@wilcoachterberg

LEIDS UNIVERSITAIR MEDISCH CENTRUM

Medical spending of the US elderly

Dollars well spent?
Remarks from a Futile care perspective

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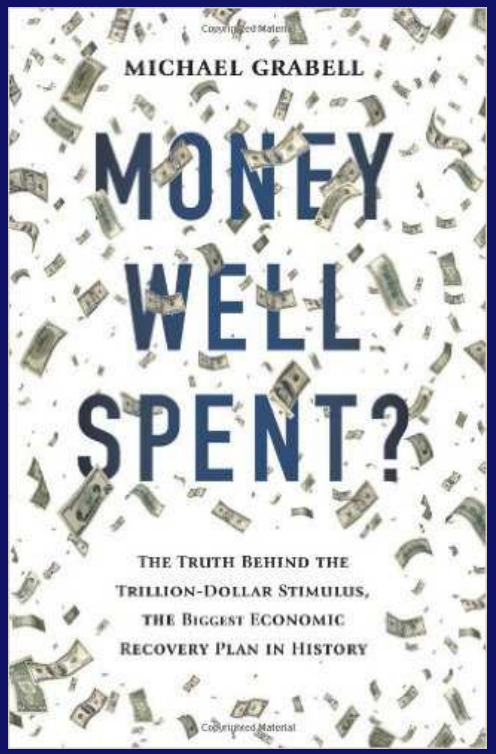
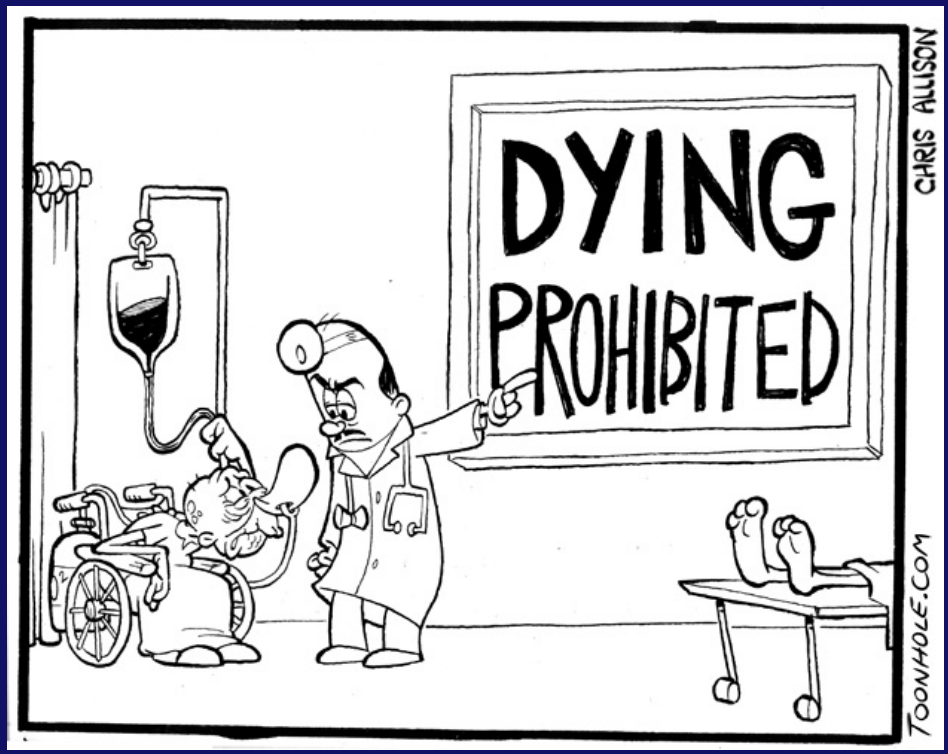
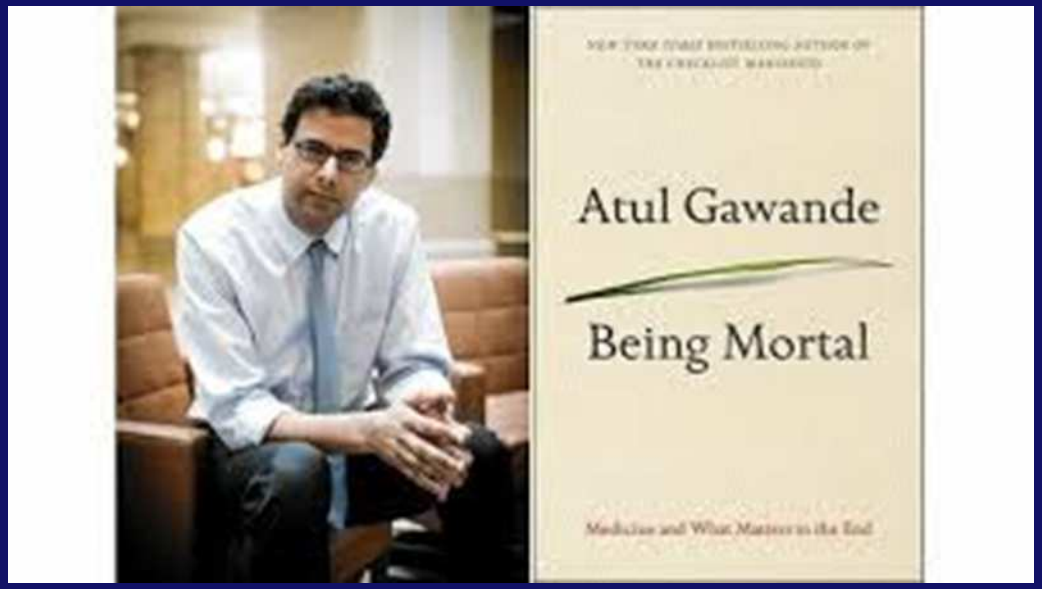
- Medical expenses double 70-90
- Expenses are large before death (5% last year, 13% last 3 y)
- But relatively only a small fraction of total spending

