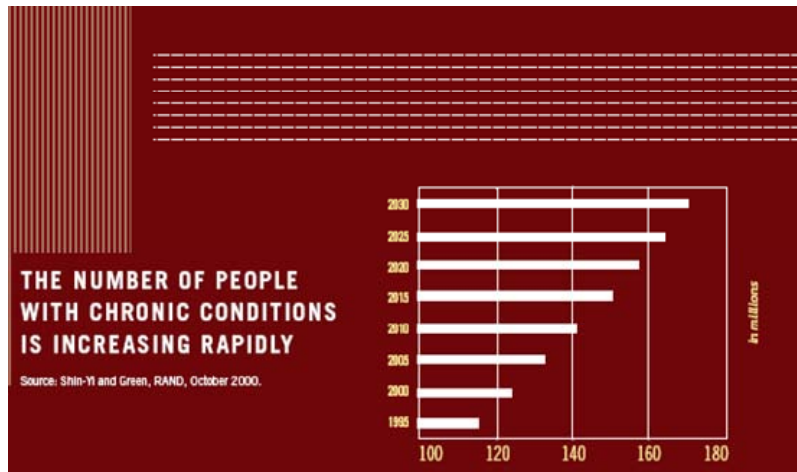


Our Health Ministry has a commitment to the sick and dying; a return to the Sisters' roots.

American Hospitals are filling rapidly with chronically ill adults. 80% of us will die of chronic progressive illness.

The Case for Inpatient Palliative Care: Rapid Growth of Persons with Chronic Disease



8

Through our Supportive Care Initiative we have developed Palliative Care Programs at each of our 7 hospitals.

Do you know who heads up the Palliative Care Program at your facility? If not, your chief medical officer will be happy to let you know.

Good Morning,

It has been said that every hospitalization for chronic progressive disease should be a rehearsal for the final admission.

You have probably heard that patients who are hospitalized with new onset Congestive Heart Failure often have 5 year survival rates – worse than most cancer diagnoses.

When hospitalized, aggressive treatment can result in a return to *nearly* the same status as when the patient was admitted.

Ask yourself this question: Would you be surprised if this patient died within one year? Clinical judgment must always be applied to each individual patient.

The likelihood of mortality increases with patients who show:

- Symptoms of CHF at rest
- Patients classified as New York Heart Association Class IV
- Ejection fraction of 20% or less
- Patients already optimally treated with diuretics, vasodilators, and ACE inhibitors if appropriate
- Symptomatic arrhythmias
- History of syncope
- History of cardiac arrest
- History of CVA of cardiac origin.
- Other co-morbidities

P.S. As a follow up to yesterday's extra "Connections", here is a link to the Editorial from the New England Journal that discusses the article about the impact of early palliative care in lung cancer patients:

<http://www.nejm.org/doi/full/10.1056/NEJMe1004139>

P. P.S. Be sure to visit <http://www.osfhomecare.org/medical-professionals/> to see all the Supportive Care Connections!

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Good day:

This week, I am sending a link to an article in the New York Times, where I have been finding a lot of interesting reading related to Supportive Care recently. I want you all to understand that there are things in this article that I don't agree with (the whole Compassion and Choices organization), but it is a very moving story of the suffering that our patients endure. It is not surprising, then, that if we are not supporting them well, they may be seeking other paths.

It is one of our goals that our patients should never be overwhelmed by their suffering.

Have a great weekend!

<http://www.nytimes.com/2010/06/20/magazine/20pacemaker-t.html?pagewanted=1>

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Good Afternoon!

Characteristics of highly successful Palliative Care programs include:

- Linked to mission, philosophy and strategy of the organization
 - Our Health Ministry has a commitment to the sick and dying – a return to the Sisters' roots
- Administrative commitment and support
 - Each hospital CEO has developed a facility-specific plan for their Palliative Care program which includes a clinical champion
 - Do you know who serves as your OSF Hospital's Palliative Care clinical champion?
- Palliative Care teams are staffed for growth
 - Re-allocation of time for selected members of our Community of Caregivers to devote to patients needing Palliative Care
- Board Certified Palliative Care physician leaders at the facility level
 - We need more physicians ... if you are interested please contact me...thanks!

Good Day!

The case for in-patient Palliative Care is anchored by improved quality of care and enhanced financial viability.

Regarding quality of care, an in-patient Palliative Care Program ...

- Improves the quality of life for patients and families struggling with chronic illness
- Supports families with complex decision-making regarding treatment
- Provides expertise in treating physical, emotional, and spiritual distress at end of life
- Coordinates care for patients and families dealing with a fragmented system

Here are comments from some of our Palliative Care family satisfaction surveys,

"Our family was very happy with Palliative Care. It made everything a little easier to deal with."

"All team members were extremely kind and patient with our large family. They listened well and repeatedly gave us explanations, options, and support. We could not have had a more positive experience at the time of our mother's death. They went ABOVE AND BEYOND, and we are very grateful."

