Palliative Care Improves Quality, Reduces Cost (by Matching Care to Patient and Family’s Needs)

Diane E. Meier, MD
Director
Center to Advance Palliative Care
diane.meier@mssm.edu
www.capc.org
www.getpalliativecare.org

Objectives

1. How is palliative care important to improving value (quality and cost) in health care delivery?
2. Changing the delivery system to improve access to quality palliative care in and beyond the hospital
Core Principle

1. “The secret of the care of the patient is caring for the patient.”
   Francis Peabody, Harvard University, 1921

The Ends of Medicine:
Our Professional Obligations

“I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients”
   - Oath of Hippocrates, 400 BC

“May I never see in the patient anything but a fellow creature in pain.”
   - Maimonides, 12th century AD
International Comparison of Spending on Health, 1980–2009

Average spending on health per capita ($US PPP*)
- United States
- Canada
- Germany
- France
- Australia
- United Kingdom

Total expenditures on health as percent of GDP
- United States
- France
- Germany
- Canada
- United Kingdom
- Australia

* PPP=Purchasing Power Parity.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Medical bills push family to bankruptcy

BY KATIE SWATCHE

The day their daughter was born should have been one of the happiest days ever. However, Katie, a middle-class family, found themselves struggling with high medical bills.

Sun Sentinel (Broward County edition)
Tuesday, August 9, 2011
What is this money buying us?

Organization for Economic Development and Cooperation

Among OECD member nations, the United States has the:

- Lowest life expectancy at birth.
- Highest mortality preventable by health care.
Medical Spending in the U.S.
$2.9 trillion in 2010

- Health care spending is highly concentrated among people who are sick.
- The costliest 5% account for 50% of all healthcare spending.

nchc.org/facts/cost.shtml

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Palliative Care is Central to Improving the Value Equation

Because our patient population is driving most of the spending

Conceptual Shift for Palliative Care

Disease-Directed Therapies

- Diagnosis
- Palliative Care
- Death and Bereavement
**Palliative Care Language**

*Endorsed by the Public*

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.

**Palliative Care Hits a Triple**


**Key Messages:**

Palliative care sees the person beyond the cancer treatment.

Palliative care is all about treating the person as well as the disease.

It’s a big shift in focus for health care delivery—and it works.
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 at all hospitals for patients with serious illness and their families.

Why It Matters: Mrs. S

A 79 year old woman admitted via the ED for management of pain due to metastatic lung cancer. Pain is 8/10 on admission, for which she is taking OTC acetaminophen. **Admitted 4 times in 6 months for pain (2x), nausea/volume depletion, and altered mental status.**

Her 87 year old husband (and primary caregiver) is overwhelmed.
Mrs. 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.”

Mr. S: “She 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 her myself, so I called the ambulance. It was the only thing I could do.”

Challenges of Serious Illness

For people/families:
- Uncoordinated care
- Lack of psychosocial support
- Inadequate attention to goals/preferences
- Poor symptom management

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

With thanks to Dave Casarett
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

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
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 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, 1999-2000KP Study Brumley, R.D. et al. JAGS 2007

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<th>Palliative care intervention</th>
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<td>2.4</td>
</tr>
<tr>
<td>SNF days</td>
<td>5.3</td>
<td>4.6</td>
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</table>

Diagram showing the reduction in service use and cost.
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

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
Effect of Palliative Care on Hospital Costs

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

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 2000 palliative care patients who were discharged alive, 2830 palliative care patients (89%) were matched to 18423 usual care patients; and of the 2389 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $2748 and $1499 in direct costs per admission ($P < .001) and per hospital 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.
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

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

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
Hope for the Future: Younger physicians exposed to palliative care more than their predecessors.

% “Great Deal” or “Some” Exposure to Palliative Care by Physician Age

- 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
Who Has the Strongest Incentives to Bring Palliative Care to the Community?

- Where is the business case?
- PAYORS, especially commercial payers with Medicare Advantage and Managed Medicaid contracts
- LARGE EMPLOYERS seeking value for their healthcare dollar (Walmart example)
- INTEGRATED or ACCOUNTABLE Care Organizations

UnitedHealth's 3rd-quarter Profit Jumps 23%

Jim Mone, File/Associated Press - UnitedHealth Group Inc. said Tuesday, Oct. 16, 2012, that its third-quarter earnings jumped 23 percent, thanks in part to Medicare and Medicaid business growth that helped the nation's largest health insurer beat analyst expectations.

Goldman Predicts More Medicaid-Tied M&A After WellPoint Deal

By Jon Hilsenrath

Goldman Sachs expects more consolidation in managed care following WellPoint's deal to buy Amerigroup.

Investors were clearly thinking the same thing Monday, when the news sent shares of Amerigroup soars. Centene and WellCare soaring. Each remains up significantly this week, with Molina up 14% to $24.22; Centene up 15% to $34.41; and WellCare up 16% to $63.24.

