Palliative Care in a Changing Health System

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Tennessee Oncology

Objectives

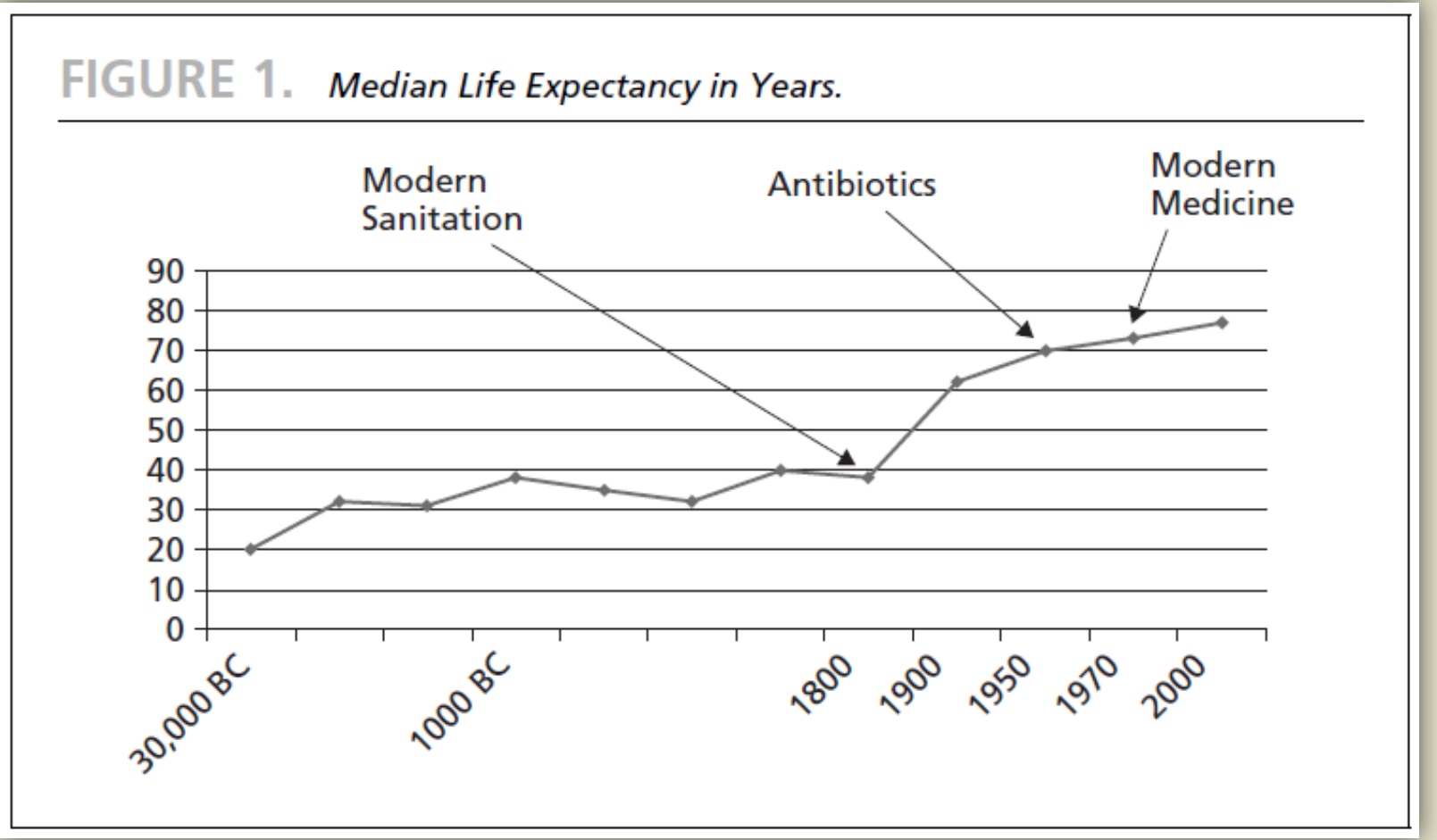
Discuss the needs of the seriously ill and the imperatives for change

Palliative Care: Definition and Need

Palliative Care and Hospice: Current Status

Healthcare Evolution and Legislation

Median Life Expectancy



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

	Cancer	Other
Pain	84	67
Dyspnea	47	49
Nausea/Vomiting	51	27
Insomnia	51	36
Confusion	33	38
Depression	38	36
Loss of Appetite	71	38
Constipation	47	32
Bedsores	28	14
Incontinence	37	33