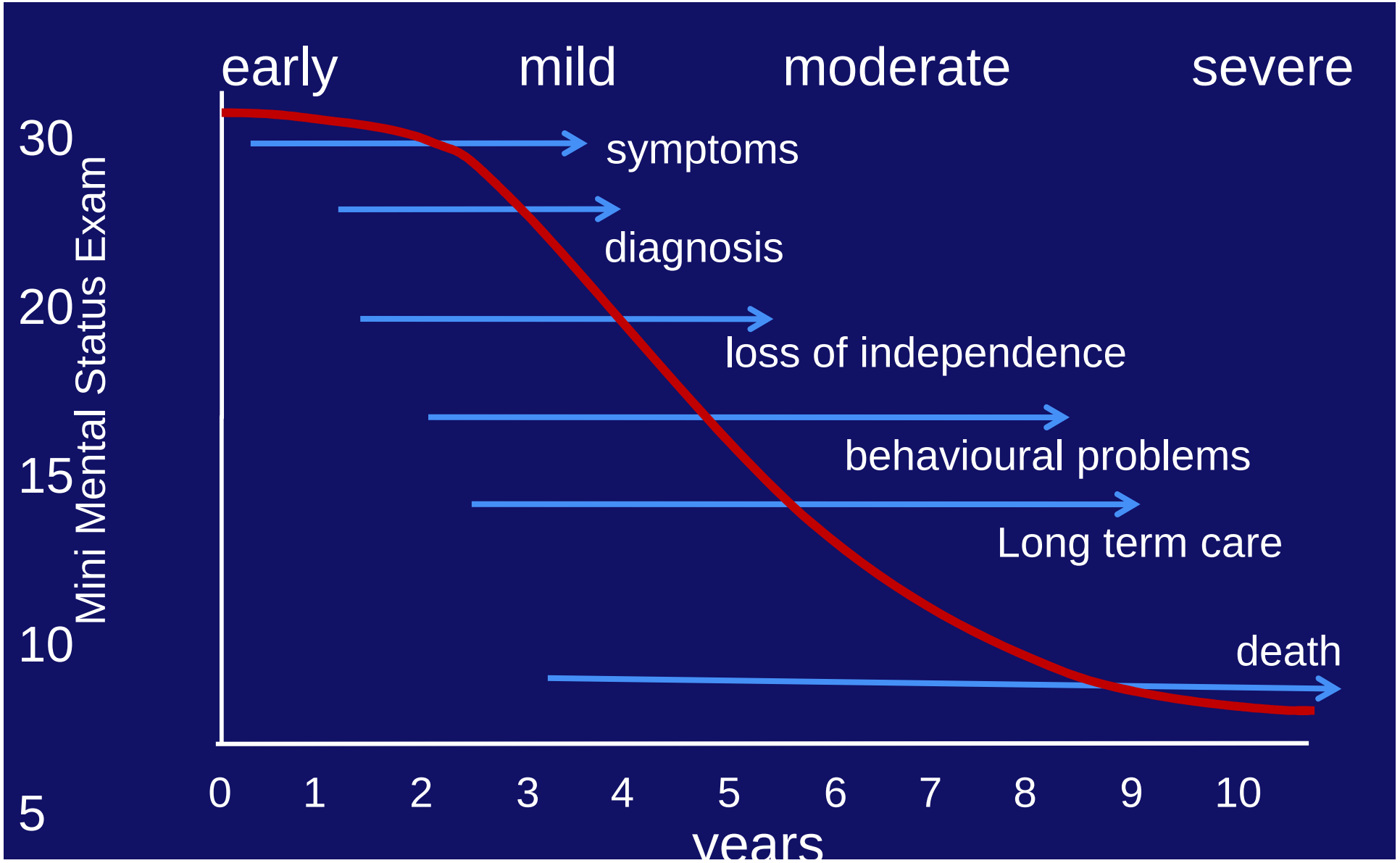




Should we do all that we can? About Futile care



Progression of Alzheimer's disease



adapted from Feldman and Gracon 1996

Leads to shifting goals of care

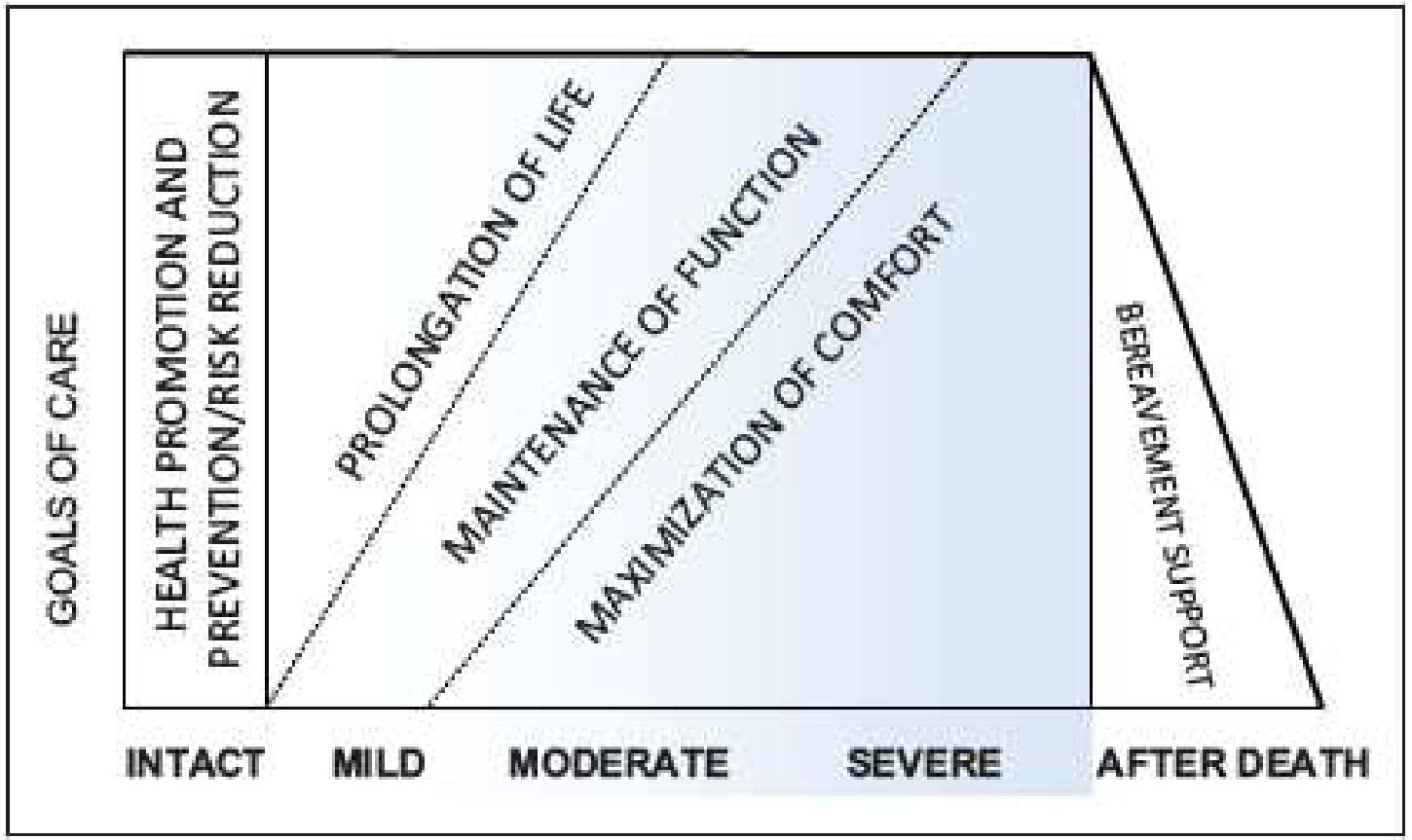


Figure 1. Dementia progression and suggested prioritizing of care goals.

Physical discomfort encountered in last stages

- Challenging/inappropriate/aggressive behavior
- Pain
- Shortness of breath
- Incontinence
- Pressure ulcers
- Communication with spouse and care givers
- Malnutrition
- Depression and apathy
- Muscle contractures
- Dental/mouth care
- ……etc

How is medical care different in these stage?