Medicaid insurers may have an edge in state-based competitions for dual-eligible patients on Medicare and Medicaid-a sought-after prize in industry and key reason for WellPoint's buy. Based on their experience working with states, but capital requirements needed to serve dual market could drive them to bigger firms, Goldman said.

Goldman also believes larger managed care names, like WellPoint, are seeking to broaden exposure to public-sector managed care and the growth opportunities that it presents. Goldman doesn't expect the big companies to merge together, citing antitrust concerns, but expects the smaller firms to be targets.

Goldman bumped up the price target on Centene by $7 to $39 while raising its M&A probability ranking for that firm. It also raised price target on Molina by $4 to $24, though it gives Molina a slightly less chance of being acquired because it is largely owned by a family. Goldman says Centene and WellCare have a 30% to 40% probability of being bought out, while Molina has a 15% to 20%.
Implementation Strategies: Engaging our Colleagues

1. Identify opinion leaders: Start with them

2. Informational interviewing and relationship-building: what is their perception of the problems, and how might we help address them?

3. Gather data on quality: symptoms, HCAHPS, LOS, ICU LOS, in-hospital mortality, hospice referral rates/LOS, 30 day re-admits on the service you are trying to engage


Implementation Strategies: Use Social Media

Recent Blog Post on How to Improve Access to Palliative Care

http://healthaffairs.org/blog/2012/04/30/learning-from-amy-berman-barriers-to-palliative-care-and-how-we-might-overcome-them/
Implementation Strategies: Partnerships
National Quality Forum: Palliative Care is One of Six National Priorities for Action

http://www.nationalprioritiespartnership.org/Priorities

Implementation Strategies: VBP
NQF-Endorsed Palliative Care Measures 02/14/2012

- 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
Implementation Strategies: National Recognition of Importance of Palliative Care

The Joint Commission: September 2011 release of a Palliative Care Advanced Certification Program.

Commission on Cancer: 2012 requires palliative care program as condition of accreditation.
Palliative Care: “on the map” with IHI

http://www.ihi.org/IHI/Programs/ImprovementMap

Partners
Implementation Strategies: Articulate Centrality to Success of Health Reform

Adding palliative care targeted to the highest risk/cost populations to the specifications for ACOs, PCMHs, bundling, global budgets, and population health strategies is key to their success at improving quality and reducing cost.

(Present) and Future

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

William Gibson
The Economist, 2003
Palliative Care Across the Continuum: The Future

Major Health Systems 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
- Iowa Health System
- Ohio Health
Payers Get It

Private sector approaches to community-based palliative care

How Payers Think About It: Matching (Payer) Resources to Patient Needs

RESOURCES

NEEDS

Demand Management  DM/CM  CCM-palliative care
Payer Models

Case Study: @HOME

Advanced Illness Services Program

Highmark Introduces

Hospice Care

2-20 yrs

12-18 mos

6 mos

Rural Palliative Care Emerging as a Health Care Priority

End of Life Care

Aetna Compassionate Care \( @HOMe \) Program

Public Service Announcements on End-of-Life Care Earn Bronze Telly

Advanced Illness Management

2-20 yrs

12-18 mos

6 mos
Partnership:
@HOMe: a wholly owned subsidiary of Hospice of Michigan +
Payer: BCBS Michigan +
Providers: ACOs 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?

![Diagram showing Tier 3 and various services provided by @HOMe](image)
The Future is Here Now

- @HOMe: BCBS Michigan
- VNSNY SPARK: Medicare Advantage
- CLAIM at Penn: CMS/CMMI
- Iowa Health System ACO
- Kaiser Health System
- VA HBPC
- And many others

Although the world is full of suffering, it is full also of the overcoming of it.

Helen Keller
Optimism 1903
Appendix

Resources to use at home

Implementation Strategies: Resources for Leaders to Reduce Opportunity Costs

Don’t Waste Time/$ Reinventing the Wheel
- www.capc.org
- www.getpalliativecare.org
- Registry  https://registry.capc.org/
- Audioconferences  http://www.capc.org/support-from-capc/audio-conf/
- E-learning via CAPCcampus on-line  http://campus.capc.org/
- CAPCconnect forum  http://www.capc.org/forums/
- Joint Commission technical assistance  http://www.capc.org/palliative-care-
  professional-development/Licensing/joint-commission

- IPAL TA Series: ICU, ED, Home, OPT
- Palliative Care Leadership Centers  http://www.capc.org/palliative-care-leadership-initiative/overview
Staff Training Opportunities

