Palliative Medicine Futurist: Matching Care to Patient and Family Needs

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Objectives

1. How is palliative care important to improving value (better quality and lower cost) in U.S. health care?

2. How do we change the delivery system to improve access to quality palliative care for all persons with serious illness and their families?
Center to Advance Palliative Care

• *Who are we?* Philanthropically funded national organization with mission to increase access to quality palliative care for all persons with serious illness, and their families.

• *How do we do it?* 1. Develop and disseminate tools and technical assistance to help front line clinicians deliver palliative care; 2. Influence regulatory, accreditation, training, payment, and quality policies to drive access.
Goals for 2020

1. All patients and families will know to request palliative care in the setting of serious illness.

2. All healthcare professionals will have the knowledge and skills to provide palliative care.

3. All healthcare institutions will be able to support and deliver high quality palliative care.
Palliative Care is Central to Improving the Value Equation

Why? Because health care delivery (and spending) is highly concentrated on the sick.
Example (and true story): Mr. S

• An 84 year old man admitted via the ED for management of pain due to metastatic lung cancer.

• Pain is 8/10 on admission, for which he is taking OTC acetaminophen.

• Admitted 3 times in 3 months for pain (2x), nausea/volume depletion, and altered mental status.

• His family (77 year old wife) is overwhelmed.
Mr. S:

• Mr. S: “I told the Dr. that I never wanted to go back to the hospital again. It’s torture—you have no control and can’t do anything for yourself. And you get weaker and sicker. Every time I’m in the hospital it feels like I’ll never get out.”

• Mrs. S: “He hates being in the hospital, but what could I do? The pain was terrible and I couldn’t reach the oncologist. I couldn’t even move him myself, so I called the ambulance. It was the only thing I could do.”
Challenges of Serious Illness

For patients/families
- Uncoordinated care
- Lack of psychosocial support
- Inadequate attention to goals/preferences
- Poor symptom management
- ED+hospital = only option

For health systems?
- High-cost care
- Frequent (re)hospitalizations
- Dissatisfaction with care (HCAHPS scores)
- Financial penalties/adverse effect on public reporting

Leverage

With thanks to Dave Casarett
The Future of Palliative Care

• Not enough to have access to palliative care in hospitals
• Most illness occurs at home and in communities
• Home palliative care needed without regard to prognosis or goals of care
• Goal = insure access to palliative care across all settings and stages of illness
Access to Palliative Care Across the Continuum: The Future

Hospital Consult Service

Provider Home Visits

NH Services

Outpatient PCP Clinics

Inpatient Unit

Outpatient Specialty Clinics

Cancer Center
Conceptual Shift for Palliative Care

Disease-Directed Therapies

Diagnosis  Palliative Care  Death and Bereavement
Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
Exceptionally High Positives

Once informed, consumers are extremely positive about palliative care and want access to this care if they need it:

✓ 95% of respondents agree that it is important that patients with serious illness and their families be educated about palliative care.

✓ 92% of respondents say they would be likely to consider palliative care for a loved one if they had a serious illness.

✓ 92% of respondents say it is important that palliative care services be made available for patients with serious illness and their families.
Palliative Care Teams Address 3 Domains

1. Physical, emotional, and spiritual distress
2. Patient-family-professional communication about achievable goals for care and the decision-making that follows
3. Coordinated, communicated, continuity of care and support for practical needs of both patients and families across settings
Core Principle of Palliative Care

“Don’t ask what’s the matter with me. Ask what matters to me.”
Palliative Care Improves Value

Quality improves
- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- Care matched to patient centered goals

Costs reduced
- Hospital costs decrease
- Need for hospitalization/ICU decreases
- 30 day readmissions decrease
- Hospital mortality decreases
- Imaging/lab/pharmaceutical use decreases
Palliative Care Improves Quality in Office Setting

Randomized trial simultaneous standard cancer care with palliative care co-management from diagnosis versus control group receiving standard cancer care only:

- Improved quality of life
- Reduced major depression
- Reduced ‘aggressiveness’ (less chemo < 14d before death, more likely to get hospice, less likely to be hospitalized in last month)
- **Improved survival** (11.6 mos. vs 8.9 mos., p<0.02)

Palliative care in addition to usual oncology care allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.