- Advance care planning: resuscitation? Tube feeding? Hospital admission? Medication review
- When needed: high quality medical/nursing treatment

- Comfort care:
- - medical
- - nursing
- - social
- - spiritual

Physicians "Missing in Action": Family Perspectives on Physician and Staffing Problems in End-of-Life Care in the Nursing Home

Renée R. Shield, PhD, Terrie Wetle, PhD, Joan Teno, MD, MS, Susan C. Miller, PhD, MBA, and Lisa Welch, PhD

- Little admissions to hospital

Avoid aggressive, burdensome or futile treatment

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The Clinical Course of Advanced Dementia

Susan L. Mitchell, M.D., M.P.H., Joan M. Teno, M.D., Dan K. Kiely, M.P.H., Michele L. Shaffer, Ph.D., Richard N. Jones, Sc.D., Holly G. Prigerson, Ph.D., Ladislav Volicer, M.D., Ph.D., Jane L. Givens, M.D., M.S.C.E., and Mary Beth Hamel, M.D., M.P.H.

Intervention	N (%)
Parental therapy	52 (29.4%)
Hospitalisation	22 (12.4%)
Emergency Room visit	5 (2.8%)
Tube feeding	13 (7.3%)
Any intervention	72 (40.7%)

Permanent enteral tube feeding may not be beneficial and should as a rule be avoided in dementia

Cohort: “No increased survival in dementia patients receiving enteral tube feeding”

Enteral tube feeding for older people with advanced dementia (Review)

Sampson EL, Candy B, Jones L

THE COCHRANE COLLABORATION®

ETHICS, PUBLIC POLICY, AND MEDICAL ECONOMICS

Comfort Feeding Only: A Proposal to Bring Clarity to Decision-Making Regarding Difficulty with Eating for Persons with Advanced Dementia

(See Editorial Comments by Dr. Daniel J. Brauner, pp 599–601)

Eric J. Palecek, MSIV, Joan M. Teno, MD, MS,† David J. Casarett, MD, MA,‡ Laura C. Hanson, MD, MPH,§ Ramona L. Rhodes, MD, MPH,‖ and Susan L. Mitchell, MD, MPH#*

“Comfort feeding only through careful hand feeding as an alternative to tube feeding

Referral rate to hospital

	Mild to moderate dementia		Severe dementia	
	US (n=421)	NL (n=223)	US (n=280)	NL (n=328)
Hospital transfer within 30 days after diagnosis	29 %	1 %	22 %	0.3 %
Intensive care unit	2 %	0 %	4 %	0 %
Antibiotics	84 %	89 %	76 %	67 %
Oxygen	10 %	12 %	12 %	15 %

Treatment of Nursing Home Residents with Dementia and Lower Respiratory Tract Infection in the United States and the Netherlands: An Ocean Apart J Am Geriatr Soc 52: 691–699, 2004

NETSPAR LEIDEN 2016

Figure 1. Conceptual model of influences on US physician decision-making regarding care of demented nursing home patients who develop pneumonia.

