



Advance Directives, End of Life Issues and Palliative Care for Patients with HIV/AIDS

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June 26, 2009

Rivington House

Thank You's

- Sponsors
 - St. Vincent's AIDS Education and Training Center
 - Tibotec Pharmaceuticals
 - Merck Laboratories
 - Greater New York Chapter Association of Nurses in AIDS Care
- Our Speakers
- Staff of Rivington House and VCNY and AETC

Housekeeping Issues

- Bathrooms
- Smoking – Please Don't
- Beepers and Cell Phones – turn off or place on vibrate

Housekeeping Issues

- Forms - please write clearly:
 - AETC form – “PIF” form very important for AETC funding
 - Evaluation forms
 - For CME’s and Certificates of Attendance - must complete AETC form
 - For CEU’s must complete Greater NY ANAC form
- Return all forms at the end of the program

Schedule:

- 7:45 – Registration and Breakfast
- 8:30 – Dr. Starrett – Welcome
- 8:45 – Dr. Patricia Bomba – Introduction to Advance Care Planning
- 9:30 – Dr. Lauren Shaiova – Symptom Management
- 10:15 – Q and A
- 10:30 – Coffee Break
- 10:45 – Dr. Lyla Correoso – Cultural Issues and Advance Care Planning
- 11:15 – Dr. Patricia Bomba – Getting Your Program Started
- 12:00 – Panel Q and A
- 12:30 - Lunch

NY Times: June 9, 2009

Health Care Spending Disparities Stir a Fight

- President Obama has been intrigued by the June 1, 2009, article from the New Yorker, making the article required reading for White House staffers
- Article points out the significant differences in health care spending depending upon where a patient lives
- No evidence that high cost areas have better health care outcomes
- Estimated that if spending in high cost areas was similar to low cost areas, decrease spending by approx 30%

What Drives the Costs at the End of Life:

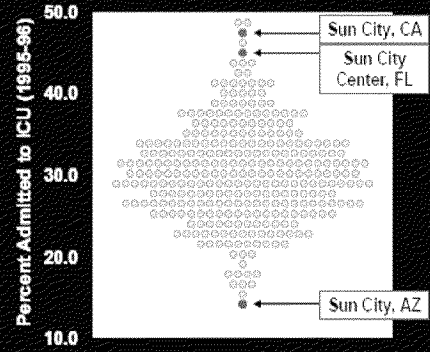
- Hospitalizations for chronic medical conditions
- Stays in ICU’s
- Physician Visits
- Specialist Referrals

Dartmouth Atlas of Health Care

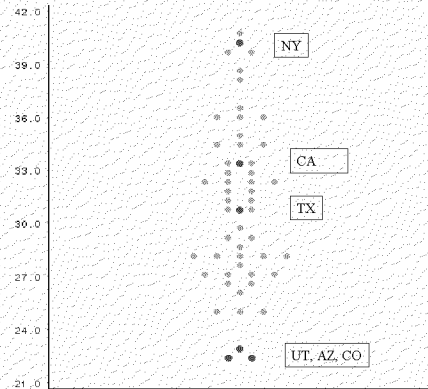
Percent of Medicare Enrollees Seeing Ten or More Physicians During the Last Six Months of Life (1995-96)



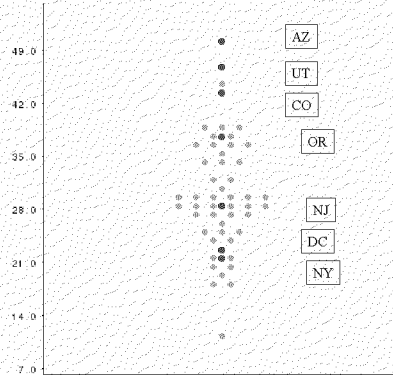
Percent of Medicare Decedents Admitted to Intensive Care During the Last Six Months of Life (1995-96)



