Palliative Care in a Changing Health System

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Tennessee Oncology
Objectives

Discuss the needs of the seriously ill and the imperatives for change

Palliative Care: Definition and Need

Palliative Care and Hospice: Current Status

Healthcare Evolution and Legislation
FIGURE 1. Median Life Expectancy in Years.

- Modern Sanitation
- Antibiotics
- Modern Medicine

- 30,000 BC
- 1000 BC
- 1800
- 1900
- 1950
- 1970
- 2000
Life Expectancy

- Median age of death is 78 years
- Live to 65 and it’s 82 years
- Live to 80 and it’s 88 years
- # of people age >85 will double to 9 million by 2030 (CDC)
The Current Facts

90% of Americans die from incurable illness

Patients and Families have a high illness burden

- Poor symptom control
- Psychiatric, psychosocial, and spiritual distress
- Logistical needs in the home
- Complex health system to navigate
- Caregiver burden and financial distress
- Fear of death and managing the dying process
Symptoms of persons with serious or Life-threatening Illness in last year of life

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Cancer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>84</td>
<td>67</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>51</td>
<td>27</td>
</tr>
<tr>
<td>Insomnia</td>
<td>51</td>
<td>36</td>
</tr>
<tr>
<td>Confusion</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>Depression</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Loss of Appetite</td>
<td>71</td>
<td>38</td>
</tr>
<tr>
<td>Constipation</td>
<td>47</td>
<td>32</td>
</tr>
<tr>
<td>Bedsores</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Incontinence</td>
<td>37</td>
<td>33</td>
</tr>
</tbody>
</table>
Symptom burden of patients hospitalized with serious illness at 5 US academic medical centers

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Cancer</td>
<td>60%</td>
</tr>
<tr>
<td>Liver Failure</td>
<td>60%</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>57%</td>
</tr>
<tr>
<td>End organ failure + Cancer</td>
<td>53%</td>
</tr>
<tr>
<td>End organ failure + sepsis</td>
<td>52%</td>
</tr>
<tr>
<td>COPD</td>
<td>44%</td>
</tr>
<tr>
<td>CHF</td>
<td>43%</td>
</tr>
</tbody>
</table>

Patients with Mod-Severe Pain Between Hospital Day 8-12
FIGURE 7. When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?

<table>
<thead>
<tr>
<th>Year</th>
<th>% Yes</th>
<th>% No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1947 Jun 6-11</td>
<td>54</td>
<td>37</td>
</tr>
<tr>
<td>1950 Jan 8-13</td>
<td>54</td>
<td>36</td>
</tr>
<tr>
<td>1973 Jul 6-9</td>
<td>53</td>
<td>40</td>
</tr>
<tr>
<td>1990 Nov 15-18</td>
<td>65</td>
<td>31</td>
</tr>
<tr>
<td>1996 Jul 26-28</td>
<td>75</td>
<td>22</td>
</tr>
<tr>
<td>1996 Apr 9-10</td>
<td>69</td>
<td>26</td>
</tr>
<tr>
<td>2001 May 10-14</td>
<td>65</td>
<td>31</td>
</tr>
<tr>
<td>2002 May 6-9</td>
<td>72</td>
<td>26</td>
</tr>
<tr>
<td>2003 May 19-21</td>
<td>72</td>
<td>25</td>
</tr>
<tr>
<td>2004 May 2-4</td>
<td>69</td>
<td>29</td>
</tr>
<tr>
<td>2005 May 2-5</td>
<td>75</td>
<td>24</td>
</tr>
<tr>
<td>2006 May 8-11</td>
<td>69</td>
<td>27</td>
</tr>
<tr>
<td>2007 May 10-13</td>
<td>71</td>
<td>27</td>
</tr>
</tbody>
</table>
Children Suffering

![Bar chart showing the proportion of children with symptoms](chart.jpg)
Illness burned and access to care are influenced by:

Socioeconomic status and demography
- Poverty – poorer outcomes
- Minority – poorer outcomes

Insurance Status
- 50 million uninsured
Health Care Costs

95% of Medicare budget goes to the chronically ill

1/3 of health costs accrue in the last 6 months of life

Health costs increase with...
- Older Age
- Multiple Chronic Conditions
- Declining health status

So who’s is the target group to save money?
FIGURE 5. Two-Thirds of Medicare Spending Is for People with Five or More Chronic Conditions.


