

spouse's physician about the death so that he or she is aware of symptoms that might require professional attention.

PALLIATIVE CARE SERVICES: HOW AND WHERE

Determining the best approach to providing palliative care to patients will depend on patient preferences, the availability of caregivers and specialized services in close proximity, institutional resources, and reimbursement. Hospice is a leading, but not the only, model of palliative care services. In the United States, a plurality—41.5%—of hospice care is provided in residential homes. In 2012, just over 17% of hospice care was provided in nursing homes. In the United States, Medicare pays for hospice services under Part A, the hospital insurance part of reimbursement. Two physicians must certify that the patient has a prognosis of ≤ 6 months if the disease runs its usual course. Prognoses are probabilistic by their nature; patients are not required to die within 6 months but rather to have a condition from which half the individuals with it would not be alive within 6 months. Patients sign a hospice enrollment form that states their intent to forgo curative services related to their terminal illness, but they can still receive medical services for other comorbid conditions. Patients also can withdraw enrollment and reenroll later; the hospice Medicare benefit can be revoked later to secure traditional Medicare benefits. Payments to the hospice are per diem (or capitated), not fee-for-service. Payments are intended to cover physician services for the medical direction of the care team; regular home care visits by registered nurses and licensed practical nurses; home health aid and homemaker services; chaplain services; social work services; bereavement counseling; and medical equipment, supplies, and medications. No specific therapy is excluded, and the goal is for each therapy to be considered for its symptomatic (as opposed to disease-modifying) effect. Additional clinical care, including services of the primary physician, is covered by Medicare Part B even while the hospice Medicare benefit is in place. The health reform legislation signed into law in March 2010—the Affordable Care Act—directs the Secretary of Health and Human Services to gather data on Medicare hospice reimbursement with the goal of reforming payment rates to account for resource use over an entire episode of care. The legislation also requires additional evaluations and reviews of eligibility for hospice care by hospice physicians or nurses. Finally, the legislation establishes a demonstration project for concurrent hospice care in Medicare, which would test and evaluate allowing patients to remain eligible for regular Medicare during hospice care.

By 2012, the mean length of enrollment in a hospice was around 71.8 days, with the median being 18.7 days. Such short stays create barriers to establishing high-quality palliative services in patients' homes and also place financial strains on hospice providers because the initial assessments are resource intensive. Physicians should initiate early referrals to the hospice to allow more time for patients to receive palliative care.

Hospice care has been the main method in the United States for securing palliative services for terminally ill patients. However, efforts are being made to ensure continuity of palliative care across settings and through time. Palliative care services are becoming available as consultative services and more rarely as palliative care units in hospitals, in day care and other outpatient settings, and in nursing homes. Palliative care consultations for nonhospice patients can be billed as for other consultations under Medicare Part B, the physician reimbursement part. Many believe palliative care should be offered to patients regardless of their prognosis. A patient, his or her family, and physicians should not have to make a "curative versus palliative care" decision because it is rarely possible to make such a decisive switch to embracing mortality.

FUTURE DIRECTIONS

OUTCOME MEASURES

Care near the end of life cannot be measured by most of the available validated outcome measures because palliative care does not consider death a bad outcome. Similarly, the family and patients receiving end-of-life care may not desire the elements elicited in current quality-of-life measurements. Symptom control, enhanced family relationships, and quality of bereavement are difficult to measure and are

rarely the primary focus of carefully developed or widely used outcome measures. Nevertheless, outcomes are as important in end-of-life care as in any other field of medical care. Specific end-of-life care instruments are being developed both for assessment, such as The Brief Hospice Inventory and NEST (*needs near the end of life screening tool*), and for outcome measures, such as the Palliative Care Outcomes Scale, as well as for prognosis, such as the Palliative Prognostic Index. The field of end-of-life care is entering an era of evidence-based practice and continuous improvement through clinical trials.

11 Clinical Problems of Aging

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While an in-depth understanding of internal medicine serves as a foundation, proper care of older adults should be complemented by insight into the multidimensional effects of aging on disease manifestations, consequences, and response to treatment. In younger adults, individual diseases tend to have a more distinct pathophysiology with well-defined risk factors; the same diseases in older persons may have a less distinct pathophysiology and are often the result of failed homeostatic mechanisms. Causes and clinical manifestations are less specific and can vary widely between individuals. Therefore, the care of older patients demands an understanding of the effects of aging on human physiology and a broader perspective that incorporates geriatric syndromes, disability, social contexts, and goals of care. For example, care planning for the older patient should account for the substantial portion of the wide variability in life expectancy across individuals of the same age that can be predicted by simple and inexpensive measures such as walking speed. Estimation of the expected remaining years of life can guide recommendations about appropriate preventive and other long-term interventions and can shape discussions about treatment alternatives.

DEMOGRAPHY

(See also Chap. 93e) Population aging emerged as a worldwide phenomenon for the first time in history within the past century. Since aging influences many facets of life, governments and societies—as well as families and communities—now face new social and economic challenges that affect health care. Fig. 11-1 highlights recent and predicted changes in U.S. population structure.

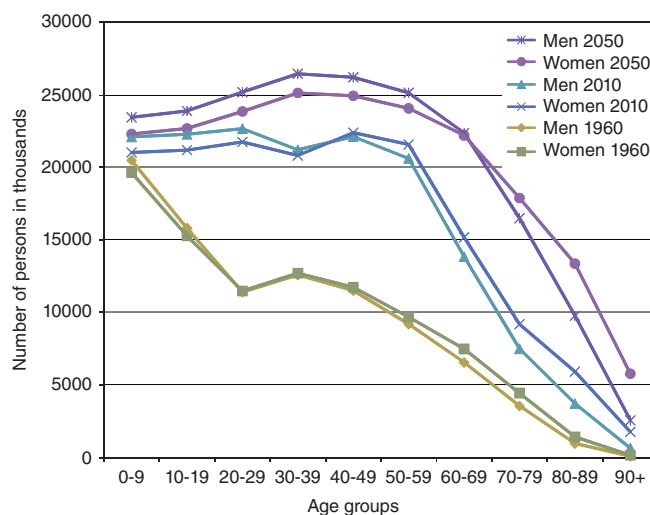


FIGURE 11-1 Change in the structure of the U.S. population between 1960 and 2050. (From United Nations World Population Prospects: The 2008 Revision, http://www.un.org/esa/population/publications/wpp2008/wpp2008_highlights.pdf.)