ASSESSING SAFETY OF PERIOPERATIVE β-BLOCKADE, PAGE 11

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Palliative care is offered in 41% of public hospitals and 29% of sole community provider hospitals, Dr. R. Sean Morrison said.

Hospitals Get a 'C' In Palliative Care

BY ALICIA AULT
Associate Editor, Practice Trends

Hospitals are rapidly adding palliative care services, but their availability is widely disparate, according to a report that gave a grade of "C" to the state of palliative care services in the nation's hospitals.

Overall, 53% of U.S. hospitals with 50 or more beds reported offering palliative care, according to the report card that was compiled by the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC), which is based at Mt. Sinai School of Medicine in New York.

But geographic access varies widely, the report found. In three states—Alabama, Mississippi, and Oklahoma—10%-20% of hospitals offer palliative care. In Vermont, every hospital offers the service. The results were published online in the Journal of Palliative Medicine (2008 Oct. 2 [doi:10.1089/jpm.2008.0053]).

Hospitals were graded on patient access to palliative care services, patient access to board-certified palliative medicine specialists, medical student access to clinical training in palliative medicine, and physician access to specialty-level training in the field. The report is based on the American Hospital Association's 2006 Annual Survey Database and a more recent survey that was mailed to hospitals by the CAPC.

The report excluded rehabilitation, psychiatric, and pediatric hospitals. Children's hospitals were excluded because many pediatric palliative care programs are within general acute care facilities and there was no way to distinguish them, Dr. R. Sean Morrison, director of the NPCRC, said in an interview. Veterans Affairs hospitals also were excluded because the government requires every VA facility to offer palliative care, said Dr. Mor-

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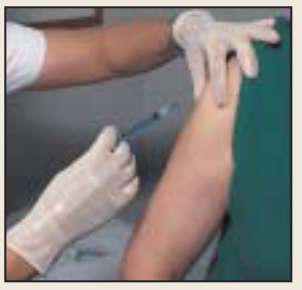
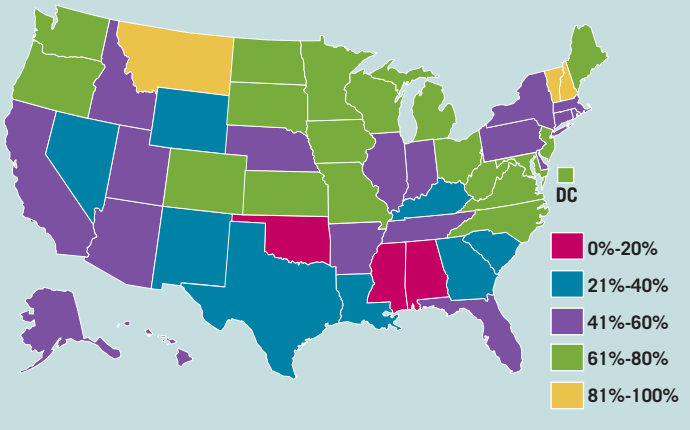
INSIDE



VITAL SIGNS

Percentage of Hospitals With Palliative Care Programs in FY 2006



Sources: Center to Advance Palliative Care and the National Palliative Care Research Center

ELSEVIER GLOBAL MEDICAL NEWS

Acute Coronary Syndrome Risk High in Pneumonia

Bacterial CAP increases risk 8-fold.

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — The development of acute coronary syndrome was eight times more common among patients hospitalized with community-acquired bacterial pneumonia than among hospitalized controls.

In a 7-year study at a Veterans Affairs hospital, there were 22 (11%) cases of ACS in 206 patients with community-acquired pneumonia (CAP) and 6 (1.5%) cases in 395 controls, a significant difference with an odds ratio of 7.8.

Moreover, when risk was assessed for coronary events in the year before and in the year after their pneumonia, the risk was 45 times greater in the first 15 days after admission for pneumonia—and more than 100 times greater during the first 3 days after admission. Of the 36 CAP patients with at least one ACS during the 2-year span, 58% of the events occurred within 15 days after admission. The relative incidence ratios for ACS were 47 for days 1-15 after the CAP admission and 132 for days 1-3, compared with 3 for days 4-15 after the CAP admission.

Acute coronary syndromes were defined as evolving or diagnostic ECG changes, diagnostic biomarkers, or electrocardiogram findings consistent with ischemia

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Protocol for Preventing Infections Streamlined

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — A new compendium issued by five leading health care organizations provides a set of simplified protocols for the prevention of health care–associated infections within hospitals.

The Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals was jointly produced by the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the American Hospital Association, the Association for Professionals in Infection Control and Epidemiology, and the Joint Commission, which accredits and certifies hospitals.

The document was endorsed or supported by another 29 organizations, including the American Medical Association, the Pediatric Infectious Disease Society, the American College of Physicians, and the American College of Surgeons.

The goal was to streamline the many competing current guidelines into easy-to-follow steps, Dr. David Classen explained at a press briefing on *Clostridium difficile* held during the jointly held annual Interscience Conference on Antimicrobial Agents and Chemotherapy and the annual meeting of the Infectious Diseases Society of America.

"U.S. hospitals are under the gun to prevent and detect several hospital-acquired infections," said Dr. Classen, an infectious disease specialist at the University of Utah, Salt Lake City, who was one of the compendium's authors.

The compendium offers "practical and easy-to-implement advice" on how to achieve those goals.

The document is organized

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Hospitalists Positioned to Lead Palliative Services

BY ALICIA AULT
Associate Editor, Practice Trends

Palliative care can increase patient and family satisfaction, enhance the quality of care, and lead to greater efficiency and savings, according to hospitalists who have taken the lead in managing palliative care services at their institutions.

Palliative care addresses physical, emotional, and spiritual comfort at the end of life. Once primarily the purview of hospice programs, palliative care services are now also offered at a growing number of hospitals—30% of institutions overall and 70% of hospitals with more than 250 beds. The numbers represent an increase of 96% since 2000, according to the American Hospital Association.

See related story on page 22.

Hospitalists are in a good position to lead or participate in interdisciplinary palliative care teams that work with patients to understand their goals and preferences for end of life care, according to Dr. Steve Pantilat, a professor of clinical medicine and the Alan M. Kates and John M. Burnard Endowed Chair in palliative care at the University of California, San Francisco.

Palliative care has been a core competency for hospitalist medicine, he said in an interview. Hospitalists regularly see patients who are in need of palliative care or are ready for hospice. Hospitalists also play an important role in educating their colleagues about patients' needs for palliative care.

In recognition of the growing importance of palliative care, the American Board of Medical Specialties offered its first subspecialty exam in hospice and palliative medicine in late October. The exam will be offered every other year until 2012. After that time, only fellowship-trained physicians will be eligible to take the exam.

Dr. Pantilat, a past president of the Society of Hospital Medicine, noted that certification is a positive move because it "recognizes palliative medicine as a distinct set of skills and knowledge," and establishes rigorous standards for training.

Dr. Woody English, the consulting palliative care physician at Providence St. Vincent Medical Center in Portland, Ore., said that frequent hands-on work with palliative care puts hospitalists at an advantage, but emphasized that specific training is still needed.

Much of this training centers on good communication and negotiation skills, said Dr. English, who helped start both the hospitalist and the palliative care consulting programs at Providence, which is part of a nonprofit integrated health care system.

Before the palliative care service was established, care plans often would not be executed. The problems were largely because of shift changes, but also because of conflicting goals among the patient, the family, and physicians, he said.

"I came to understand after several years that what hospitalists really need is training in goal-setting," Dr. English said. A palliative care physician "tries to put the patient in the center and direct traffic among the family members."

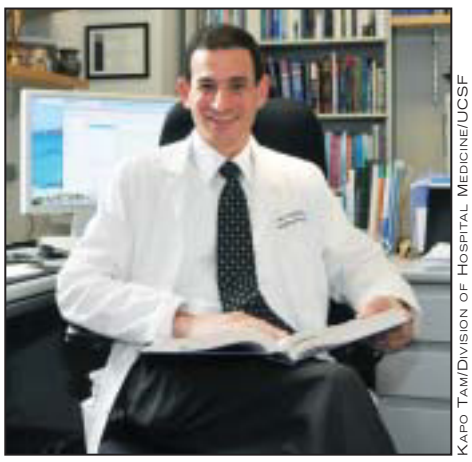
Once a hospitalist has mastered the traffic cop and negotiation skills, he or she is better equipped to communicate with patients and families in ways that encourage them to be more open to the physician's guidance.

And those skills benefit the hospital's administration, too. "By having us there and being skilled in listening and valuing people wherever they are, we found that we've taken a lot of angry people and made them less angry," he said.

Similarly, several studies have shown that palliative care improves parent and child satisfaction in pediatrics, said Dr. Margaret Hood, who is director of pediatric palliative care services at the Arnold Palmer Hospital for Children and Women in Orlando.

The American Academy of Pediatrics created a new section on hospice and palliative medicine this year to expand education and to support growth of the field, she said.