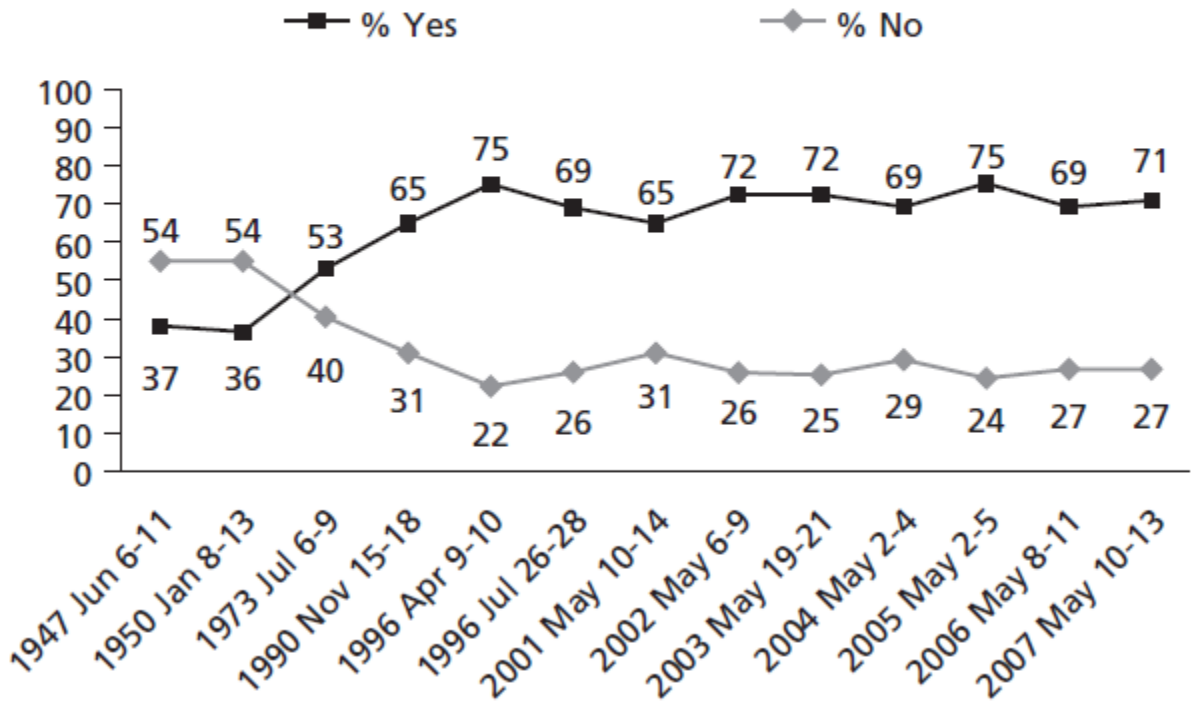
Symptom burden of patients hospitalized with serious illness at 5 US academic medical centers

Colon Cancer	**60%**
Liver Failure	**60%**
Lung Cancer	**57%**
End organ failure + Cancer	**53%**
End organ failure + sepsis	**52%**
COPD	**44%**
CHF	**43%**

