When specialty palliative care is integrated into standard oncology, for example, it "leads to significant improvements in quality of life and care and possibly survival." As one concrete example, they note that advanced cancer patients who receive the benefit of palliative care consultations early on in their disease report that symptom control is better, compared with those who did not receive such consultations. There is clear and growing evidence that specialty palliative care has an important role to play in improving clinical results for those facing serious illness.

The authors also offer an economic rationale for the importance of palliative medicine. They are quick to point out that "cost savings are never the primary intent of providing palliative care," and that "ensuring the best quality of life is paramount." Nevertheless, they write that there is clear evidence to suggest that the effective use of palliative medicine can reduce costs across the medical field, especially since "10% of the sickest Medicare beneficiaries account for nearly 60% of total program spending." The quality improvements offered by early palliative measures can be substantial. "One study estimated that inpatient palliative care consultations are associated with more than $2,500 in net cost savings per patient admission." While cost should never be the primary consideration in medical treatment, the economic benefits of palliative care are, at the very least, a happy side effect of a process that ultimately offers patients higher quality of life, regardless of cost.

Finally, Parikh and colleagues suggest that there is also a political case to be made for a more robust palliative care infrastructure. Though there has been fierce resistance to many forms of end-of-life care - especially highlighted by controversial, high-profile cases like those of Terry Schiavo and Dr. Jack Kevorkian - the authors note that "policy momentum is now building, bolstered by evidence establishing the quality-of-life benefit of palliative care for

patients with advanced cancer." **A variety of federal legislative measures are resulting in bipartisan support for legislation - on both the federal and state levels - that address "palliative care research, the palliative care workforce, and barriers to accessing care."**

Clearly, however, there is still a lot of work to be done in the political arena. Much of this has to do with public perception. The authors remark, "Although legislation is a key step toward changing policy regarding palliative care, the main impediment remains a matter of messaging. Reframing the policy and professional discussion around palliative care as a means to improve quality of life without decreasing survival is essential to make this advocacy agenda more politically tenable." **Parikh and colleagues urge advocates of palliative medicine to consistently use language describing palliative care as "an extra layer of support," which is appropriate at "any stage in a serious illness," as this framing elicits a positive reaction from more than 90% of Americans.**

The authors conclude with a variety of solutions, which they believe will help make the transition from the present state of palliative care to a more robust, effective system. One of these solutions would be a change in reimbursements and incentives for hospitals and doctors. Alongside this, the authors call for educational reform, increasing the knowledge and awareness of clinicians about the importance of palliative care. Finally, they urge the expansion of hospital-based palliative care teams, which can bring clinical practice up to date with a plan of coordinated care. (*The New England Journal of Medicine*, 12/12, www.nejm.org/doi/full/10.1056/NEJMsb1305469)

HOSPICE NOTES

*** A dying inmate in Iowa has been released from prison to hospice.** The dying 33-year-old woman, sentenced to life in prison when she was a teenager, was released to be taken into hospice care after the Iowa Parole Board granted her release on compassionate grounds. (*The News Observer*, 12/10, www.newsobserver.com/2013/12/10/3449386/dying-iowa-inmate-released-from.html)

*** A recent article highlights one hospice's use of technology to reduce ER visits.** Cornerstone Hospice, with 800 at-home patients, is employing iPads with software that allows nurses to remotely monitor health conditions and speak with patients immediately. (*MHealthNews*, 12/6, www.kansascity.com/2013/12/11/4685263/trial-over-nms-assisted-suicide.html)

*** There is more to hospice than death and dying.** "Hospice is more about providing care, comfort and support to terminally ill patients while helping them navigate—and optimize—the final days of their lives." (*Voice of America*, 11/27, www.voanews.com/content/hospice-teams-help-patients-face-death/1798764.html)

*** A recent radio program features details on hospice and palliative care.** *Smart Talk* focuses on "what to know about hospice and palliative care." (*WITF*, 11/19, www.witf.org/smart-talk/2013/11/smart-talk-what-to-know-hospice-and-end-of-life-care.php)

*** Hospice provides a variety of services, including many that most wouldn't guess. From dementia support groups to pet bereavement support, hospice care is about more than dying.** (*The Times-Tribune*, 11/25, http://thetimes-tribune.com/news/health-science/more-to-hospice-than-you-probably-think-1.1590699)