Dollars in billions

Note: Figures for 2010 and 2015 are projected.
Source: The Commonwealth Fund; Data from 2006 Medicare Trustees’ Report.
Exhibit 1. International Comparison of Spending on Health, 1980–2009

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.

Source: OECD Health Data 2011 (Nov. 2011).
Health Care Costs

Total health expenditure as a share of GDP, 2009

OECD Health Data
2009
US Leads the world in per capita spending yet:

• Lowest life expectancy at birth
• Highest mortality amenable to health care
• 20th in quality indices
• 27th in life expectancy
• 37th in overall quality of healthcare system (WHO)
• 100,000 deaths/year from medical errors
Healthcare Spending

**FIGURE 4.** Magnetic Resonance Imaging (MRI) Units per Million Population, 2006.

- US: 26.5
- SWITZ: 14.0
- DEN**: 10.2
- GER: 7.7
- OECD Median: 7.7
- NETH*: 6.6
- CAN: 6.2
- UK: 5.6
- FRA: 5.3
- AUS: 4.9

*2005
**2004

Source: The Commonwealth Fund; Data from OECD Health Data 2008 (June 2008). Reprinted with permission.
Healthcare Spending and Quality

The Cost of a Long Life

Average Life Expectancy

Per Capita Spending

Life Expectancy  Per Capita Spending (International Dollars)
Family Burden of Seriously Ill

- 65 Million caregivers deliver care at home to seriously ill relative (16.8 million to children)
- Mean hours = 20/week
- 87% state they need more help
- 33% in poor health themselves

- Stressed caregivers at risk of death, major depression, reduced QoL, loss of work

- Cost equivalent = $375 Billion/year
### Impact of serious Illness on Patient Families

<table>
<thead>
<tr>
<th>Impact</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need large amount of family caregiving</td>
<td>34%</td>
</tr>
<tr>
<td>Lost most family savings</td>
<td>31%</td>
</tr>
<tr>
<td>Lost major source of income</td>
<td>29%</td>
</tr>
<tr>
<td>Major life change for family member</td>
<td>20%</td>
</tr>
<tr>
<td>Other family illness from stress</td>
<td>12%</td>
</tr>
<tr>
<td>At least one of the above</td>
<td>55%</td>
</tr>
</tbody>
</table>
Projection of non-institutionalized population Age 65 and over with ADL limitations
FIGURE 8. *Family Concerns About Quality of Care at the End of Life for Adult Relatives Who Died of a Chronic Illness in 2000 (Percentage of Family Respondents Expressing Concerns).*

- Patient emotional support: 50%
- Family emotional support: 35%
- No contact with physician: 30%
- Information about what to expect: 29%
- Communication with physician: 24%
- Help with pain: 24%
- Help with shortness of breath: 22%
- Respect for patient: 21%
- Coordination of care*: 15%

*Staff did not know enough about patient’s medical history to provide the best care.

n=1578
FIGURE 10. Family Concerns About Quality of Care at the End of Life for Adult Relatives Who Died of a Chronic Illness in 2000 (Percentage of Family Respondents Expressing Concerns).

Note: Results shown represent a subset of nine aspects of care measured in the study.
*Information about what to expect while patient was dying.

Are values and expectations being fulfilled?

- >¾ of patients and healthy people prefer to die at home
- Reality = ¾ die in institutions
Where do we stand

- Unprecedented gains in life expectancy
- Cause of death shifting from acute to chronic conditions
- Untreated physical symptoms
- Unmet patient/family needs
- Disparities in access to care
- Inadequately trained health care professionals
- An unresponsive health care system facing enormous and increasing expenditures
Why have a specialty?
Why have a specialty?

• Diseases are complex
• Treatments are complex
• Symptoms are complex
• Patients are complex
• The system is complex
Evolution

• With time, new needs are realized
• Focus on quality is growing
• Knowledge is rapidly expanding
• Benefits are being discovered
Palliative care focuses on improving a patient’s quality of life by managing pain and other distressing symptoms, relieving family burdens, and coordinating care in the setting of a serious illness.