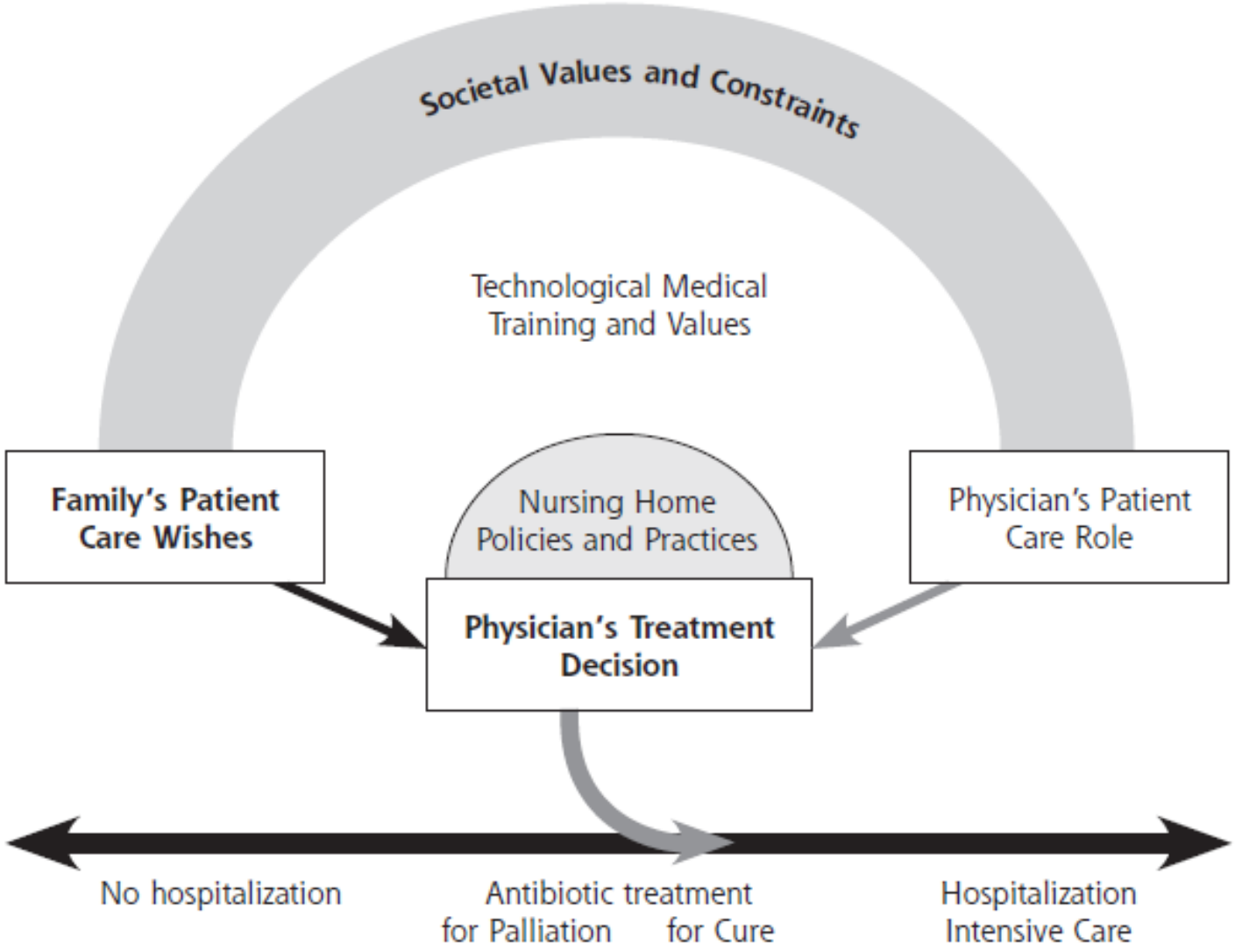
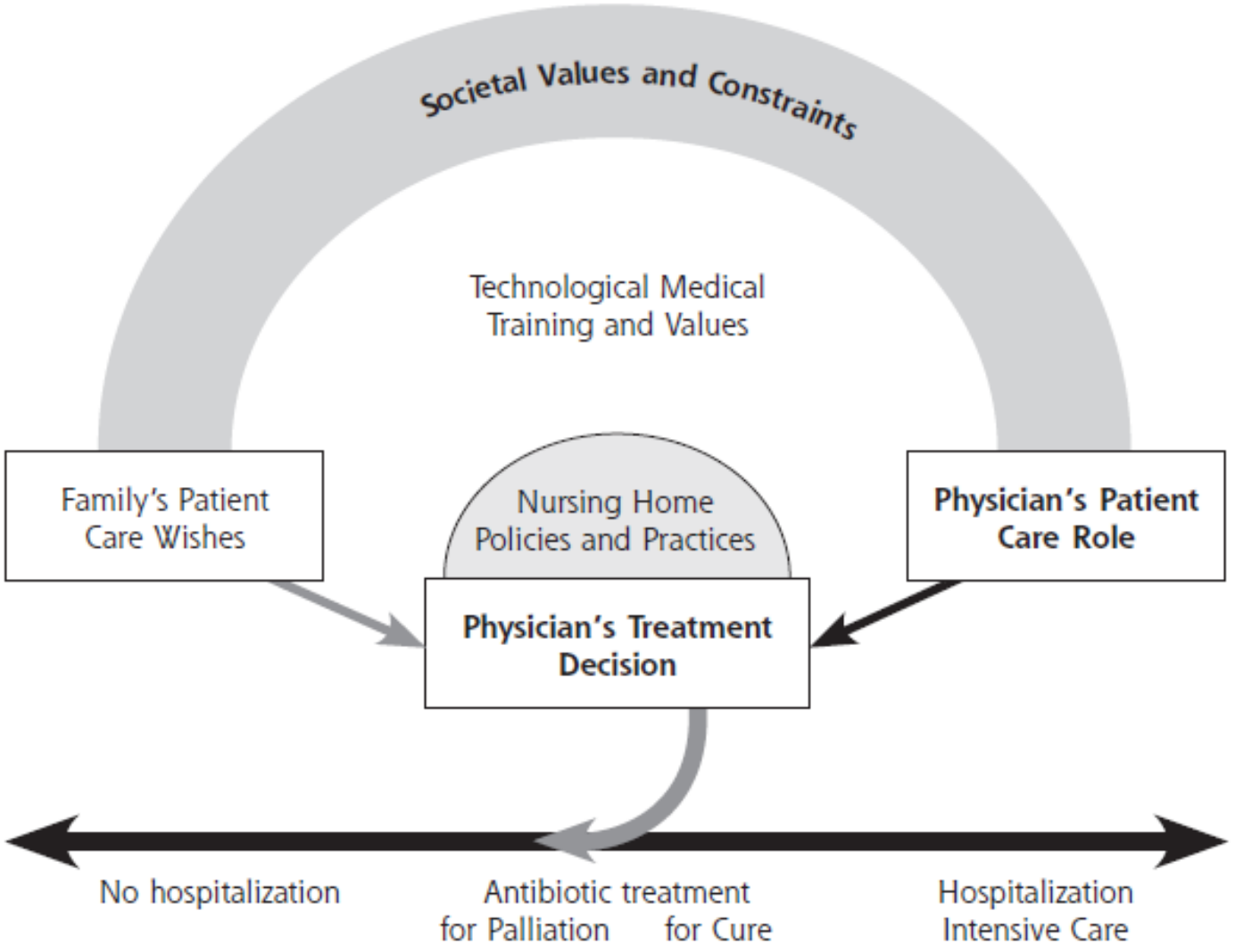
