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Feature Article

Geriatric palliative care: Meeting the needs of a growing population

Rebecca M. Saracino, PhD^{a,*}, Mei Bai, PhD^b, Leslie Blatt, APRN^a, Larry Solomon, MD^a, Ruth McCorkle, PhD^b^a Yale School of Medicine, New Haven, CT, USA^b Yale School of Nursing, Orange, CT, USA

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ABSTRACT

The implementation of effective geriatric palliative care (PC) services will be increasingly important as the number of patients ages ≥ 65 years continues to grow. However, literature characterizing the utilization of PC services by older adults remains scant. The objective of these analyses was to characterize the nature and outcomes of PC services for older adults. A retrospective analysis of records of inpatient PC consultations provided to patients ≥ 65 years at an academic hospital was performed (N = 743). Logistic regressions identified factors associated with goals of care discussions (GOC), end-of-life (EOL) coordination, and hospital readmission. Differences between older adult subgroups (i.e., 65–84 years and 85 years and older) were also examined. Discharge to home was associated with higher odds of readmission and discharge to hospice or having a GOC discussion was associated with lower odds of readmission. Those patients who were 85 years or older were significantly less likely to have cancer or to be referred for pain management, and more likely to be referred for GOC discussions and discharged to hospice. This study revealed dynamic factors associated with PC consultation for older adults. GOC discussions in initial PC consultations for older patients might reduce the odds of hospital readmission. Additionally, the needs of patients ages 85 and older appear distinct from the traditional PC cancer model.

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Introduction

As the number of older adults (i.e., 65 years or older) living with multiple chronic illnesses continues to increase, so too does the need to develop targeted screening and referral processes for managing these patients' often complicated symptom presentations.¹ Three out of 4 older Americans have multiple chronic medical conditions and over half report bothersome pain.^{2,3} However, many of these older adults are never engaged in goals of care (GOC) discussions in which they are able to make their preferences for care known to their treatment teams.⁴ One answer to this public health concern is the growth and development of geriatric palliative care.⁵ In fact, the number of hospitals with palliative care teams has steadily risen over the past two decades such that over 90% of hospitals with 300 beds or more now provide these services.⁶ The World Health Organization (WHO) defines palliative care as an approach that "improves the quality of life of patients [...] who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct

assessment, and treatment of pain and other problems, whether physical, psychosocial or spiritual."⁷ Not only do these services significantly improve patients' quality of life and satisfaction with care, but they also tend to reduce hospital readmissions and service utilization, thereby lowering total healthcare costs.⁸

Despite clear imperative and calls to action for prioritizing research in geriatric palliative care,⁵ the empirical literature characterizing the utilization of palliative care services by older adults remains scant. What is clear, however, is that older adults often receive inadequate palliative care at the end of life due to a number of provider and systems-level barriers.^{9,10} To date, only two retrospective chart reviews specifically examined the clinical presentations and consultation content of palliative care services for younger compared to older adults.^{11,12} Evers and colleagues¹¹ analyzed 1184 palliative care consultations from a large teaching hospital and concluded that the needs of older adults differ significantly from their younger counterparts. Specifically, patients aged 80 or older were less likely to have a cancer diagnosis but more likely to have dementia and incapacity. These older patients were also more likely to have a DNR order present at the time of initial consultation, or to have one put into place upon consultation. There were also more recommendations to withhold life-sustaining treatments in this cohort. Olden et al.¹² later reviewed 2383 initial inpatient palliative care consultations in which they found that the majority of referrals were for patients older than

* Corresponding author. Yale School of Nursing, Room 20401, 400, West Campus Drive, Orange, CT, 06477, USA.

E-mail addresses: rebecca.saracino@yale.edu (R.M. Saracino), mei.bai@yale.edu (M. Bai), leslie.blatt@ynhh.org (L. Blatt), ruth.mccorkle@yale.edu (R. McCorkle).

65 years. Additionally, those 85 and older were consulted for earlier on in the course of hospitalization and more often for end of life care compared to younger patients. Taken together, these findings indicate that the palliative care needs and referral patterns for older patients are indeed distinct from younger patients. However, more research is necessary to determine the consistency of the findings and how they shape patient outcomes.

Given the paucity of literature characterizing the nature and outcomes of palliative care services for older adults despite growing public health significance, the current paper sought to expand upon the existing evidence base. Thus, the primary aims of the current paper are to: (1) describe the demographic and clinical characteristics, including reasons for referral, of older adult inpatients referred for palliative care consultation; (2) identify factors that are associated with being referred for a goals-of-care discussion or end-of-life care planning; and (3) determine the relationship between referral for a goals-of-care discussion or for end-of-life care planning and hospital readmissions. Exploratory analyses also sought to identify any significant differences in personal and clinical characteristics between those patients aged 65 to 84 and those patients aged 85 and older. We hypothesized that occurrence of goals of care discussions and end of life care planning would be associated with fewer hospital re-admissions. We also expected those patients in the 85 and older group to be more likely to be referred for end of life care planning and to be discharged to hospice or an extended care facility (ECF) compared to those in the 65–84 year old group.

