

## Death the Final Approach

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### Introduction

A palliative care program offers assessment and management of patient needs throughout the inpatient environment. The team behaves interactively on the principle that palliative care is a service. Common reasons for palliative care are [1]:

- Pain and symptom control
- Discharge planning and continuity of care
- End-of-life decision making
- Psychosocial issues involving patients and families
- Ethical issues.

Palliative care is an essential component that is necessary to strengthen our health care system and enhance coordination of care, quality, and cost.

### The Shared Circle

The ancient and universal symbol of the “circle of life” is one we all share. Each of us lives our lives as a piece of the whole. Everything in existence participates in this great cycle. The four stages are Birth, Development, Creation and Passing.

The “Circle of Life” refers to the fact that death is not really the end but the seed for something new. The First Law of Thermodynamics, “Energy can be neither created nor destroyed, only changed”, is a fundamental truth. The field of thermodynamics is the foundational basis for the study of Energy flow in natural systems.

This concept applies to other systems and processes. “When you think of the modern American hospital, it is designed to take care of the average person”, Dr. Morrison explained. “Most hospitals’ systems are aligned to rapidly bring such people in, diagnose them, treat them and transition them to an appropriate care setting, usually home” [2].

In contrast, palliative care programs are specialized for taking care of the very complex 5% of the population that drive 40% of health care costs. “They make a highly inefficient system efficient for most complex patients” [2].

Why are palliative care programs so cost-effective? Essentially standard hospital care is ineffective at managing complex patients with life-threatening illnesses. By necessity these patients are the chosen for a palliative care program [2]. Palliative care has matured and been nurtured by 53% of American hospitals with 50 or more beds, compared with almost none 10 years ago [2]. A 2008 report from the Center to Advance Palliative Care gave the nation overall a grade of C in access to hospital-based palliative care. More than 20% of the 50 states received “unacceptable” grades of D or F, and only four states received an A [2].

Flourishing palliative care programs are aligned with the corporate mission of compassion and absorbed into the foundation of the corporate culture.

## Sustainable Design

Core elements differentiate palliative care programs. First, palliative care programs aggressively treat pain, infection, and other symptoms. “When people are comfortable, and in some control, they can make decisions. They tend to stay in the hospital for a shorter period of time” [2].

Second, palliative care programs help patients and families make decisions and develop clear treatment plans in the challenging setting of complex illness. “Treatments in palliative care aren’t ‘one size fits all, people are individuals” [2].

Third, palliative care teams know their patients and community very well. “This means they know the needs of people with serious and life-threatening illnesses and can marshal resources for them, allowing these patients to leave the hospital with safer care plans” [2].

Palliative care “shifts” the course of care off the usual hospital pathway and, in doing so, significantly reduces costs. Direct hospital costs could be reduced by almost \$1,700 per admission (\$174 per day) for live discharges and by almost \$5,000 per admission (\$374 per day) for patients who died [3]. The average 400-bed hospital providing palliative care to 500 patients during the year could see an annual net savings of \$1.3 million [3]. After the process began decreases in costs consistently occurred [3].

The savings came from reductions in laboratory work, intensive care costs and pharmaceuticals [4]. Palliative care is about providing support, options and choices, not rationing care. It is about giving and receiving from all perspectives and contexts. Witnessing the process, allowing it to unfold, and providing as much comfort as possible in order for the patient to live their final days as they choose. Therein lays the gift.

## Inspired Goals

*“And in the end, it’s not the years in your life that count. It is the Life in your years”.*

Abraham Lincoln

Palliative care management is in alignment with the patient’s wishes and desires. The therapies complement these goals. Palliative care teams interview patients and their families early in treatment to identify what they want from therapy. They also assist with day-to-day care of patients [5]. Meticulous criteria to assessment and treatment of patients is a competency standard. “Physical symptoms, goals of care and transition planning must be consistently addressed in the same manner” [2].

Principles of palliative care are ones that place the patient at the focal point. They provide information and personal assistance in support of a patient’s right of choice. Additionally they emphasize the patient and provider relationship while enabling maximum effect of insurance benefits with less costly and more satisfying results.