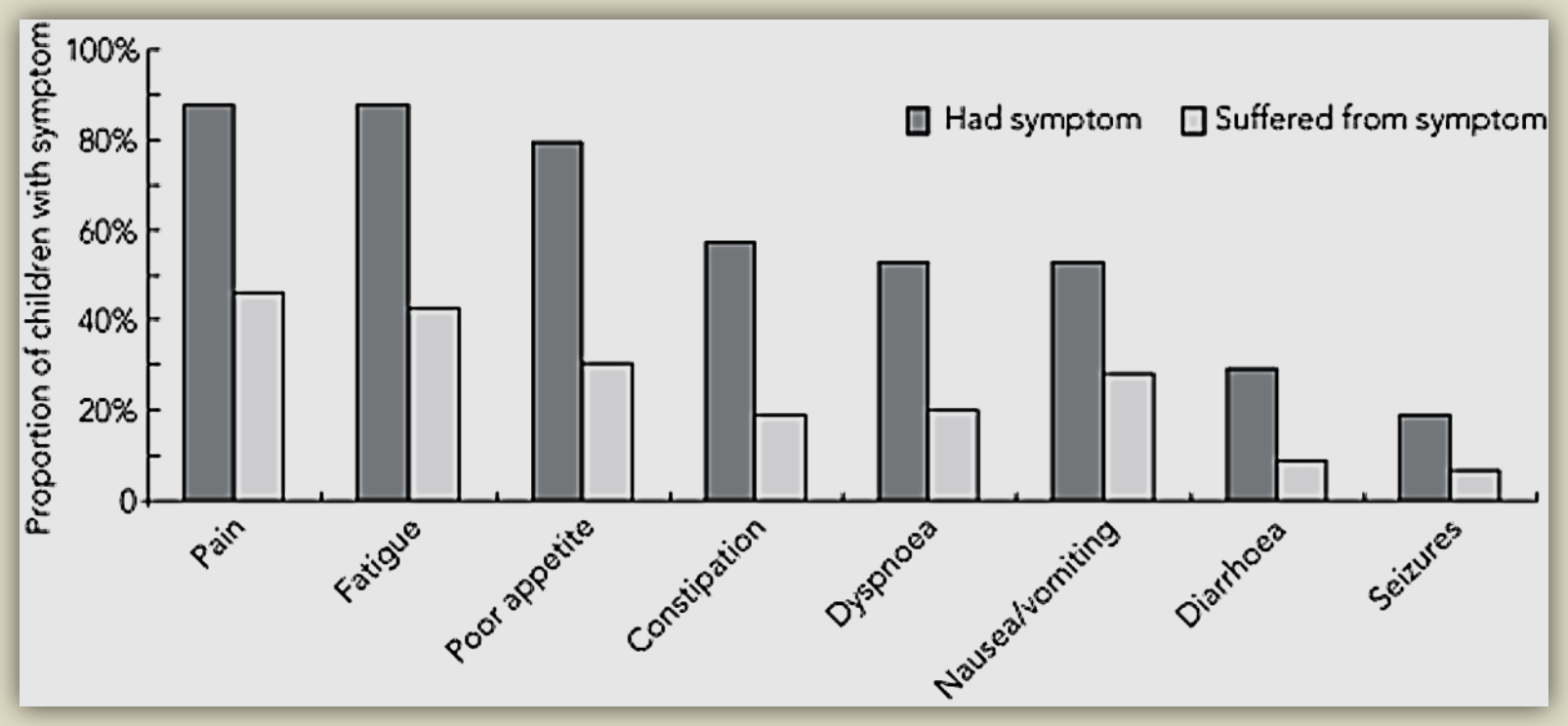
Patients with Mod-Severe Pain Between Hospital Day 8-12