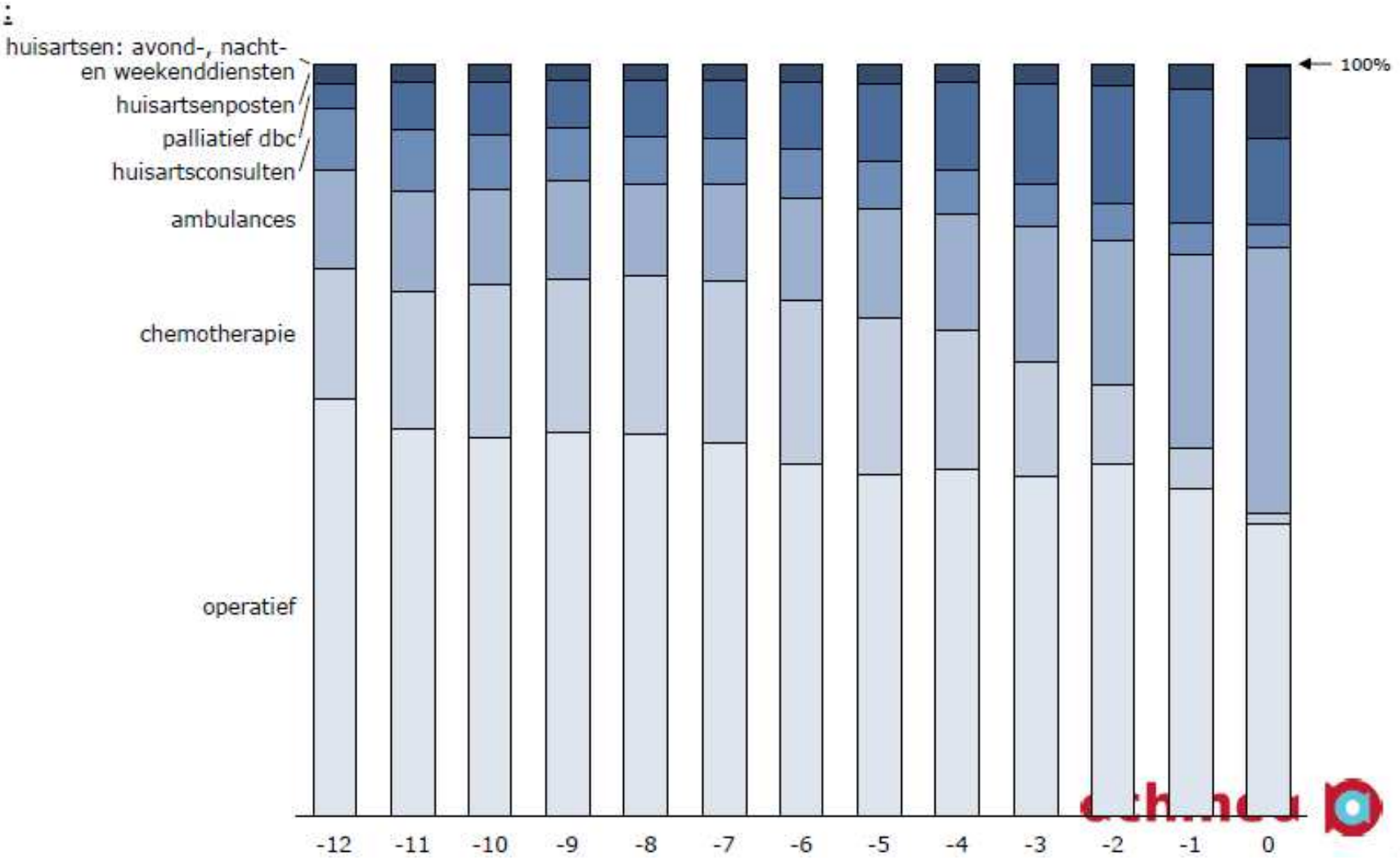


