

Working to Bridge the Gap Between Acute Care and Hospice Care

The hospice movement began 41 years ago in the United Kingdom, even more recently in the United States, but in that short time end-of-life care has seen tremendous advances. Most physicians have endorsed the hospice philosophy, more options are available for symptom control, psychologists and social workers have a greater understanding of grief, and consumers are more educated about hospice care.



BY MYRA DOWNS

improvement in care for terminally-ill patients.

Funding, however, remains a challenge. There's often a gap in coverage between acute care and hospice care. The hospice community is working to bring attention to the problem nationally with the goal of making palliative care more available for all patients. It's been shown that without palliative care these patients often have higher re-hospitalization rates resulting in higher health-

care costs. And if hospice care is not available, patients often spend their final days in more expensive, acute care environments.

Maybe as a community we are still holding too tightly to the myth that hospice is about dying. It's about improving quality of life. And improvements in funding will ultimately help everyone in the hospice community stay true to that mission.

Myra Downs, Executive Director, Hospice Atlanta, a Division of Visiting Nurse Health System, can be reached at Myra_downs@vnhs.org or (404) 869-3000.

Professional organizations now include hospice certification among their offerings. Joint Commission accredits hospice programs on a voluntary basis, the National Hospice and Palliative Care Organization offers professional certification for nurses and other caregivers, and physicians can receive certification from the American Board of Hospice and Palliative Medicine.

The fact that professionals refer to the hospice "movement" is no accident. Hospice started primarily as a volunteer-led program dedicated to improving the quality of care for people dying alone, isolated or in institutional settings. Now hospice is a significant part of the healthcare system.

The growth of hospice has afforded death with dignity to millions of patients, as well as comfort and support to their families. It is estimated that more than 1.5 million people receive hospice care each year. According to an independent 2007 Duke University study, hospice care saves Medicare an average of \$2,300 per patient, amounting to a total savings of about \$2 billion a year. Research also has shown hospice care is highly rated by family members and enables the patient to die at home in most cases.

But there are still challenges to overcome. Patients are considered hospice-appropriate and covered by Medicare and most insurance plans when their physicians estimate they have six months or less to live, if their disease follows its normal progression. However, treatments given to alleviate distressing symptoms may coincidentally prolong or stabilize patients' lives. When this happens, patients may be considered by Medicare and other insurance plans to be not appropriate for hospice care.

Nonprofit hospices such as ours, Visiting Nurse | Hospice Atlanta, have a mission to serve hospice patients regardless of their diagnosis or means. There are times, however, when a terminally-ill patient is reluctant to give up curative treatments. It is in this type of situation that a service – palliative home care – might be helpful and supportive.

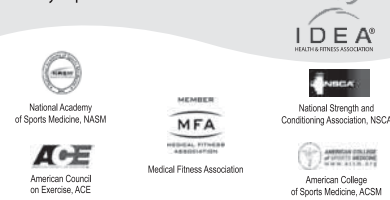
Hospice services and palliative care programs share similar goals of providing symptom relief and management of pain associated with physical, psychosocial or spiritual symptoms. Palliative care can best be described as a "bridge" between traditional curative treatment of disease and end-of-life care in hospice.

Many metro Atlanta hospitals now have palliative care teams that work closely with patients and their families as well as with community agencies such as home health or hospice. That's been a big

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The time-honored technique of treating superficial venous insufficiency was by saphenous vein stripping which involves several incisions in the leg as well as pulling out the saphenous vein in its entirety. This typically results in a post-operative convalescence period of at least two weeks. A significant amount of discoloration and subcutaneous tissue bruising, swelling, and discomfort was associated with this.

Currently for many patients, we can now offer them two minimally invasive procedures known as the Radiofrequency Closure (RF) and the Laser Closure procedures. The RF procedure uses radiofrequency energy to ablate or occlude the greater saphenous vein. This procedure is performed through a single small incision; with the aid of ultrasound a catheter is positioned near the saphenofemoral junction. Then while pulling the catheter back and delivering heat energy the vein is ablated and turned into scar tissue. An alternative source of heat energy to ablate the saphenous vein is the Laser Closure procedure which is performed in exactly the same fashion as RF closure. The decision of which method is best suited for you is made by one of our surgeons during consultation. In conjunction with this procedure, we also often perform phlebectomies of minor varicose veins through incisions which are only 2 to 3 mm in length. THIS PROCEDURE IS DONE UNDER LOCAL ANESTHESIA IN OUR OFFICE, AND THE PATIENT CAN RETURN TO WORK IMMEDIATELY.

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John E. Jones, M.D.



Douglasville
6002 Professional Pkwy.
Suite 240
Douglasville, GA 30134
770.874.0572

Marietta
61 Whitcher St.
Suite 2120
Marietta, GA 30060
770.423.0595

Austell
1700 Hospital Dr.
Suite 410
Austell, GA 30106
770.944.8315

Woodstock Office
120 Stonebridge Pkwy.
Suite 320
Woodstock, GA 30189
770.874.7631

Hiram Office
148 Bill Carruth Pkwy.
Suite 240
Hiram, GA 30141
770.874.0703

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