Temel J, et al. NEJM 2010

Figure 3 Kaplan–Meier Estimates of Survival According to Study Group.
Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% confidence interval [CI], 7.9 to 11.7) in the entire sample (151 patients), 11.6 months (95% CI, 6.4 to 16.9) in the group assigned to early palliative care (77 patients), and 8.9 months (95% CI, 6.3 to 11.4) in the standard care group (74 patients) (P=0.02 with the use of the log-rank test). After adjustment for age, sex, and baseline Eastern Cooperative Oncology Group performance status, the group assignment remained a significant predictor of survival (hazard ratio for death in the standard care group, 1.70; 95% CI, 1.14 to 2.54; P=0.01). Tick marks indicate censoring of data.
Palliative Care at Home for the Chronically Ill
Improves Quality, Markedly Reduces Cost

RCT of Service Use Among Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer Patients While Enrolled in a Home Palliative Care Intervention or Receiving Usual Home Care, 1999–2000

KP Study Brumley, R.D. et al. JAGS 2007
NH Palliative Care

• Retrospective case control study comparing care processes in 125 end stage dementia patients receiving palliative care consultations to 125 controls receiving usual care
• Single facility (Hebrew Rehabilitation) in Boston
• Data source: MDS

• Results: Residents receiving palliative care consultation had fewer ED visits (p<.001) and less depression (P=.03).

RCT of Nurse-Led Telephonic Palliative Care Intervention

- N= 322 advanced cancer patients in rural NH+VT
- Improved quality of life and less depression (p=0.02)
- Trend towards reduced symptom intensity (p=0.06)
- No difference in utilization, (but v. low in both groups)
- Median survival: intervention group 14 months, control group 8.5 months, p = 0.14

Bakitas M et al. JAMA 2009;302(7):741-9
US Oncology: 
Pathways Include Palliative Care

Clinical pathways specify:
• Number of regimens
• Exact drugs to use
• *Goals of care discussion early*
  – Advance medical directives and health agent appointment “up front” as standard of care.
  – Use of homecare and hospice as standard of care.

(In contrast, NCCN pathways allow 16 individual drugs in multiple combinations. No mention of non-chemo care until the end.)
U S Oncology pathways preserve survival, reduce cost by 35% in lung cancer.

New guidelines have AMDs DPMA, hospice visit

Less chemo
More hospice
Longer LOS

For NSCLC, equal results, less toxicity, less cost.
Chemo beyond 3rd line off pathway.
U S Oncology pathways preserve survival, reduce cost by 34% in metastatic colon cancer.

Table 1: Impact of pathways in colon cancer

<table>
<thead>
<tr>
<th></th>
<th>Overall survival (mos)</th>
<th>Chemo Cost ($)</th>
<th>Total Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathway</td>
<td>26.9</td>
<td>22,564</td>
<td>103,379</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-34%</td>
</tr>
<tr>
<td>Non-pathway</td>
<td>20.1</td>
<td>60,787</td>
<td>156,020</td>
</tr>
<tr>
<td>P value</td>
<td>0.03</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
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Consequences of Late Referral to Palliative Care

Serious Adverse Outcomes for Bereaved Caregivers:

Compared to care at home with hospice,

- Care in ICU associated with 5X family risk of Post Traumatic Stress Disorder; and

- Care in hospital associated with 8.8X family risk of prolonged grief disorder

Wright A et al. Place of death: Correlation with quality of life of patients with cancer and predictors of bereaved caregivers mental health. JCO 2010; Sept 13 epub ahead of print
Congratulations

Good luck with the American health-care system

Get well
Effect of Palliative Care on Hospital Costs

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers’ Outcomes Group

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18,427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 21,24 usual care patients. The palliative care patients who were discharged alive had an adjusted net significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4906 in direct costs per admission ($P=.003) and $374 in direct costs per day ($P < .001) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients. Two confirmatory analyses were performed. Including mean costs per day before palliative care and before a comparable reference day for usual care patients in the propensity score models resulted in similar results. Estimating costs for palliative care patients assuming that they did not receive palliative care resulted in projected costs that were not significantly different from usual care costs.