Per Cent of Deaths in Hospital 2001-2005 – by State

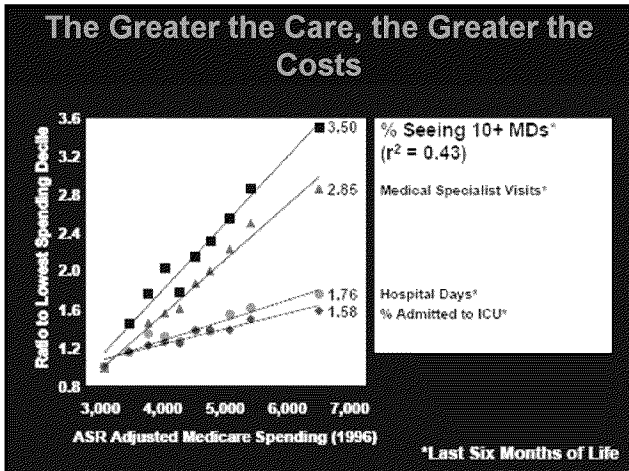


Percent Enrolled in Hospice 2001-2005 – by State



State Name	Total physician visits per decedent during the last six months of life (2001 - 2005)	Medical specialist visits per decedent during the last six months of life (2001 - 2005)	Percent of decedents seeing 10 or more different physicians during the last six months of life (2001 - 2005)	Number of different physicians seen per decedent during the last six months of life (2001 - 2005)
National Average	30.51	14.4	30.36	7.78
New York	37.6	17.42	39.72	9.24

Hospital Name	Deaths by location percent of deaths occurring in hospital	Percent of decedents enrolled in hospice during the last six months of life	Hospice days per decedent during the last six months of life
National Average	36.19	31.6	11.55
State Average	46.31	20.35	6.75
Mount Sinai Hospital	53.26	13.98	4.64
St. Luke's-Roosevelt Hospital Center	47.37	18.21	7.54
Beth Israel Medical Center	53.65	18.25	5.5
New York University Medical Center	50.52	20.06	6.74
St. Vincent's Hospital-Manhattan	45.02	16.39	6.55

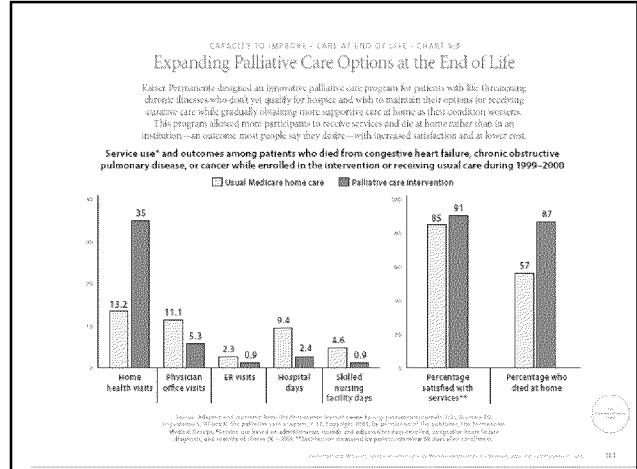
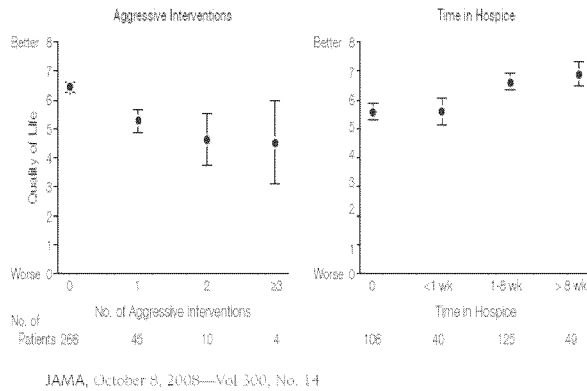


What Does More Health Care Spending at the End of Life Buy?

- Improved Survival - No
- Improved QOL - No
- Better Access to Care - No
- More Specialists - Yes
- More Tests - Yes
- More Days in the Hospital - Yes
- More Days in the ICU - Yes
- More Likely to Die in the Hospital - Yes

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Figure. Relationship Between Quality of Life and End-of-Life Care



If More Care is Not Better Care, How Do We Adjust the Disparities

- Improve the Quality of Clinical Decision Making
 - Improving Prognostic Information with treatment outcomes research – so that a provider can better inform his patient of the value of an intervention
 - Promoting Shared Decision- Making between Medical Providers and Patient
- Creating a different “culture” about the End of Life
 - Role of patients, communities and health care providers – for community level norms that promote conservative practice patterns at the end of life
 - Learning how to communicate
 - Accepting the idea that more care is not always better care

What Can We Do?

- Increase the percentage of your clients who have a valid health care proxy
- Continually update this information to insure its accuracy
- Reassess your clients when their medical condition changes

What Can We Do?

- Identify patients who might benefit from Hospice and Palliative Care
- Help them with their decision making by providing them with information on how to balance what they will gain or lose from their decisions on care
- Help them deal with uncertainty
- Help them deal with any regret or misgivings they have about their decisions
- Help with the resources they will need to accomplish their goals