It is provided simultaneously with all other appropriate medical treatments.

It helps align treatments with patients’ goals.
Palliative Care: Key Features

Multidimensional Concerns
• Within the purview of multiple professional disciplines

Relevant throughout the course of the disease
• EOL care is a ‘slice’ of palliative care
• Removes the need for prognostication

Patient and family are the central unit of care
Palliative Care: Key Features

Palliative care promotes:

• Comfort through **symptom control**
• Psychosocial and spiritual **distress** management
• Improved **communication** that is patient centered, goal oriented
• Shared **decision making**
• Advanced care **planning**
• Practical help in the **home**
• Expert management of **active dying** and its aftermath
• **Family support** while caregiving and when bereaved
Palliative Care

- **Old definition**

  \[
  \text{LIFE PROLONGING CARE} \quad \text{HOSPICE} \quad \text{Death}
  \]

  (Quantity)    (Quality)

  \[
  \text{Progression of disease over time}
  \]

  Medicare Hospice Benefit
Reality of the last year of life

Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients:
- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)
People have an abiding desire not to be dead

“I don’t want to achieve immortality through my work. I’d rather achieve it be not dying”

Woody Allen
What tormented Ivan Ilych was the lie, this lie that for some reason they all accepted, that he was only sick and not dying, and that if he would only remain calm and take care of himself, everything would be fine; whereas he knew very well that no matter what was done the result would be only worse suffering and death. He suffered because no one was willing to admit what everyone, including himself, could see clearly. He suffered because they lied and forced him to take part in this deception. This lie that was being told on the eve of his death, that degraded the formidable and solemn act of his death... had become horribly painful to Ivan Ilych.

Leo Tolstoy, “The Death of Ivan Ilych”

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Palliative Care

Progression of disease over time

LIFE PROLONGING CARE (Quantity)

PALLIATIVE MEDICINE (Quality & Quantity)

HOSPICE (Quality)

Death

Medicare Hospice Benefit
How does palliative care address the health care crisis?

4-ways

• Improves clinical quality
Patient Benefit

Phase II Study of an Outpatient Palliative Care Intervention in Patients With Metastatic Cancer

This study assessed prospectively the efficacy of an Oncology Palliative Care Clinic (OPCC) in improving patient symptom distress and satisfaction.

- 150 patients enrolled, 123 completed 1-week assessments, and 88 completed 4-week assessments
- The mean improvement in EDS was 8.8 points ($P < .0001$) at 1 week and 7.0 points ($P < .0001$) at 1 month
- **Statistically significant improvements were observed for pain, fatigue, nausea, depression, anxiety, drowsiness, appetite, dyspnea, insomnia, and constipation at 1 week (all $P \leq .005$) and 1 month (all $P \leq .05$)**
- The mean improvement in FAMCARE score was 6.1 points ($P < .0001$) at 1 week and 5.0 points ($P < .0001$) at 1 month.
“Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer”

Patients assigned to palliative care had better quality of life, reflected in a mean FACT-L score of 98.0 at 12 weeks compared with 91.5 for the control group (P=0.03).

Additionally, only 16% of the palliative care group had depressive symptoms versus 38% of the control group (P=0.01).

Palliative-care patients were also less likely to receive aggressive end-of-life care. The authors reported that 33% of patients receiving palliative care had aggressive end-of-life care versus 54% of the standard-care group (P=0.05).

Median survival in the patients who received early palliative care was 11.6 months compared with 8.9 months in the control group (P=0.02).