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.
THE CARE SPAN

By R. Sean Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

THE CARE SPAN

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries
How Palliative Care Reduces Cost

- Improved resource use
- Reduced bottlenecks in high cost units
- Improved throughput and consistency

The Conceptual Model:
Dedicated medical team = Focus + Time =
Decision Making / Clarity / Follow through
Palliative Care Growth

Prevalence of U.S. Hospital Palliative Care Teams 2000–2009

Source: Center to Advance Palliative Care, March 2011

Distribution of Palliative Care Programs by Region

Source: Center to Advance Palliative Care, 2011  capc.org/reportcard
VARIATION: America’s Care for Serious Illness
A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals

Source: Center to Advance Palliative Care, 2011  capc.org/reportcard
South Carolina Data

- Grade of C: compared to US average of B

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<thead>
<tr>
<th></th>
<th>USA</th>
<th>South</th>
<th>South Carolina</th>
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<tbody>
<tr>
<td>% &gt;50 beds</td>
<td>67%</td>
<td>28%</td>
<td>51%</td>
</tr>
<tr>
<td>% &gt;300 beds</td>
<td>85%</td>
<td>50%</td>
<td>92%</td>
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The Present

• >1,900 hospital palliative care teams in U.S., of highly variable quality, penetration, staffing, outreach
• New medical and nursing subspecialty
• Highly variable undergraduate and graduate medical/nursing/social work education in palliative care
• Changing cognitive frame for palliative care in context of an aging population, multimorbidity, and chronic disease
Goal 1: All patients and families will know to request palliative care in the setting of serious illness

Public awareness via social marketing and media campaign-ongoing
Treating the person beyond the disease

Palliative care sees the person beyond the cancer treatment. It gives the patient control. It brings trained specialists together with doctors and nurses in a team-based approach to manage pain and other symptoms, explain treatment options, and improve quality of life during serious illness. Palliative care is all about treating the patient as well as the disease. It’s a big shift in focus for health care delivery—and it works.

Goal 2

All healthcare professionals will have the knowledge and skills to provide palliative care
THE FINALISTS

"Any stiffness?"
Ryan Scott Misener, Tampa, Fla.

"Sorry about the wait."
Bob Howard, Eugene, Ore.

"Any family history with death?"
Stephanie Nilva, New York City
Why is it so bad? One reason is deficiencies in medical education

- 74% of residencies in U.S. offer no training in palliative care
- 83% of residencies offer no palliative care rotation
- 41% of medical students never witnessed an attending talking with a dying person or family about goals for care and 35% never discussed the care of a dying patient with a teaching attending

Billings & Block JAMA 1997;278:733.
Workforce: The Major Barrier to Access

- Oncologists: 1 for every 145 patients with new cancer diagnosis
- Cardiologists: 1 for every 71 heart attack victims
- Palliative Medicine: 1 for every 1,300 people with serious illness
- In 20 states no access to post graduate training in palliative medicine
"It is thornlike in appearance, but I need to order a battery of tests."
Workforce Priorities

• Increase number of fellowship programs, fellows in training, and funding

• Develop *mid-career board certification track*

• Promote ‘generalist level’ palliative care through undergraduate, graduate, and mid career training
Goal 3
All healthcare institutions will be able to support and deliver high quality palliative care:
- Regulatory and accreditation requirements
- VBP: Quality measures linked to payment, incentives
- System redesign using checklists, pathways
- Integrate into new delivery models
- Benefit design
New! Advanced Certification for Palliative Care

Recognizing hospital inpatient programs that demonstrate exceptional care for patients with serious illness.

