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Utilization of palliative care and acute care services in older adults with advanced cancer



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ABSTRACT

Objectives: There is a gap in knowledge regarding the rates of utilization of palliative care services (PCS) and acute care services (ACS) among older patients with advanced cancer close to end of life. We analyzed the utilization of these services among older adults (65 years and older) and compared them to those in younger adults (40–64 years) with advanced cancer.

Materials and Methods: A retrospective chart review of 567 veterans who died with advanced cancer between 2002 and 2009 and utilized PCS and ACS prior to death was conducted after IRB approval. To assess PCS utilization, we studied the mean duration between day of hospice referral and time of death (DOR) and the mean length of stay with hospice (LoS). The frequency of emergency room visits (ERVLM), hospital admissions (HALM), and ICU admissions (ICULM) in the last month of life was used as a measure for ACS. The differences among older and younger patients were compared using two sample t-tests.

Results: Older adults had earlier referral to PCS [mean DOR: 47.3 versus 34.5 days, $p = 0.015$], longer stay with hospice [mean LoS: 32.5 versus 20.2 days, $p = 0.007$], fewer hospital [HALM: 0.7 versus 0.9, $p = 0.043$], and ICU admissions [ICULM: 0.1 versus 0.2, $p = 0.030$] per patient. The proportion of patients utilizing ER visits [53.5 % versus 59.5%, $p = 0.173$] and hospital admissions [58.6% versus 65.1%, $p = 0.13$] in the last month of life was similar in both age groups with fewer older adults utilizing ICU care [13.2% versus 19.5%, $p = 0.047$].

Conclusion: Older patients with cancer are likely to be referred to PCS earlier than younger patients and spend a longer duration with PCS prior to death. However, there continues to be significant utilization of ACS in all patients with advanced cancer. Better understanding of the goals of care in older adults with cancer and education of oncology providers regarding the need to utilize and integrate palliative care services earlier in the course of disease is imperative.

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1. Introduction

1.1. Background

Timely utilization of palliative care services (PCS), including hospice care has been shown to improve survival rates in

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patients with advanced cancer and decrease the need for acute medical interventions close to the end of life (EOL).^{1,2} Early integration of palliative care in the treatment of adults with advanced cancer can lead to measurable improvements in quality of life, less aggressive care at the EOL, improvement in overall survival, as well as longer enrollment in hospice services.³ Family members of patients with home hospice reported higher satisfaction, fewer unmet needs, and a better communication with physicians about medical decision-making.⁴

The majority of Americans prefer to die at home if they are terminally ill.⁵ Additionally, it has been noted that the site of death may be associated with perceived quality of life at the end of life. Thus patients who die at home especially with hospice services tend to have a better quality of care than in an institutional setting.⁶

The role of PCS may be greater in the elderly with advanced cancer. Given that individuals age 65 years and older represent the fastest growing segment of the population in Western countries, there is an urgent need to assess availability, acceptance, and utilization of PCS close to end of life in patients with advanced cancer. With burgeoning health care costs, especially in the United States, and given the high expense incurred close to end of life in patients with advanced cancer, as well as among older adults, this area needs to be studied further. High utilization of acute care settings, including emergency room visits, hospitalizations, and intensive care monitoring, all contribute to these rising costs in addition to taxing the capacity of health care delivery services. In the absence of appropriate use of PCS, greater proportion of adults with advanced cancer rely on acute care services (ACS) at the end of life.⁷ However, there are limited data regarding the utilization of these services by this specific population of older adults with advanced cancer. A recent study in the *Journal of Geriatric Oncology* aimed at evaluating the needs in elderly patients affected by cancer and the state of the research in palliative care failed to meet its aim due to a paucity of literature focusing on these issues.⁸

Hence, to compare the utilization of PCS and ACS in older adults with advanced, incurable cancer, we carried out a retrospective study of adult patients with advanced, incurable cancer at the Syracuse VA medical center (VAMC) with the intent to study the impact of age upon such use. We defined PCS as the referral to and acceptance of palliative care: this was synonymous with formal hospice care in a vast majority of the patients but also included care rendered via a home nursing agency with palliative care goals (without formal hospice designation). The actual PCS could have been rendered in the home setting, at a skilled nursing facility or a hospice unit, as is the case of the VAMC which is housed physically within the hospital itself. Irrespective of the setting, the principles of PCS were adhered to (i.e., focus on maintaining comfort and dignity as well as the discontinuation of all cancer fighting treatments). Information was collected on factors that could potentially impact a patient's decision to accept PCS including demographics (age, gender, and race), tumor factors (type of cancer), and living situation (alone vs accompanied and marital status). It was decided to include patients with solid tumors and lymphoma but not those with leukemia or myeloma since in the latter, the status of remission is not always immediately obvious and these

diseases often require ongoing acute care such as transfusion support and management of infectious complications post chemotherapy. While the prime objective was to study the utilization of PCS and ACS in older adults, we included younger patients from the same time period to compare the differences based on age. Thus, the purpose of this analysis was to assess whether there are differences in patterns of referral, acceptance and ultimately, utilization of PCS based on age. Our hypothesis was that older adults with cancer will likely be referred to PCS earlier than younger patients, accept PCS more often and spend greater time with PCS prior to death than younger patients. As a corollary, older adults will use ACS with decreased frequency in the last month of life compared to younger patients.

2. Methods

2.1. Objectives

2.1.1 To study the utilization of PCS at our institution for adults who died as a consequence of advanced cancer by calculating the mean duration between day of hospice referral and time of death (DoR) and the mean length of stay with hospice (LoS) for each age group.

2.1.2 To compare the utilization of PCS between older (≥ 65 years) and younger adults (40–64 years) with advanced cancer.

2.1.3 To study rates of ACS utilization in the last month of life between older and younger patients by identifying

Emergency room visits in the last month of life (ERVLM), Hospital admissions in the last month of life (HALM), and Intensive care unit admissions in the last month of life (ICULM).

2.1.4 To study the association of living situation and marital status with duration of PCS.

2.2. Setting and Population

The study setting was Syracuse Veterans Affairs Medical Center (SVAMC). All patients who died as a consequence of advanced cancer at the SVAMC from 2002 to 2009 were included in the cohort. These patients were identified from the VAMC tumor registry. At the SVAMC, all patients with advanced cancer are referred to an “advanced illness care coordinator”, a function served by a licensed social worker. Patients who are referred have the right to decline PCS until they are psychologically ready to make such a transition.

Data regarding date of referral, acceptance of PCS and death were collected from the notes entered by the palliative service in the electronic medical record. Admissions to the hospital and emergency room visits were collected from the patient chart. Thus, inclusion criteria as defined for this analysis include: patients (age more than 40 years or less than 100 years) with advanced cancer who died during the stated period, who were referred to PCS irrespective of whether they accepted PCS or continued with acute care for their cancer. The patients who presented with acute illness and early

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