Palliative care teams’ ongoing involvement in patient care is critical for success. Teams contribute to the clarification of goals of care with the patient and family. Families are guided as they seek appropriate medical treatments and decisions. Most patients are discharged alive. The emphasis is not end-of-life care [6].

## Regenerative Strategies

A major cost for the palliative care program will be staffing. Determine how many FTEs are needed in each staff category-whether comprised of part-time, full-time or both-based upon projected daily census. A downloadable, sample consult service budget can be used to create a program budget from the Center to Advance Palliative Care website. The references below are taken from this spreadsheet [7]. The Department Administrator or Human Resources can provide average salary rates to use in:

- Budgeting (A), as well as
- Benefits percentages (B).
- Salary plus benefits can now be determined (A+C=D).

The staff expense (D) is then pro-rated by the actual number of FTEs (F) to determine the total cost of each staff category. That is, if salary plus benefits equal \$216,000, then the staff expense of 0.3 FTE is equal to  $\$216,000 \times 0.3$  or \$64,800(F). Summing the total cost for each staff category provides the total staff and overhead costs [7].

In most cases, a cost efficient inpatient unit needs to be of a certain size due to the need to staff for continuous direct clinical care (3 shifts, 24/7). Achieving economic efficiencies with a small unit will be difficult unless staff can be shared with an adjacent unit or the unit's beds can be used by others (inpatient hospice or float overflow from other services) [7].

### **Integrative Leadership Management-Collaborative Partnership**

A collaborative undertaking concentrated on care management brought together the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York City and Franklin Health, Inc. (FHI) of Saddle River, New Jersey and Blue Cross/Blue Shield of South Carolina, which supplied patients with complex illnesses who could benefit from palliative care and care management [8].

FHI, one of the country's leading disease management firms, has established the gold standard for the effective coordination and management of difficult, costly, high-utilization cases. Managed care organizations across the country contract with FHI to identify such patients from utilization data, provide on-site care coordination and work with health plan officials and primary care physicians to optimize coordination of care and prevent medical complications that lead to costly hospitalizations [8].

"Most hospitalizations occur in a crisis, when the whole care system falls apart and the patient ends up in the emergency room-the place of last resort and a highly inefficient setting to manage this patient population. The hospital avoidance occurs not because somebody says, 'You can't go because we won't pay for it,' but because the need is averted-which is also good for the patient. When patients feel safe at home because they know they have a care coordinator who knows them and can help them at a moment's notice, they are much less likely to take their problems to the emergency room. It's the ones who don't feel safe at home, who feel abandoned, and who end up in the hospital". Dr. Diane E. Meier, Mount Sinai School of Medicine [8].

The company's preliminary data also shed light on other measurable results from the palliative care initiative, including:

- Significant reduction in perceived burden of symptoms by seriously ill patients and improved symptom management scores eight weeks following admission in a number of key areas;
- Increase in the number of advanced directives completed and used in clinical decision making;
- Very high acceptance and patient satisfaction rates, as well as high acceptability rates from clinicians;
- Increase in the number of identified domains of care that the nurse care manager identified as problems to be addressed; and
- Increase in the number of new prescriptions ordered to treat specific symptoms (from 28 percent per patient in the control group to 64 percent in the palliative care intervention group) [8].

"Patients in the intervention group received more prescription drugs aimed at symptomatic distress, including pain medications, which means the care manager has successfully contacted busy primary care doctors in their offices and, when indicated, gotten them to prescribe controlled substances", Meier explains. "That's incredible. The doctor still has to sign the order for the prescription, but I thought that would prove to be one of the biggest barriers to the project" [8] with advanced illness have a long length of stay and high cost of admission. The outcomes of palliative care are multifold.

**Palliative Care results in:**

- Reduction in Length of Stay
- Reduction in Total Costs/Admission
- Opportunity for New Admissions
- Better Quality of Care
- Highly Satisfied Families [6].

**Length of Stay Reduction Mount Sinai Hospital Data -2001 [6]**

Medicare Data: Palliative Care Patients spent 360 fewer days in Mt. Sinai as compared to Diagnosis Related Group Matched patients not followed by Palliative care.