Palliative Outcomes

Survival Analysis

Median Survival
- Early palliative care 11.6 mo
- Standard care 8.9 mo
  p=0.02

Controlling for age, gender and PS, adjusted HR=0.59 (0.40-0.88), p=0.01

Temel, ASCO 2010, #7509
What about aflibercept?
Provisional Clinical Opinion: Based on strong evidence from a phase III RCT, patients with metastatic non–small-cell lung cancer should be offered concurrent palliative care and standard oncologic care at initial diagnosis. While a survival benefit from early involvement of palliative care has not yet been demonstrated in other oncology settings, substantial evidence demonstrates that palliative care–when combined with standard cancer care or as the main focus of care–leads to better patient and caregiver outcomes. These include improvement in symptoms, QOL, and patient satisfaction, with reduced caregiver burden. Earlier involvement of palliative care also leads to more appropriate referral to and use of hospice, and reduced use of futile intensive care. While evidence clarifying optimal delivery of palliative care to improve patient outcomes is evolving, no trials to date have demonstrated harm to patients and caregivers, or excessive costs, from early involvement of palliative care. Therefore, it is the Panel's expert consensus that combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden. Strategies to optimize concurrent palliative care and standard oncology care, with evaluation of its impact on important patient and caregiver outcomes (eg, QOL, survival, health care services utilization, and costs) and on society, should be an area of intense research.
How does palliative care address the health care crisis?

4-ways

• Improves clinical quality
• Helps families cope in the setting of a serious or life-threatening illness
Palliative care assists families in coping

• 54 died with palliative care
• 95 died with usual care
  • 65% of family members of PC reported having emotional and spiritual needs met vs 35% (P=0.004)
  • 67% of PC families reported confidence in one or more self-efficacy domains vs 44% (p=0.03)
Mortality follow back survey palliative care vs. usual care

• N=524 family survivors
• Overall satisfaction markedly SUPERIOR in pall care group p<.001
• Pall Care superior for
  • Emotional/spiritual support
  • Information/communication
  • Care at time of death
  • Access to services in community
  • Well-being/dignity
  • Care + setting concordant with patient preference
  • Pain improvement
  • Decreased PTSD for family

How does palliative care address the health care crisis?

4-ways

• Improves clinical quality
• Helps families cope in the setting of a serious or life-threatening illness
• Assists doctors in the care of their most complex and challenging patients
PC helps physicians

• Saves time by helping handle repeated, intensive patient-family communications, care across settings, and comprehensive d/c planning

• Providing bedside management of pain and distressing symptoms

• Helping patients match treatment goals
How does palliative care address the health care crisis?

4-ways

• Improves clinical quality
• Helps families cope in the setting of a serious or life-threatening illness
• Assists doctors in the care of their most complex and challenging patients
• Allows hospitals to meet their fiscal challenges
Financial Landscape of Healthcare

- 16.3% of GDP
- Medicare spending expected to increase to $844 Billion in 2017
- 10% of Medicare enrollees account for 67% of spending
- Hospitals are facing the most hostile operating environment in the history of modern medicine

Footing the Bill
The cost of insuring aging baby boomers will help push up national health expenditures in the next decade

Source: Centers for Medicare & Medicaid Services
How are hospitals responding

• Increase revenues
  • Increase profitable service lines – high margins, short length of stay, surgical admissions

• Reduce Expenditures
  • Reduce length of stay
  • Standardize care of uncomplicated admissions and reduce “over-utilization”

Is this a feasible solution?
PC helps hospitals

• PC programs provide a means of...
  • Reducing expenditures
  • Improving throughput as hospitals shrink bed capacity
  • ICU
  • Reducing unnecessary admissions
  • Early hospice referrals
  • Outpatient clinics
  • Emergency department consultations
PC reduces hospital costs

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

8 Hospitals from 2002-2004

Live discharge saved about $174 / day ($1,700/admission) – (P 0.004)

Death discharge saved $374 / day ($5000/admission) – (P 0.003)

Patients who received palliative care were significantly less likely to die in an intensive care unit than a regular bed, yet their survival time was exactly the same

Assume that 50% of hospitals now have palliative care programs, which are seeing about 1.5% of all hospitalized patients that’s $1.2 billion in savings per year in 2010. At 5% of hospitalized patients, savings are $4 billion per year. At 7.5% of hospitalized patients it’s $6 billion per year.

