Funders Improving Care at the End–of–Life

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<table>
<thead>
<tr>
<th>Where We Are</th>
<th>Pittsburg</th>
<th>USA</th>
<th>Portland</th>
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</thead>
<tbody>
<tr>
<td>High Intensity of End–of–Life Care in Last 6 Months of Life (2005) Comparison to a Community with a Strategy</td>
<td></td>
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<tr>
<td>% of hospitalized Medicare deaths</td>
<td>29%</td>
<td>29%</td>
<td>22%</td>
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<tr>
<td>Hospital days</td>
<td>11.96</td>
<td>10.81</td>
<td>6.05</td>
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<tr>
<td>In-patient Medicare reimbursements</td>
<td>$14,107</td>
<td>$13,805</td>
<td>$10,024</td>
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<tr>
<td>% admitted to intensive care during final hospitalization</td>
<td>18%</td>
<td>17%</td>
<td>12%</td>
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<tr>
<td>% admitted to intensive care</td>
<td>43%</td>
<td>39%</td>
<td>25%</td>
</tr>
<tr>
<td>% spending seven or more days in intensive care</td>
<td>15%</td>
<td>14%</td>
<td>5%</td>
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<tr>
<td>Hospice days per decedent during the last 6 months of life (2001-2005)</td>
<td>9.26</td>
<td>11.55</td>
<td>13.19</td>
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Data extracted from: The Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences at Dartmouth Medical School, Population-based rates for geographic regions.

Data extracted from: The Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences at Dartmouth Medical School, Provider-based rates for geographic regions;
This is What We Hear

- **Specialist:** “I saved him, but I am not sure I did him any favors. He didn’t think so, nor did his wife.”
- **Family:** “Too many decisions are made at the moment of acute terror. We should talk beforehand.”
- **Clergy:** “Do care and cure have to be united? I can accept supporting death as caring?”
- **Social Worker:** “Death is still seen as a failure. Our docs can’t deal with it.”

What We’ve Funded

- Hospice
- Pain Management Pilots
- Chair in Palliative and EOL Care
- Physician/Patient Conversations
- Creative Non-Fiction Special Issue
- Institute to Enhance Palliative Care
- Compassionate Sabbath – clergy retreat
- APPEAL – Palliative care education for African Americans
- **Closure** – Conversations at End-of-Life
Closure Vision

- Patients and loved ones are informed about choices and challenges
- Resources, support systems, curricula and planning tools are widely accessible in all settings
- End-of-life issues are openly discussed; End-of-life viewed as meaningful and personal

Closure: Conversations About End-of-Life

Overview of Issues: How do most Americans die? What makes a “good” end-of-life experience for patients, families and practitioners?

The Family and Providers Experiences: Can caregivers and providers listen and learn from each other’s perspectives and experience?

Values: How do ethical issues and religious customs influence end-of-life decisions?

The Planning Tool Kit: What are the essential documents and resources for successful preparation? Who helps with this?

Resources and Implementation: When should we access palliative care services and hospice referrals?

Planning for Culture Change
A Policy Agenda
Closure Participants:
Attended Six Monthly Sessions/ 18 Hours

Physicians and Registered Nurses
- AIDS Specialists
- Cardiology
- Critical Care
- Emergency Care
- Family Medicine
- Geriatrics
- Hospice Care
- Long-Term Care
- Oncology
- Palliative Care
- Pathology
- Pediatric Palliative Care
- Primary Care
- Psychiatry
- Surgery

Professional Caregivers
- Adult Day Care
- Home Healthcare / Direct Care Workers
- Hospice Care
- Palliative Care

Service Providers
- Clergy
- Estate and Financial Planners
- Lawyers
- Senior Service Providers
- Social Workers

“Family” Caregivers
- Children
- Neighbors
- Siblings
- Spouses

Closure Talking Points

Society - What is a “good” death; can we consider death as a part of the lifecycle?

System - Why is the “default” setting cure vs. care? Why does reimbursement incentivize treatment over palliative care?

Family - Why do we limit advanced care planning palliative care options? Where is the guidance and support?

Provider - Where is the training and support to admit “failure,” and to help families transition from “cure” to “care”? How do I access other resources to support patients and families through their life threatening/chronic illnesses?
Ongoing efforts in Pittsburgh

- Replicating Closure
  - Catholic and African American Communities, and through the Veterans’ Administration VISN 4

- Readmissions Prevention Demonstration Project
  - in Long-Term Care (Dementia Unit) with VA

- [www.Closure.org](http://www.Closure.org)
  - downloadable, advance planning documents and a 12-modules core curriculum for families and professionals