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<th>Opportunity</th>
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<td>ELNEC</td>
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<tr>
<td>EPEC</td>
<td><a href="http://www.epec.net">www.epec.net</a></td>
</tr>
<tr>
<td>EPERC-teaching tools</td>
<td><a href="http://www.eperc.mcw.edu">www.eperc.mcw.edu</a></td>
</tr>
<tr>
<td>AAHPM -MD org</td>
<td><a href="http://www.aahpm.org">www.aahpm.org</a></td>
</tr>
<tr>
<td>Harvard courses</td>
<td><a href="http://www.hms.harvard.edu/cdi/pallcare/">www.hms.harvard.edu/cdi/pallcare/</a></td>
</tr>
<tr>
<td>Palliative care clinical</td>
<td><a href="http://www.aahpm.org">www.aahpm.org</a>; <a href="http://www.hpna.org">www.hpna.org</a>;</td>
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<td>training programs</td>
<td><a href="http://www.nursingworld.org">www.nursingworld.org</a>; <a href="http://www.capc.org">www.capc.org</a></td>
</tr>
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Communication Resources


3. EPEC and ELNEC - Continuing medical/nursing education programs providing detailed protocols for major communication+clinical topics (www.epec.net and www.aacn.nche.edu/elnec)

4. The Center for Palliative Care of Harvard University Medical School – CME/CEU programs in communication/clinical skills for practitioners (http://www.hms.harvard.edu/cdi/pallcare/)


Palliative Care Guidelines

- NCCN Guidelines:  

- National Consensus Project for Quality Palliative Care:  
  http://www.nationalconsensusproject.org/Guidelines_Download.asp

- National Quality Forum:  
  http://www.qualityforum.org/Projects/n-r/Palliative_and_Hospice_Care_Framework/Palliative___Hospice_Care_Framework_and_Practices.aspx

- The Joint Commission:  
  http://www.jointcommission.org/certification/palliative_care.aspx

- Commission on Cancer:  

The IPAL Project:

IPAL-ICU—IPAL-EM—IPAL-OP

Capc.org/IPAL

IPAL-ICU
Improving Palliative Care in the ICU

IPAL-EM
Improving Palliative Care in Emergency Medicine

IPAL-OP
Improving Outpatient Palliative Care

The IPAL Project:
Improving palliative care principles should be integrated into all facets of the healthcare delivery system. Building on the work of palliative care teams now in place at the majority of US hospitals, this integration is easily achievable.

The IPAL Project, an initiative of the Center to Advance Palliative Care, is designed to provide a forum for sharing palliative care models, tools, and resources essential to the integration and improvement of palliative care in specific health care settings. Our first project was IPAL-ICU (Improving Palliative Care in the ICU), launched in June 2010, led by Judith Hahn, MD, a palliative care specialist and professor at the University of Wisconsin School of Medicine and Public Health. The project aimed to develop a palliative care teaching curriculum for the ICU and to develop a toolkit for improving palliative care in the ICU.

The second project was IPAL-EM (Improving Palliative Care in Emergency Medicine), launched in November 2011, led by Tamara L. Doan, MD, with support from the American Academy of Emergency Medicine. The project focused on developing a palliative care curriculum for emergency medicine residents and promoting palliative care within the emergency department.

The third project was IPAL-OP (Improving Palliative Care in Outpatient Settings), launched in June 2012, led by Lynne A. Givens, MD, and David E. Mathews, MD, with support from the American Society of Clinical Oncology (ASCO) and the National Palliative Care Research Foundation (NPCRF). The project aimed to develop a palliative care curriculum for outpatient oncology settings and to promote palliative care within these settings.

Each IPAL project has been developed using a similar process:
- A steering committee of nationally recognized leaders in hospital-based palliative care has been formed.
- A core team has been assembled to develop and refine the curriculum.
- A curriculum is developed for the target audience.
- A toolkit is developed to support the curriculum.
- The curriculum and toolkit are tested and refined.
- The curriculum is implemented and evaluated in the target setting.
- The process is repeated as necessary.

We hope you find this site useful as you work to improve palliative care services in your hospital.

Thank you.
Put Your Program on the Map!

National Palliative Care
Registry™

registry.capc.org

Metrics: The CAPC Registry

Leverages data you collect for several purposes

Your data, compared and combined

Provides outside perspective & validation to plans

Your data, local use

Builds consistency and critical mass for field & research
Don’t Wait for the Consult!
New Tool to Help “Move Upstream” with Triggers & Checklists

Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting
A Consensus Report from the Center to Advance Palliative Care
David E. Weisman, M.D.1 and Diane E. Meier, M.D.2

Tables to support system change include:
• Primary Palliative Care Assessment Components
• Criteria for a Palliative Care Assessment at the Time of Admission
• Criteria for Palliative Care Assessment during Each Hospital Day

Approach to Triggers
Uses a risk assessment pathway to identify patients who are most likely to have palliative care needs based on . . .

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<th>Patient variables</th>
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<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>
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<tr>
<td>• Class IV CHF</td>
<td>• ICU length of stay greater than X days</td>
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