Suffering

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?*



Children Suffering



Access Issues

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

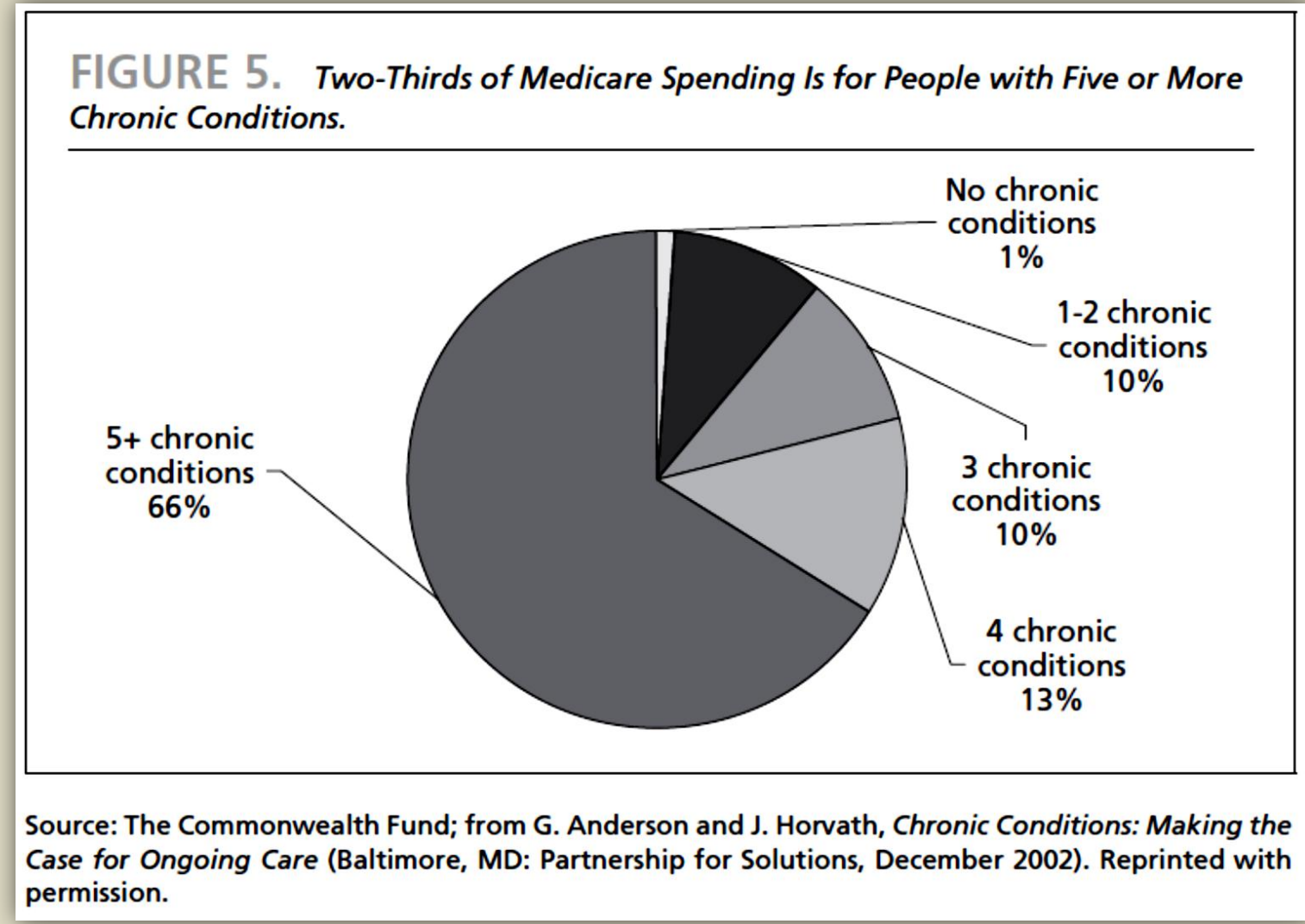
1/3 of health costs accrue in the last 6 months of life

Health costs increase with…

- Older Age
- Multiple Chronic Conditions
- Declining health status

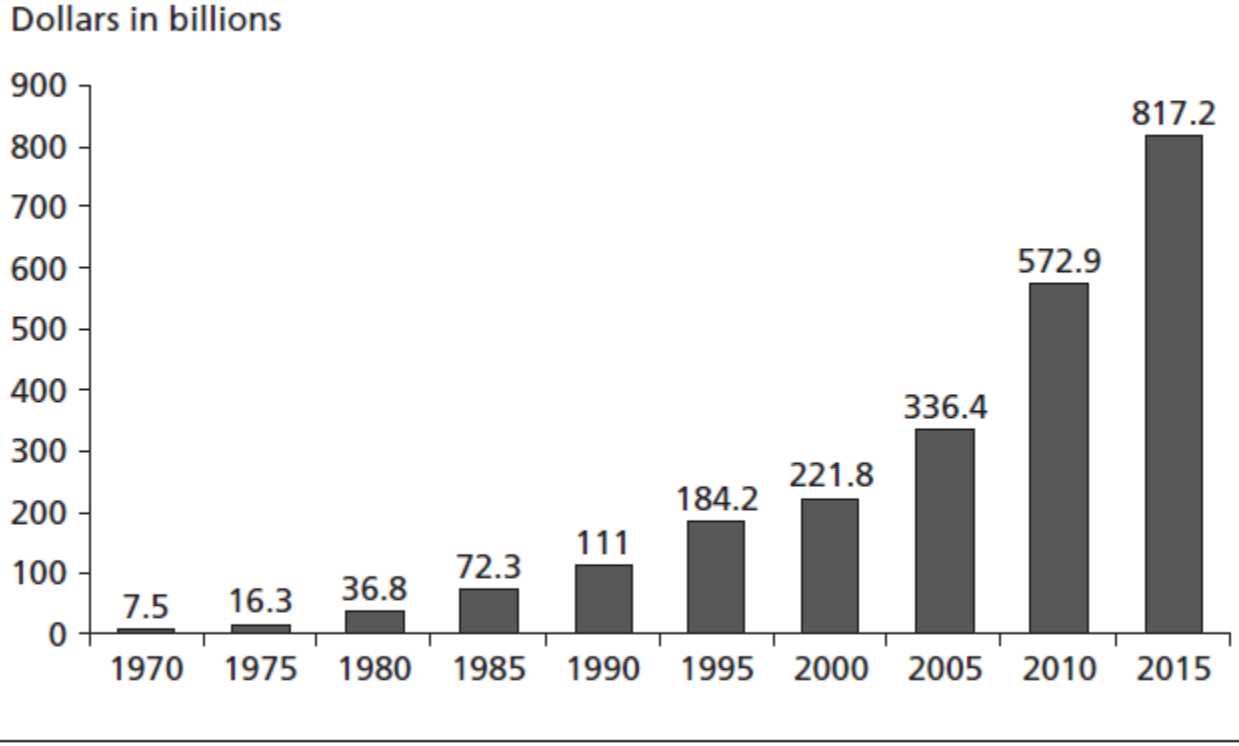
So who's is the target group to save money?