Palliative Growth

Growth of Palliative Care

Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2000 to 2010; and data from the Center to Advance Palliative Care’s (CAPC) National Palliative Care Registry™.
# Palliative Growth

## Prevalence (2000-2010)

<table>
<thead>
<tr>
<th>Data Year</th>
<th># of Teams in Hospitals</th>
<th>Total # of Hospitals</th>
<th>% of Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>658</td>
<td>2,686</td>
<td>24.5%</td>
</tr>
<tr>
<td>2001</td>
<td>805</td>
<td>2,648</td>
<td>30.4%</td>
</tr>
<tr>
<td>2002</td>
<td>946</td>
<td>2,658</td>
<td>35.6%</td>
</tr>
<tr>
<td>2003</td>
<td>1,082</td>
<td>2,683</td>
<td>40.3%</td>
</tr>
<tr>
<td>2004</td>
<td>1,150</td>
<td>2,569</td>
<td>44.8%</td>
</tr>
<tr>
<td>2005</td>
<td>1,265</td>
<td>2,509</td>
<td>50.4%</td>
</tr>
<tr>
<td>2006</td>
<td>1,357</td>
<td>2,452</td>
<td>55.3%</td>
</tr>
<tr>
<td>2007</td>
<td>1,373</td>
<td>2,505</td>
<td>54.8%</td>
</tr>
<tr>
<td>2008</td>
<td>1,486</td>
<td>2,517</td>
<td>58.5%</td>
</tr>
<tr>
<td>2009</td>
<td>1,568</td>
<td>2,489</td>
<td>63.0%</td>
</tr>
<tr>
<td>2010</td>
<td>1,635</td>
<td>2,489</td>
<td>65.7%</td>
</tr>
</tbody>
</table>

Change in palliative care teams 2000 to 2010: 148.5%
### Region 2010

<table>
<thead>
<tr>
<th>Region</th>
<th># of Teams in Hospitals</th>
<th>Total # of Hospitals in Region</th>
<th>% of Teams in Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>339</td>
<td>447</td>
<td>75.8%</td>
</tr>
<tr>
<td>Midwest</td>
<td>459</td>
<td>609</td>
<td>75.4%</td>
</tr>
<tr>
<td>West</td>
<td>310</td>
<td>434</td>
<td>71.4%</td>
</tr>
<tr>
<td>South</td>
<td>527</td>
<td>999</td>
<td>52.7%</td>
</tr>
</tbody>
</table>

### Size (2010)

<table>
<thead>
<tr>
<th>Bed Size¹</th>
<th># of Teams in Hospitals</th>
<th>Total # of Hospitals by Bed Size</th>
<th>% of Teams by Bed Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>300+ ²</td>
<td>639</td>
<td>727</td>
<td>87.9%</td>
</tr>
<tr>
<td>50 to 299</td>
<td>996</td>
<td>1,762</td>
<td>56.5%</td>
</tr>
<tr>
<td>Under 50</td>
<td>347</td>
<td>1,492</td>
<td>23.2%</td>
</tr>
</tbody>
</table>
Palliative Growth - TN

STATE RANKINGS

Click on a hospital group to compare the state, regional and national values in a chart.

<table>
<thead>
<tr>
<th>Hospital Group</th>
<th>State</th>
<th>Region</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-profit</td>
<td>22% (4/18)</td>
<td>6% (1/18)</td>
<td>26% (108/419)</td>
</tr>
<tr>
<td>Public</td>
<td>38% (3/8)</td>
<td>38% (10/26)</td>
<td>54% (192/356)</td>
</tr>
<tr>
<td>Sole Community Provider</td>
<td>33% (1/3)</td>
<td>11% (1/9)</td>
<td>37% (151/406)</td>
</tr>
<tr>
<td>300 or more beds</td>
<td>76% (13/17)</td>
<td>50% (6/12)</td>
<td>85% (597/699)</td>
</tr>
<tr>
<td>50 or more beds</td>
<td>52% (28/54)</td>
<td>28% (16/58)</td>
<td>63% (1568/2489)</td>
</tr>
<tr>
<td>Less than 50 beds</td>
<td>46% (12/26)</td>
<td>4% (1/28)</td>
<td>22% (326/1500)</td>
</tr>
</tbody>
</table>
Palliative vs. Hospice

Both focus on improved qualify of life

Both are delivered by specialists

Both have been shown to improve survival
Palliative vs. Hospice

Both tend to be delivered by a team of individuals with knowledge of complex symptom management.

