Blue Ridge Hospice™

Physician Newsletter

April 2009

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Definition:

Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

DID YOU KNOW?

Our top ten referring physicians are in the following specialties:

1. Oncology
2. Internal Medicine
3. Family Practice

Our top five hospice diagnoses are:

1. Cancer
2. Debility
3. Dementia
4. Lung
5. Heart

Our average length of stay:

In 2006:

64 days

In 2007:

73 days

In 2008:

81 days

Find out what's new at Blue Ridge Hospice, visit our website at www.blueridgehospice.org

Palliative Care — It's Here To Stay, But Why?

"Our powers as individuals are multiplied when we gather together focused on common goals, and shared visions. The collective strength far outdistances the reach of the individual. As individuals we lose nothing, we are only enhanced." *Unknown*

Times are changing. The practice of medicine today focuses more on patient-centered care. This indicates that today's patients are better informed, wish to know more about their disease, and exert greater control over their own care. Physicians should provide evidence-based options (i.e. treatments) along with the option not to treat. With that comes the greater responsibility of better communication between physician and patient about advanced directives, goals of care, and perceiving the patient as a whole (physically, emotionally, and spiritually).

Optimal management of a patient becomes a team effort. Physicians no longer have to feel alone, uncomfortable, or time-pressured in addressing the patient's (many) concerns.

Physicians can consult our palliative medicine team to facilitate the necessary and ongoing communication about disease progression and realistic treatment options, goals of care, advanced directives, caregiver needs, symptoms, and pain issues.

The following is part of a report from AMERICA'S CARE OF SERIOUS ILLNESS:

A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals from the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC). (September 2008).

Recent studies examining the experience of

being hospitalized with a serious illness in the United States have reported the following:

- **1 in 2 caregivers of Americans hospitalized with a life-threatening illness report suboptimal care.**[1]
- **3 in 4 Americans who die of chronic illness each year are admitted to a hospital during the last six months of their life.**[2]
- **1 in 4 patients report inadequate treatment of pain and shortness of breath.**[3]
- **1 in 3 families report inadequate emotional support.**[4]
- **1 in 3 patients report that they receive no education on how to treat their pain and other symptoms following a hospital stay.**[5]

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- **1 in 3 patients are not provided with arrangements for follow-up care after hospital discharge.[6]**

To help address these shortcomings, hospitals have begun establishing palliative care programs. Patients with serious and life-threatening illness typically live with multiple disease processes (such as advanced heart and lung disease, diabetes, arthritis, cancer), multiple symptoms (pain, nausea, shortness of breath, fatigue, sleep disorders), caregiving requirements (assistance with feeding, bathing, toileting, walking) and complicated transition planning (rehabilitation, visiting-nurse services, care coordination) that can be met only by specialized teams of health care providers. The absence of team-supported, coordinated care for the seriously ill results in health care that is often unsafe, ineffective, untimely, inefficient, inequitable, and rarely patient-centered.

By starting with the patients' needs and goals, palliative care teams ensure the care patients receive addresses their needs and is driven by their agenda, not that of the physician. Furthermore, and perhaps most importantly, such an approach ensures that the person is viewed in his or her entirety, not as a collection of organs and systems. By following this approach, palliative care programs have been shown to:

- **Reduce unwanted, unnecessary and painful interventions**
- **Establish patients' care goals and focusing on what are important and achievable outcomes for medical treatment**
- **Ensure that patients receive the most effective and timely treatments and that their valuable time and energy is not spent undergoing burdensome tests and procedures that will not lead to improvements or changes in care**
- **Enhance the ability of patients' families to cope with and care for a loved one with serious illness.**
- **Identify family needs, fears and knowledge gaps, palliative care programs have been shown to improve a family's feelings of self-efficacy in the setting of a loved one's serious illness.**
- **Improve patient and family satisfaction with care. Surveys of patients cared for by hospital palliative care teams routinely reveal very high patient and family satisfaction—among the highest rates observed in hospitalized patients**

Accessed July 14, 2008.

1 Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7;291(1):88–93. *JAMA.* 1994 Dec 21;272(23):1839–44.

2 *Dartmouth Atlas of Health Care.*

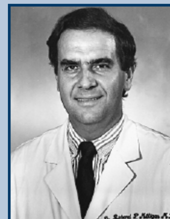
3 Teno et al. *Family perspectives.*

4 Ibid.

5 The Commonweath Fund. Care coordination. *Quality Matters*. 2007 May/June;24.

6 Ibid.

New Hospice Physician on Staff



We would like to welcome Richard Milligan, MD to Blue Ridge Hospice. Dr. Milligan attended medical school at Wright State University and completed his residency at Riverside Methodist Hospital in Columbus, Ohio. He is board certified in Internal Medicine and Geriatrics. Dr. Milligan most recently worked as a physician at Woodstock Internal Medicine Specialists and has now transitioned to a full-time hospice physician.

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