Yet even with hospitalist leadership, palliative care can be a tough sell to administrators. A 2-year grant funding the St. Vincent program is about to expire and, despite increased patient satisfaction, it's unclear whether the administration will offer funding to continue palliative care, Dr. English said.



KAPO TAM/DIVISION OF HOSPITAL MEDICINE/UCSF

Palliative services use resources more efficiently, Dr. Steve Pantilat said.

Dr. Pantilat pointed out the need to demonstrate more efficient use of resources and cost savings around palliative care. For instance, some hospitals have found adding a palliative care program has helped to reduce pressure on the intensive care unit and the emergency department. Palliative services provide care in an alternative way that patients and families desire, and use resources more efficiently.

An oft-cited multicenter, randomized, controlled study published earlier this year found that inpatients receiving palliative care had greater satisfaction and fewer ICU admissions—12, compared with 21 for those receiving usual hospital care (J. Palliat. Med. 2008;11:180-90). They also had lower total health costs, with a 6-month net cost savings of $4,855 per patient.

A more recent study also found significant cost savings. The authors looked at administrative data for eight hospitals for 2002 through 2004, and compared propensity-matched patients receiving palliative care with those getting usual care (Arch. Intern. Med. 2008;168:1783-90). Palliative care patients who were discharged had adjusted net savings of $1,696 in direct costs per admission. These patients had significantly lower lab and ICU costs. Palliative care patients who died had savings of $4,908 in direct costs.

To achieve these savings typically requires investment by the hospital, and "this is where things seem to fall apart," Dr. Pantilat commented. It's not like opening a catheterization lab—the chief executive of the hospital "can't see the income stream."

But with Medicare coverage, "if you can provide better care that's less resource intensive for that population, you may save money," he said. Still, the main reason to have palliative care is "to improve quality."

Dr. English agreed that it is the right thing to do, adding that many physicians find being involved in palliative care takes them back to the reason they went into medicine—to help patients. ■

Palliative Care Access

Hospitals *from page 1*

rison, a coauthor of the report.

Hospitals with more than 300 beds were most likely to have palliative care, with 75% reporting a program. Nonprofit hospitals and hospitals affiliated with a medical school also were more likely to offer a palliative program.

Only 20% of for-profit hospitals report offering palliative care. Dr. Morrison said he was not sure why programs were few and far between at these facilities.

Palliative care is offered in 41% of public hospitals and 29% of sole community provider hospitals, creating a disparity of access for many urban, rural, and isolated areas, Dr. Morrison said.

The Midwest had the highest prevalence of hospitals with palliative care programs (65%), followed by the Northeast and the West. In the South, only 41% of hospitals offer palliative care.

There were some exceptions to the general trends. Montana, a largely rural state, had the second-highest prevalence, with 88% of hospitals offering palliative care. Dr. Morrison said that one of the pioneering palliative care programs was started in the state, which might explain why so many Montana hospitals have palliative care.

The report also pointed out a need for palliative care training to meet the needs of an estimated 90 million Americans living with a serious or life-threatening illness. At least one hospital palliative care program is affiliated with 88% of private U.S. medical schools and 82% of state-funded schools. There are no postgraduate fellowship training programs, however, in 23 states and Washington, D.C.

The 2,651 physicians who have board certification in palliative medicine translate to 1 certified physician per 31,000 people living with a serious or life-threatening illness. In comparison, there are 16,800 cardiologists (or 1 per 71 patients with myocardial infarctions) and 10,000 oncologists (or 1 per 145 newly diagnosed cancer patients).

A new certification program in hospice and palliative medicine being offered by the American Board of Medical Specialties should help the field grow, Dr. Morrison said. But the "dramatic growth in the number of young physicians entering palliative care [is] … not quite enough to staff all these programs that are developing, so we also need to see mid-career people make a shift."

Palliative care helps hospitals to improve patients' quality of life and satisfaction, and to match patients' goals to treatments, according to Dr. Morrison. Patients and families are demanding palliative care because it helps them to navigate care for life-threatening illness, one of the toughest times there is to get through the health care system, Dr. Morrison said.

Palliative care offers a coordinated approach to pain and symptom management, and addresses the patient's emotional, financial, and spiritual needs. Palliative care is usually delivered through a multidisciplinary team that might include physicians, nurses, social workers, pharmacists, psychiatrists, and a chaplain, priest, rabbi, or other religious representative.

The study was funded by seven nonprofit foundations and the United Hospital Fund, all of which support the CAPC and the NPCRC. The report is online at www.capc.org. ■