The Joint Commission Certification Palliative Care
Access via Quality Measurement Linked to Payment

- National Quality Forum under contract from CMS endorsed a series of palliative care measures in 2012-
- Next step is integration in Value Based Purchasing

http://www.qualityforum.org/Measures_List.aspx#e=1&s=n&so=a&p=1&cs=148
NQF-Endorsed Palliative Care Measures

02/14/2012
http://www.qualityforum.org/Measures_List.aspx#e=1&s=n&so=a&p=1&cs=148

- CARE: Consumer Assessments and Reports on End of Life Care
- Pain Screening
- Pain Assessment
- Dyspnea Screening
- Dyspnea Treatment
- Treatment Preferences

For cancer only:
- Proportion getting chemo last 14 days of life
- Proportion in ED last week of life
- Proportion >1 hospital stay in last 30 days of life
- Proportion admitted to hospice <3 days
- Proportion not admitted to hospice before death

For hospice only:
- Proportion with spiritual assessment
- Family Evaluation of Hospice Care
Standardize Care Using Triggers

Uses a routine *risk assessment pathway* to identify patients who are most likely to have palliative care needs based on:

<table>
<thead>
<tr>
<th>Disease variables</th>
<th>Patient variables</th>
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<tbody>
<tr>
<td>• Metastatic cancer</td>
<td>• More than 2 hospitalizations within 3 months</td>
</tr>
<tr>
<td>• Advanced dementia</td>
<td>• Unintentional loss of more than 10% of body weight</td>
</tr>
<tr>
<td>• Class IV CHF</td>
<td>• ICU length of stay greater than X days</td>
</tr>
<tr>
<td>• Frailty</td>
<td>• Functional impairment</td>
</tr>
<tr>
<td>• ESRD</td>
<td>• Caregiver burden</td>
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Integrate Palliative Care into New Delivery and Payment Models

Adding palliative care targeted to the highest risk populations to the specifications for new delivery models is key to their success at improving quality and reducing cost.
Major Health Systems/ACOs Get It

Making multimillion dollar investments in palliative care integration across settings:

• Partners Health System/ Harvard Medical School
• U. of Pittsburgh Health System
• Duke U. Health System
• North Shore-LIJ Health System
• OSF Health System
• Iowa Health System
• Ohio Health System
• Sharp Health System
• Banner Health System...
Payers Get It

Private sector approaches to community palliative care
A Business Case for Palliative Care in the Community

The business case for palliative care:

• PAYORS, especially commercial payers with Medicare Advantage and Managed Medicaid contracts
• LARGE EMPLOYERS seeking value for their healthcare dollar
• INTEGRATED or ACCOUNTABLE Care Organizations
Example: BCBS MI and @HOMe

The “Missing Piece” Solution

Thank you Dottie Deremo!
Partnership:
@HOMe: a wholly owned subsidiary of Hospice of Michigan
Payer: BCBS Michigan
Providers: ACOs, Employers in SE Michigan

Improves Quality Outcomes
Supports Stressed Family Caregivers

Saves 30% Net Total Health Care Costs

for Tier 3 patients demonstrated by 3rd party independent research
How? System Redesign

Tier 3

Telesupport
24/7/365

@HOME transitions
Analytics
Predictive Modeling

ER & Hospital Transition Coaches
@HOME support
Analytics

AIM Home Services
24/7/365
(Present) and Future

“The future is here now. It’s just not very evenly distributed.”

William Gibson
The Economist, 2003
Upcoming Audioconference

Building the Future of Home-Based Palliative Care

• Thursday September 19, 2013
• 1:30 – 2:30 PM EST
• https://www.capc.org/products/audio-conferences/2013-09-19/
• Learn from a CMS Innovation Grantee on integration of home palliative care within a Home Health Agency
National Seminar Nov. 7 - 9 in Dallas:
Palliative Care Across the Continuum


• Early bird rate until September 25.

• Highly interactive seminar presenting best practices from front-line innovators in care of the sickest and costliest 5% of patients.