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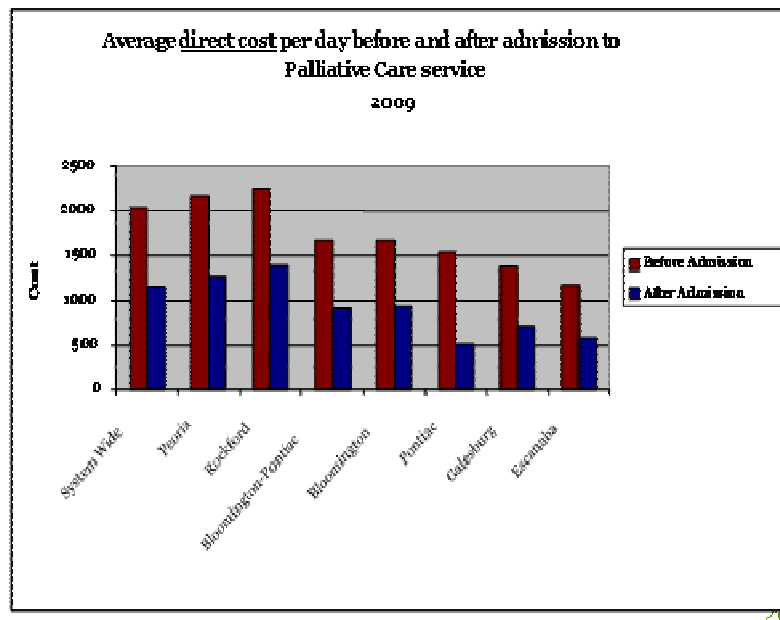
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Good Afternoon,

The case for in-patient Palliative Care is also anchored by financial viability...

- Palliative Care reduces length of stay, cost per day and the use of critical care when care is futile
- All major payers in OSF HealthCare are now on a DRG-based payment structure so cost reduction is critical

OSF Palliative Care Program Outcomes: Direct Costs



The Morrison et al Study in 2008 found that on the average, Palliative Care consultation is associated with reductions of \$1,700 per admission for live discharges and reductions of \$4,900 per admission for patients who died in the hospitals.

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Good Morning,

The physical symptoms that patients with chronic progressive diseases fear most about facing the end of their life are pain and dyspnea.

Understanding possible sources of dyspnea is the first step to identification of appropriate intervention:

- Check the oxygen equipment and tubing
- Assess for fluid overload, infectious process, anxiety, pain or the need to void or move the bowels

A patient who has elected comfort care or hospice would not need painful assessments such as blood gases. Clinical judgment is much more valuable than a CXR or EKG.

Treatment begins with general measures as positioning, fans, oxygen and relaxation techniques.

Pulse Oximetry does not correlate with symptomatology and oxygen should be titrated to relief, not a specific number.

Pharmacological measures indicate that opioids are the drug of choice for dyspnea. Specifics are noted at this link to the OSF Home Care Services website: <http://www.osfhomecare.org/medical-professionals/pdf/dyspnea.pdf>.

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Good Morning!

Continuing with respiratory disease, as dyspnea was our topic last week, patients with end-stage lung disease with the following parameters have the lowest survival rates and should be considered for hospice referral.

- Dyspnea at rest.
- Poor response to bronchodilators.
- Frequent symptoms of fatigue, cough, decreased functional status, copious sputum.
- House or chair-bound
- Cyanosis, barrel-chested, wheezing, diminished breath sounds, and use of accessory muscles of respiration.
- FEV1 of less than 30% with use of bronchodilators
- More frequent ER visits or hospitalizations
- More frequent respiratory infections
- Presence of Right Heart Failure
- Hypoxia at rest
- O2 Saturation less than 88%
- Hypercapnia
- Weight loss
- Resting Tachycardia
- Co-morbidities

It is uncertain what number or combination of the above factors might predict a worse prognosis. Clinical judgment and individual assessment is crucial. As with other patients, consider whether you would be surprised if they died within a year.

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Good day!

Can nursing home patients have hospice? Absolutely! Unfortunately, 60% of patients who die in a nursing home have no idea that they could even have hospice services.

When does my patient need a hospice referral? Common signs that nursing home patients are nearing the end of life include:

- Decline in functional status (can be quantified by various scales, including the FAST scale for patients with dementia, or Palliative Performance Scale for others)
- Weight loss
- Decline in mental status
- Increased pain
- Respiratory infections, aspiration, increased secretions
- Changes in GI functions such as dysphagia or development of ascites
- Weakness
- Increased incontinence
- Changes in vital signs and/or labs

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PPS. One principle of good palliative care is self-care so next week I'm on vacation – look for another “Connections” on the 20th.

Good morning!

In today's New England Journal of Medicine is a study that I believe everyone needs to be aware of. Let me quote the abstract of the article:

“Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival.”

(Emphasis added by me)

Here is a link to the article:

<http://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678>

The longer survival is over 2 months. If a new drug came out with these results, imagine how that would be received!

There will still be a “Connections” email tomorrow as usual. This seemed too important to wait.

Don't expect that every time I take a week off that there will be two editions to follow, though! ☺

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