**Reductions in Total Costs for Medicare Beneficiaries in 2001 [6]**

Cost savings from palliative care = \$757,555 per year for patients with LOS > 14 days

Cost savings for Palliative Care = \$455,936 per year for patients with LOS > 28 days

Cost per day = total per DRG/Avg LOS per DRG for patients who passed

Costs reduced by palliative care = Cost per day x number of days saved by Palliative Care

**Percent of Palliative Care Families Satisfied or Very Satisfied Following their Loved Ones Death with**

- Control of Pain 95%
- Control of Non-Pain Symptoms 92%
- Support of Patient's Quality of Life 89%
- Support of Family Stress and Anxiety 84%
- Manner of healthcare providers 88%
- Overall Care by the Palliative Care Program 95% [6].

**Connections for the Pharmacist and Pharmacy Technician**

A built in program support system is available within the Pharmacy Department. All participants can explore service and life-altering experiences in Palliative Care. The American Journal of Health-System Pharmacy Statement provides a framework upon which a responsibility structure can be built. Below are the seven points the Statement addresses [9]:

1. Assessing the appropriateness of medication orders and ensuring the timely provision of effective medications for symptom control. Pharmacists keep medication records and follow prescription and nonprescription medication administration. Pharmacists provide patients with essential medications within a time frame that ensures continuous symptom control (especially pain relief) and avoids the need for emergency medical services.
2. Counseling and educating the hospice team about medication therapy. Pharmacists attend hospice team meetings to advise other team members about medication therapy, including dosage forms, routes of administration, costs, and availability of various drug products. This is done through regularly scheduled educational sessions. Pharmacists develop and maintain a library of contemporary references about medications, dietary supplements, and alternative and complementary therapies. Pharmacists advise members of the hospice team about the potential for toxicity from and interactions with dietary supplements and alternative and complementary therapies.

3. Ensuring that patients and caregivers understand and follow the directions provided with medications. Pharmacists ensure that all medication labeling is complete and understandable by patients and their caregivers. Hospice pharmacists communicate with patients, either through the team or in person and answer questions about addiction, dependence, and tolerance and dispel patient and caregiver misconceptions about addiction to opiate agonists. Pharmacists ensure the availability of devices and equipment to permit accurate measurement of liquid dosage forms by patients and their caregivers. Pharmacists counsel patients about the role and potential toxicity of alternative and complementary therapies. When needed, hospice pharmacists visit patients' homes to communicate directly with patients and their caregivers and to make necessary assessments.
4. Providing efficient mechanisms for customized specialty dosing of medication. Medication compounding needs in hospice care include the preparation of dosage forms to ease administration (e.g., concentrated sublingual solutions, topical medications), flavoring medications to promote compliance, eliminating or adjusting ingredients that patients cannot tolerate, and preparing or changing drug concentrations. Whenever possible, pharmacists compound formulations for which stability and bioavailability data are available.
5. Addressing financial concerns. Hospice benefits usually cover medications. However, patients may lack insurance coverage or benefits may not cover medications that are not considered strictly palliative. Pharmacists communicate with pharmaceutical manufacturers to obtain medications through patient assistance programs.
6. Ensuring safe and legal disposal of all medications after death. Medications dispensed to patients are "owned" by the patients and, in most states, cannot be used for other patients. Medications remaining in patients' homes fall under a variety of hazard categories. Pharmacists are able to assist families with the removal of the medications from the home in compliance with federal and state drug control and environmental protection laws and regulations.
7. Establishing and maintaining effective communication with regulatory and licensing agencies. Because hospice patients often require large quantities of controlled substances, open communication with both state and federal controlled-substance agencies is important. Pharmacists ensure compliance with laws and regulations pertaining to medications.

Pharmacy technicians are indispensable. They provide pharmacists with logistical support and are essential healthcare team members. Pharmacy technicians enhance the pharmacy ensemble. This results in higher standards, efficiencies and quality. Successful programs have effectively utilized the skill sets of Pharmacy technicians to better connect with the patients and communities they serve.

## Conclusion

The author believes in the exceptional value of palliative care teams. The impact of will increase in significance as the proportion of older, complex and chronically ill patients increases. This will be an influencing force to improving the quality of care by utilizing health care resources in a sustainable and sensible way.

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