Both work with the patient’s other clinicians to provide an additional layer of patient care.
Hospice is a federal entitlement
• Medicare Part A
  • Equivalent Medicaid / similar commercial
• Highly Regulated
  • 1st managed care program
• Full Risk Program
• Capitated Reimbursement
• Significant Growth ($14 Billion industry)
Hospice

Patients must meet a prognosis limit of 6 months

Regulations do not limit disease-modifying treatments unless it affects eligibility
  • Agencies may limit coverage

Extensive data shows high satisfaction with care and health cost reductions
  • 71% Excellent Satisfaction
Hospice Team

- Hospice Nurse
- Home Health Aide
- Social Worker
- Chaplain
- Pharmacist
- Bereavement Counselor
- Other Therapist & Counselors
- Volunteers
- Hospice Medical Director
- Attending Physician

Family

Hospice Patient

Care Givers
Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window

Stephen R. Connor, PhD, Bruce Pyenson, FSA, MAAA, Kathryn Fitch, RN, MA, MEd, Carol Spence, RN, MS, and Kosuke Iwasaki, FIAJ, MAAA

National Hospice and Palliative Care Organization (S.R.C., C.S.), Alexandria, Virginia; and Milliman, Inc. (B.P., K.F., K.I.), New York, New York, USA
What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?

Donald H. Taylor Jr\textsuperscript{a,\,*}, Jan Ostermann\textsuperscript{a}, Courtney H. Van Houtven\textsuperscript{b}, James A. Tulsky\textsuperscript{c}, Karen Steinhauser\textsuperscript{c}

\textsuperscript{a}Terry Sanford Institute of Public Policy, Duke University Durham, Durham, NC, USA
\textsuperscript{b}Duke University and Durham Veterans Administration Medical Center, USA
\textsuperscript{c}Center for Palliative Care and Department of Medicine, Duke University and VA Medical Centers, USA

Available online 27 June 2007
Hospice Savings

• $2,309 savings / hospice beneficiary
• Savings until 233rd day – cancer
• Savings until 153rd day – non cancer
• Increasing stay by 3 days would save another 10%
• “Given that hospice has been widely demonstrated to improve quality of life of patients and families...the Medicare program appears to have a rare situation whereby something that improves quality of life also appears to reduce costs.”
Hospice Challenges

- Ensure quality and accountability across agencies
  - Size, location, community resources, budget
- Disparities in for-profit / non-profit
- Improved access through earlier and more appropriate referral
Hospice Challenges

• Referral Issues
  • Perception is a program for the actively dying
  • Doctors’ inability to prognosticate
  • Ignorance of a system built out of the mainstream
  • Humans’ desire to live and avoid death conversations
Palliative Care Challenges

• Challenges
  • Workforce is limited in all disciplines (certification)
  • Cost-avoidance for hospitals doesn’t provide capital for program development
  • Uncertain economic viability in community-based palliative programs
  • Large geographical variation in resources
Patient Protection and Affordable Care Act “ACA” (Public Law 111-148)

• Signed into law March 23, 2010

• Intended to:
  • Cost $1,000,000,000,000 over 10 years
  • Expand coverage to 32 million
  • Cost offset by $438 billion in new revenues and $500 billion in spending reductions
  • Reduce federal deficit by $28 billion over 10 years
ACA includes:

- New insurance exchanges
- Insurance market reforms
- Significant Medicare changes
- Incentives for primary care, including geriatrics
- Expansion of Health Care Workforce programs
- Expansion of Medicaid
- Prevention and wellness, care coordination, comparative effectiveness, quality, health IT, fraud and abuse, elder justice initiatives
ACA includes:

- Demonstrations and pilots to lay groundwork for fundamental delivery/payment reforms… (Fee-For-Service → Shared Risk)
  - Patient-centered medical homes
  - Bundled payments for episodes of care
  - Accountable Care Organizations
- Palliative care is not specifically included but is well positioned
Conclusion

• Rapidly Growing Specialty
• Evolving across the health system
• Improves quality outcomes
• Can be a piece of the solution
Moving Forward

The U.S. Health System

- Expand access to hospice while improving hospice quality
  - Change prognosis requirements
  - Concurrent model of care
- Grow institution-based palliative programs
  - Benefits already demonstrated
- Support development of community palliative programs
  - Some models have demonstrated benefit
  - Opportunity in Accountable Care Organizations
The secret of the care of the patient is the caring for the patient.

-- Francis Peabody, 1925