Figure 2. Conceptual model of influences on Dutch physician decision-making regarding care of demented nursing home patients who develop pneumonia.

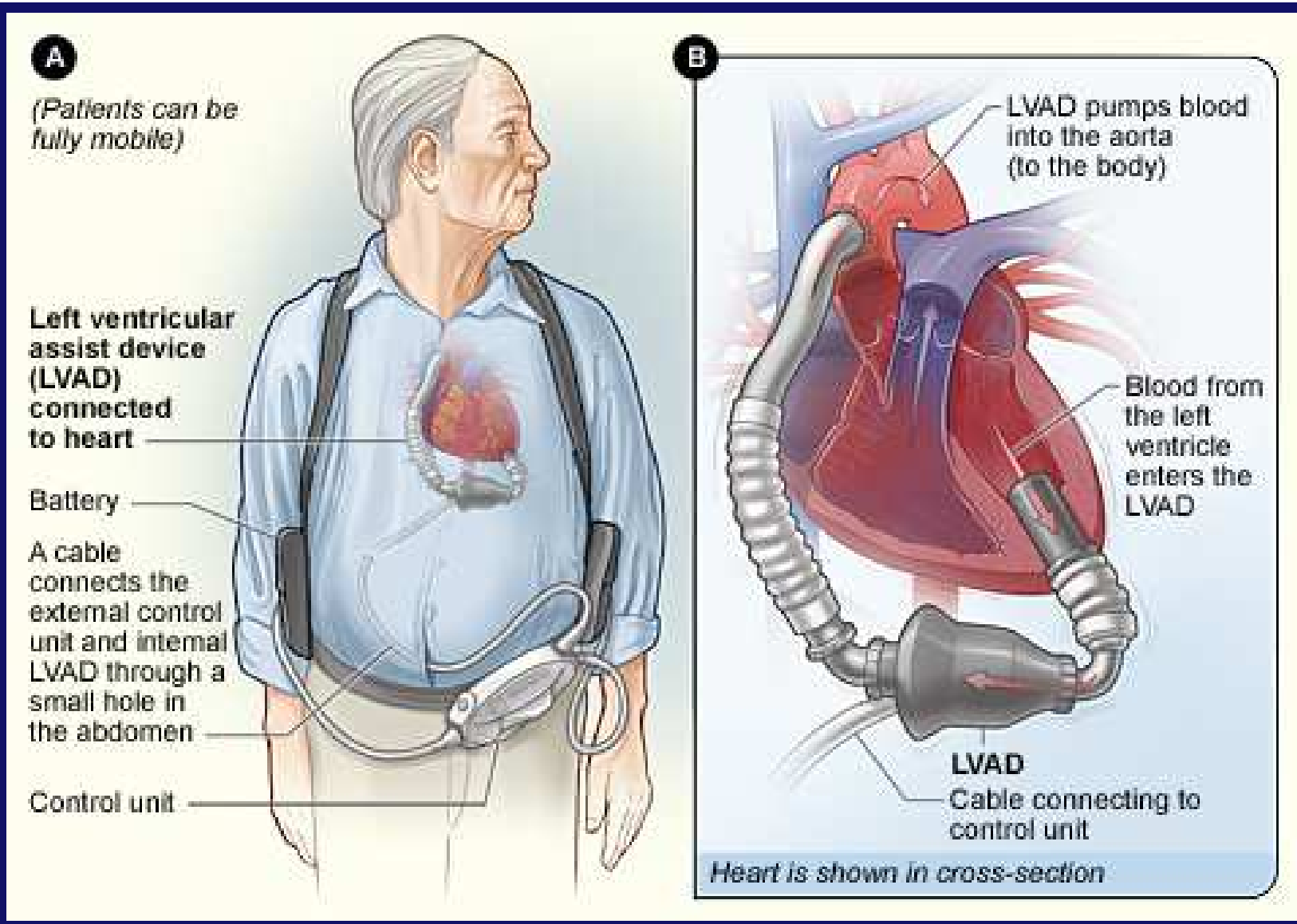


Costs in the NL in subgroups of treatment in the last year of cancer

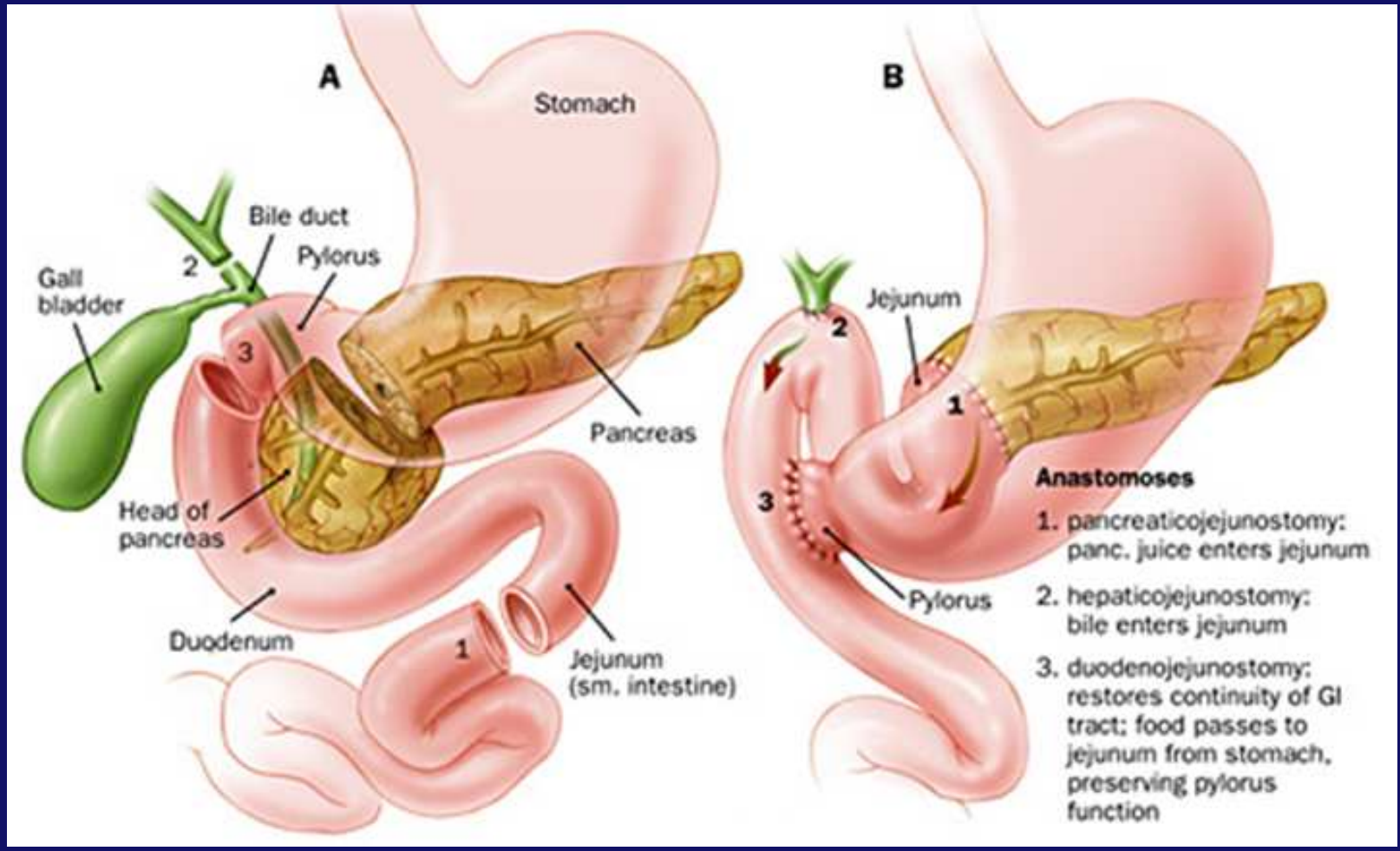
Kosten per maand van laatste levensjaar verdeeld over relevante hoofdgroepen van behandeling



Example 1: external heart for heart failure



Example 2: whipple operation for Pancreas carcinoma



JAMDA

journal homepage: www.jamda.com

Editorial

Improving the Quality of End-of-Life Care

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"Let it be a great day to die."

~ *Sioux Warrior Greeting*

Death is an inevitable consequence of being born (Figure 1). As such, it is important that human beings recognize this inevitability and plan for a good death. Although in most developed countries there is increased awareness of the need to plan for death by having advanced directives and/or a living will, in many cultures, the discussion and/or recognition of death is avoided. For example, in some Asian cultures, discussing death is bad luck, basically because of fear of death and the thinking of no world after death. In Singapore education, programs such as "both sides" and "happy coffins" have been launched to engage older persons in discussions about the end of life (www.lienfoundation.org) (Figure 2).

Much of the burden of end of life is created by inpatient admissions (40%–88%) and prolonged time spent in the intensive care units (20%–50%). Early involvement in palliative care programs cannot only improve quality of life but reduce hospital stays and even increase survival time.