END-OF-LIFE NOTES

*** Americans are still unlikely to prepare for end-of-life issues.** Most Americans don't plan ahead, and advance care planning reveals significant disparities according to race, gender, education and marital status. (*Philly.com*, 12/10, www.philly.com/philly/health/HealthDay682842_20131210_Most_Americans_Don_t_Deal_With_End-of-Life_Issues__Study_Finds.html)

*** Cardiac device deactivation is often delayed or ignored, until late in the end-of-life process.** "A review of 150 patients who, by request, had their implanted electronic cardiac devices deactivated suggests that physicians and patients are not planning ahead or including their wishes regarding deactivation in their advance directives." (*Medscape*, 11/28, www.medscape.com/viewarticle/815187)

*** A recent amendment to Michigan law will allow staff members at nursing homes in that state to honor the "Do Not Resuscitate" orders of those under their care.** Until now, nursing home staff members were required to administer CPR if they found a non-hospice patient with no pulse or respiration, regardless of their advance care directives. (*The Record-Eagle*, 12/8, www.record-eagle.com/local/x1636706170/Law-will-allow-nursing-homes-to-honor-end-of-life-wishes)

*** Why are Americans afraid to talk about dying?** An article published in *The National Journal* highlights the continuing taboo surrounding death, as indicated by the low numbers of citizens who have completed advance directives. (*The National Journal*, 12/10, http://www.nationaljournal.com/health-care/why-are-americans-scared-to-talk-about-dying-20131210)

*** In an article published in *The Huffington Post,* Nancy Brown, CEO of the American Heart Association, speaks of her family's struggle to deal with the end of her mother's life.** Brown emphasizes the importance of a "team" approach to end-of-life care, with a "multidisciplinary team of health care professionals" who strive to make the patient's end as comfortable as possible. Brown now serves at co-chair of the steering committee of the Coalition to Transform Advanced Care (C-TAC) (*The Huffington Post*, 12/9, www.huffingtonpost.com/nancy-brown/end-of-life-care_b_4409888.html)

PALLIATIVE CARE NOTES

*** Sometimes, palliative care is the best care.** *Kaiser Health News* highlights the many benefits of palliative medicine in an article focusing on the care received by a patient who recently underwent a liver transplant. **Nevertheless, the article notes that some doctors "are resistant**

to palliative care because they believe it pushes patients away from medical treatment that could help them fight their illnesses. (*Kaiser Health News*, 12/3, www.kaiserhealthnews.org/stories/2013/december/03/palliative-care-for-seriously-ill.aspx)

*** *The Hospitalist* features an article about the intensity, and rich rewards, of practicing palliative care medicine.** The article examines the growing specialty field of palliative medicine, and how it is impacting both patients and clinicians. (*The Hospitalist*, 12/2013, www.the-hospitalist.org/details/article/5572181/Palliative_Care_Can_Be_Incredibly_Intense_Richly_Rewarding_for_Hospitalists.html)

OTHER NOTES

*** The battle over physician-assisted suicide garnered press coverage in New Mexico.** "Two doctors and a Santa Fe woman with advanced uterine cancer want physicians to be able to prescribe... the needed medications for terminally ill patients who want to end their lives on their own terms." Doctors Katherine Morris and Aroop Mangalik and patient Aja Riggs have taken their case to state district court, and are being supported by the ACLU. (*The Kansas City Star*, 12/11, www.kansascity.com/2013/12/11/4685263/trial-over-nms-assisted-suicide.html)

*** Chaplains are playing an increasingly important role in helping hospital staffs and patients.** *The Wall Street Journal* details the ways chaplains are being "called on to help patients cope with fear and pain, make difficult end-of-life decisions and guide families through bereavement after a loss." (*The Wall Street Journal*, 12/8, online.wsj.com/news/articles/SB10001424052702304854804579236053907496062)

*** Americans don't cope with grief very well. A new website seeks to help.** "At *Modern Loss*, people can ask advice about coping, celebrate unorthodox responses to grief, and demand respect for their feelings instead of pretending to be over it already." (*Slate*, 11/13, www.slate.com/blogs/xx_factor/2013/11/13/modern_loss_a_new_website_hopes_to_open_up_the_conversation_about_death.html)

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