Method

A retrospective analysis of records of the inpatient palliative care consultation service at Yale New Haven Hospital was conducted with data recorded from September 29, 2007, through August 17, 2012. This retrospective study was exempted by the Human Investigation Committee at the Yale University School of Medicine.

Measures

Data on consultations provided

At the onset of the palliative care consultation service, the team developed a database in which they documented the care provided at each consultation. Data collection included patients' name, age, sex, diagnosis, and reasons for referral. Reasons for referral included pain management, symptom control, or other. The team also documented whether they conducted a goals-of-care discussion (GOC) or arranged for end-of-life (EOL) care; these were treated as reasons for referral. For the purposes of the current analyses, GOC was operationalized narrowly as discussions about transitions to comfort care and implementing DNI/DNR orders. Data was recorded at the end of each consult and entered into a database by the administrator after discharge. The administrator also recorded any subsequent admissions for patients who had previously been seen by the service.

For the following analyses, we extracted data from the team's database related to the initial consultation only, including: demographic and clinical characteristics (age, gender, primary diagnosis, admission date, consultation date(s), date of discharge, and date of death, if the patient died during hospitalization); reason for referral, discharge disposition (home, hospice, or extended care facility [ECF]); and hospital readmissions.

Data analysis

Data are described using frequencies, percentages, and measures of central tendency and dispersion. Only data for those patients aged 65 and older were analyzed. Median number of days

from admission to consultation and length of stay (days from admission to discharge) for each admission were calculated. Logistic regressions were performed to predict whether age, sex, primary diagnosis, and days from admission to consultation were independently associated with odds of receiving a goals-of-care discussion (yes/no), end-of-life care planning (yes/no), or of being readmitted to the hospital (yes/no). Differences between the 65–84 and 85 years or older subgroups were also examined within these regression analyses and with chi-square statistics. Odds ratios (OR) and the 95% confidence intervals (CI) were calculated for each logistic regression. Data were analyzed with Statistical Analysis Software for Windows version 9.4 (SAS 9.4). The level of significance was set at an alpha of 0.05 with a two-tail test.

Results

Sample characteristics

The palliative care team completed initial consultations for 743 patients aged 65 or older over the data collection period (May 2007 to August 2012; Table 1). Mean age of the sample was 77.5 (± 8.7) years old and it was roughly evenly split by gender. The most frequent primary diagnosis was cancer (62%); of those patients with a cancer diagnosis, gastrointestinal (GI) cancer was the most common (i.e., 16.7% of total sample). There were significant differences between the disease composition of the age subgroups (Table 1) such that patients in the 85 or older group were less likely to have cancer (i.e., 33% versus 72%, $p < 0.0001$) and more likely to have other non-cancer diseases (48% versus 13%, $p < 0.0001$). Additional sample characteristics are described in Table 1.

Hospitalization course and consult content

Median number of days from admission to consult was 4, as was median days from consult to death, while median length of stay

Table 1
Inpatient palliative care older adult patient characteristics (N = 743).

	Total Sample	Age 65–84 (n = 555)	Age \geq 85 (n = 188)	p
Gender				
Male	358 (48.2)	290 (52.3)	68 (36.2)	0.0001
Female	385 (51.8)	265 (47.7)	120 (63.8)	
Diagnosis				
Overall cancer	459 (61.8)	397 (71.5)	62 (33.0)	<0.0001
Gastrointestinal cancer	124 (16.7)	113 (20.4)	11 (5.9)	<0.0001
Lung cancer	101 (13.6)	93 (16.8)	8 (4.3)	<0.0001
Breast cancer	22 (3.0)	18 (3.2)	4 (2.1)	0.4354
Gynecological cancer	29 (3.9)	26 (4.7)	3 (1.6)	0.0587
Urinary cancer	55 (7.4)	42 (7.6)	13 (6.9)	0.7677
Other solid cancer	100 (13.5)	83 (15.0)	17 (9.0)	0.0401
Hematological cancer	28 (3.8)	22 (4.0)	6 (3.2)	0.6307
Cardiovascular diseases	62 (8.3)	44 (7.9)	18 (9.6)	0.4805
Respiratory diseases	36 (4.8)	29 (5.2)	7 (3.7)	0.4072
Other non-cancer diseases	161 (21.7)	71 (12.8)	90 (47.9)	<0.0001
Multisystem Organ Failure (MSOF)	25 (3.4)	14 (2.5)	11 (5.9)	0.0287
Nature of support during consult^a				
Pain management	403 (54.2)	321 (61.1)	82 (46.1)	0.0004
Pain/symptom/other support	300 (40.4)	204 (38.9)	96 (53.9)	
Discharge destination^b				
Home	202 (27.2)	176 (44.3)	26 (19.7)	<0.0001
Hospice	187 (25.2)	127 (32.0)	60 (45.5)	0.0051
Extended care facility	140 (18.8)	94 (23.7)	46 (34.8)	0.0117

^a Unspecified: n = 40.

^b Death: n = 203, unspecified: n = 11.

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