[1] In general, palliative care should be introduced approximately 2 years before the person is expected to die. Palliative care is defined as "preventing and relieving suffering while support with the United States being ranked 31st. End-of-life care was most available in the United Kingdom with the United States ranking eighth and China fortieth. Overall, Japan ranked 23rd, which is surprising, recognizing that it is the most long-lived country.

There has been a marked increase in integrating hospice care into the nursing home in the United States.[3,4] The length of hospice in nursing home residents is relatively long at 114 days, with approximately 20% of residents being longer than 6 months.[5] Hospice residents were rehospitalized 23.18% compared with 37.63% of nonhospice residents.[6] Advance care planning and advanced directives need to be discussed early. The INTERACT program has reduced hospital admissions predominantly by obtaining advanced directive planning that includes the decision not to be rehospitalized.[7–10] The FRAIL-NH questionnaire appears to be a useful instrument to identify nursing home residents suitable for hospice.[11,12]

In palliative care residents, it is important that some forms of comprehensive geriatric assessment are performed.[13] The studies of the MDS 3.0 have shown that it is superior to the inter-RAI 2.0 for doing assessments that obtained the patient's viewpoint and are clinically useful.[14–18] The Rapid Geriatric Assessment (RGA) is a simple

Poetry & medicine: a note to his doctor

Kevin Hadduck

My friend, old and passing, said,
"There is more to life than staying alive.
Don't rescue me too much."

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