

Original Article

Targeted Investment Improves Access to Hospice and Palliative Care

Amy P. Abernethy, MD, Janet Bull, MD, Elizabeth Whitten, MBA, Rebecca Shelby, PhD, Jane L. Wheeler, MSPH, and Donald H. Taylor Jr., PhD
Division of Medical Oncology (A.P.A., J.L.W.), Department of Medicine, Duke Cancer Institute (A.P.A.), and Department of Psychiatry and Behavioral Sciences (R.S.), Duke University Medical Center, Durham, North Carolina; Four Seasons (J.B., E.W.), Flat Rock, North Carolina; and Duke Sanford School of Public Policy (D.H.T.), Duke University, Durham, North Carolina, USA

Abstract

Context. Availability of hospice and palliative care is increasing, despite lack of a clear national strategy for developing and evaluating their penetration into and impact on the target population.

Objectives. To determine whether targeted investment (i.e., strategic grants made by one charitable foundation) in hospice and palliative care in one U.S. state (North Carolina [NC]) led to improved access to end-of-life care services as indicated by hospice utilization.

Methods. Access was measured by the death service ratio (DSR), defined as the proportion of people who died and were served by hospice for at least one day before death. Calculation of the DSR is based on counts of patients accessing hospice by county in a given year (numerator) and U.S. Census projected population data for that county (denominator). Multilevel modeling was the primary analytic strategy used to generate two models: 1) comparison of the DSR in counties with vs. without philanthropic funding and 2) relationship between years since receipt of a philanthropic grant and DSR.

Results. In NC, the average DSR increased from 20.7% in 2003 to 35.8% in 2009 (55% increase). In 2009, 82 of 100 NC counties had a DSR below the U.S. average (41.6%). In Model 1, significant associations were found between county population and DSR ($P=0.03$) and between receipt of philanthropic funding and DSR ($P=0.01$); on average, funded counties had a DSR that was 2.63 percentage points higher than unfunded counties.

Conclusion. Receipt of philanthropic funding appeared to be associated with improved access to palliative care and hospice services in NC. *J Pain Symptom Manage* 2013;46:629–639. © 2013 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Hospice, palliative care, death service ratio, access

Address correspondence to: Amy P. Abernethy, MD, Division of Medical Oncology, Department of Medicine, Duke University Medical Center, Box 3436,

Durham, NC 27710, USA. E-mail: amy.abernethy@duke.edu

Accepted for publication: December 5, 2012.

Introduction

Focused on optimizing quality of life for patients with advanced illnesses, palliative care provides comprehensive management for physical and psychosocial symptoms and aids patients and caregivers in health care decision making.¹ Although appropriate at any phase of disease, palliative care often focuses on the needs of patients with serious life-limiting illnesses who are nearing the end of life, when symptoms are hard to control and existential suffering increases.

Despite evidence showing that palliative care improves quality of life² and reduces spending,^{3–5} the U.S. has lacked a clear national agenda for developing palliative care models, expanding service delivery, and establishing financing mechanisms. Instead, palliative care has developed ad hoc.

Hospice, a subset of palliative care, has been shaped in the U.S. by reimbursement legislation. Since 1983, the Medicare program has included a hospice benefit. Eligibility requires 1) a life expectancy of six months or less and 2) goals of care that focus on comfort and symptom management rather than cure. Medicare coverage of hospice prompted a steady increase in the number of hospice providers and in the proportion of Medicare decedents who use hospice. The number of hospice programs

in the U.S. rose from 1545 in 1985 to 5150 in 2010.⁶ Similarly, the number of hospital-based palliative care and hospice programs increased from 632 (15% of hospitals) in 2000 to 1568 (63% of hospitals) in 2010.⁷ Factors driving the increase in service availability included high family satisfaction with hospice care;^{8–10} reduction in total costs of care with palliative care utilization;^{11–13} increasing visibility through national associations' promotion and education; grass-roots efforts (e.g., to promote advance care planning); recognition of Palliative Medicine as a subspecialty by the Accreditation Council for Graduate Medical Education, American Board of Medical Specialties, Centers for Medicare and Medicaid Services, and other national entities; and increased investment in hospice inpatient units and palliative care programs.

Current hospice and palliative care delivery models fall into four general categories: hospital-based palliative care, community-based palliative care, community-based hospice, and inpatient hospice (Fig. 1). Patients may receive care in one of these settings only or may move through settings; a typical progression is from community-based palliative care services to inpatient hospice as illness advances, functional status declines, and clinical needs increase. Representing a loosely

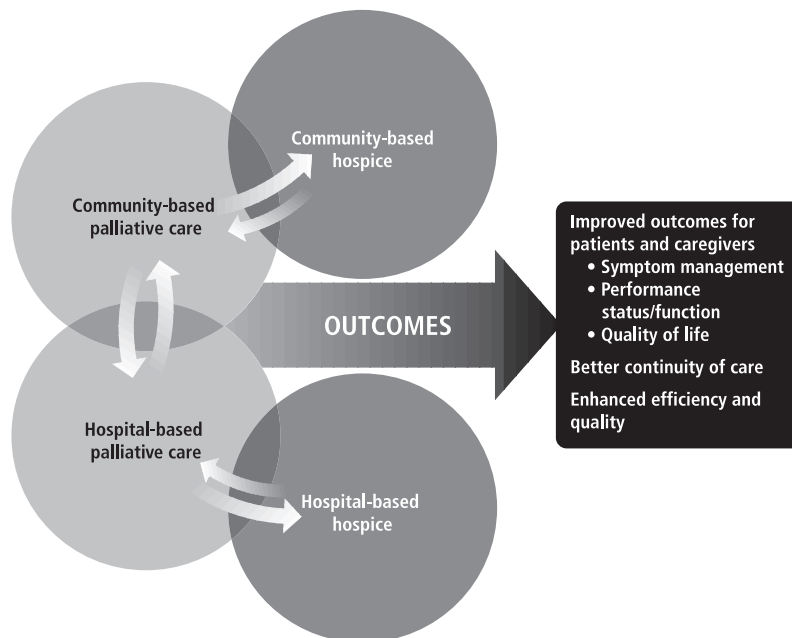


Fig. 1. Four models of palliative and hospice care.

Download English Version:

<https://daneshyari.com/en/article/5879508>

Download Persian Version:

<https://daneshyari.com/article/5879508>

[Daneshyari.com](https://daneshyari.com)