Medicare Spending



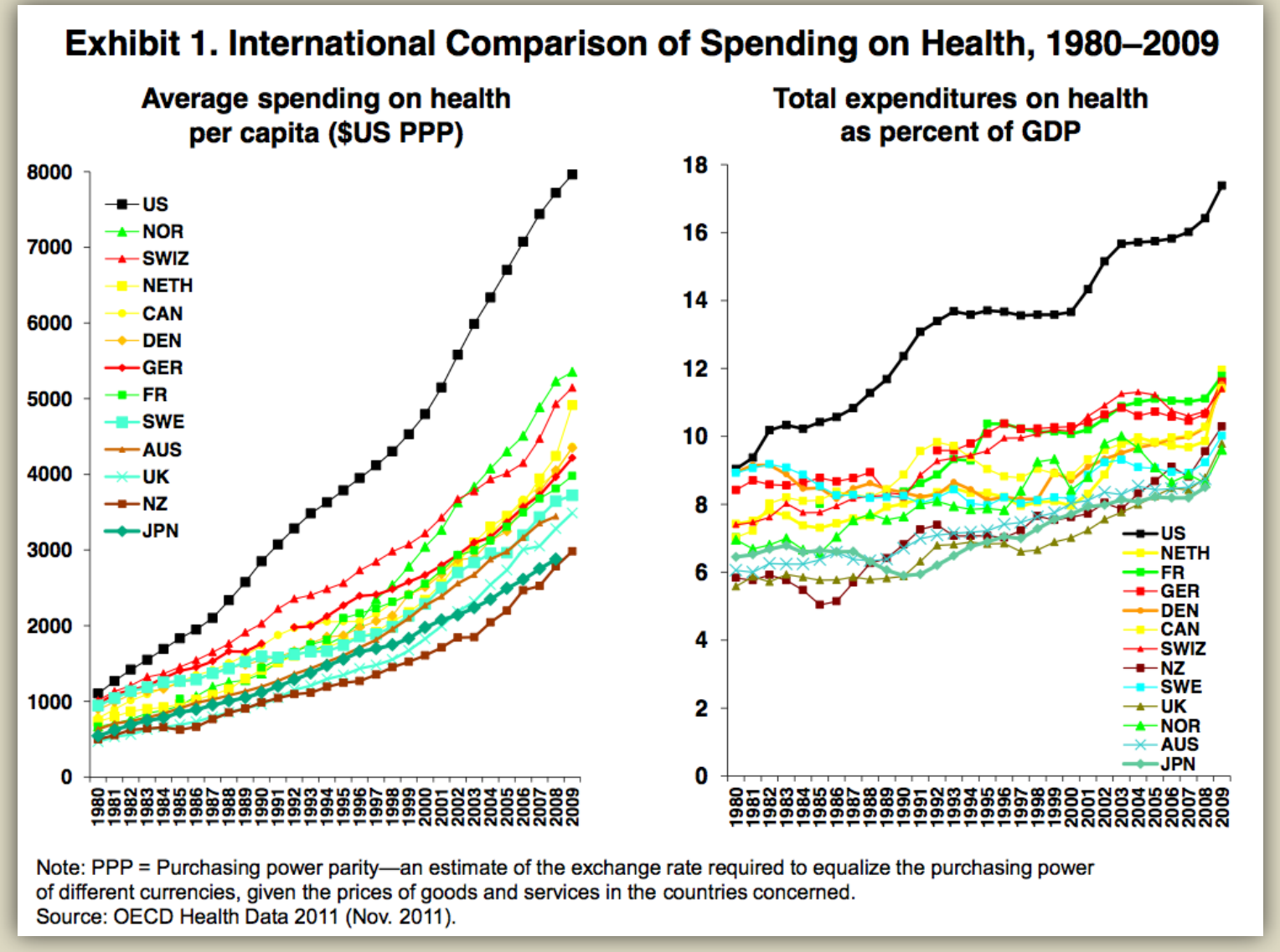
Medicare Growth

FIGURE 2. *Growth in Medicare Expenditures, 1970–2015.*



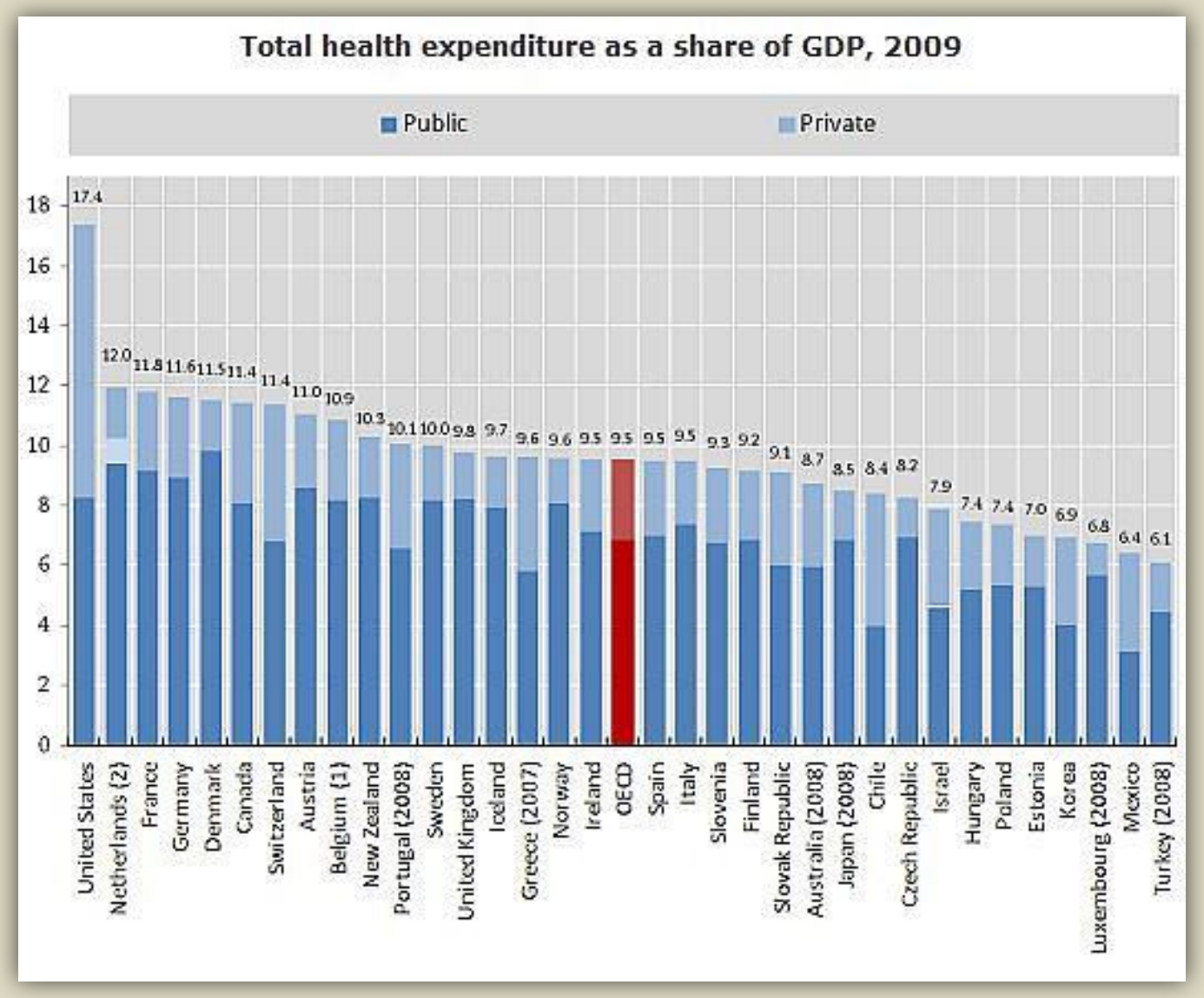
Note: Figures for 2010 and 2015 are projected.
Source: The Commonwealth Fund; Data from 2006 Medicare Trustees' Report.

Healthcare Spending



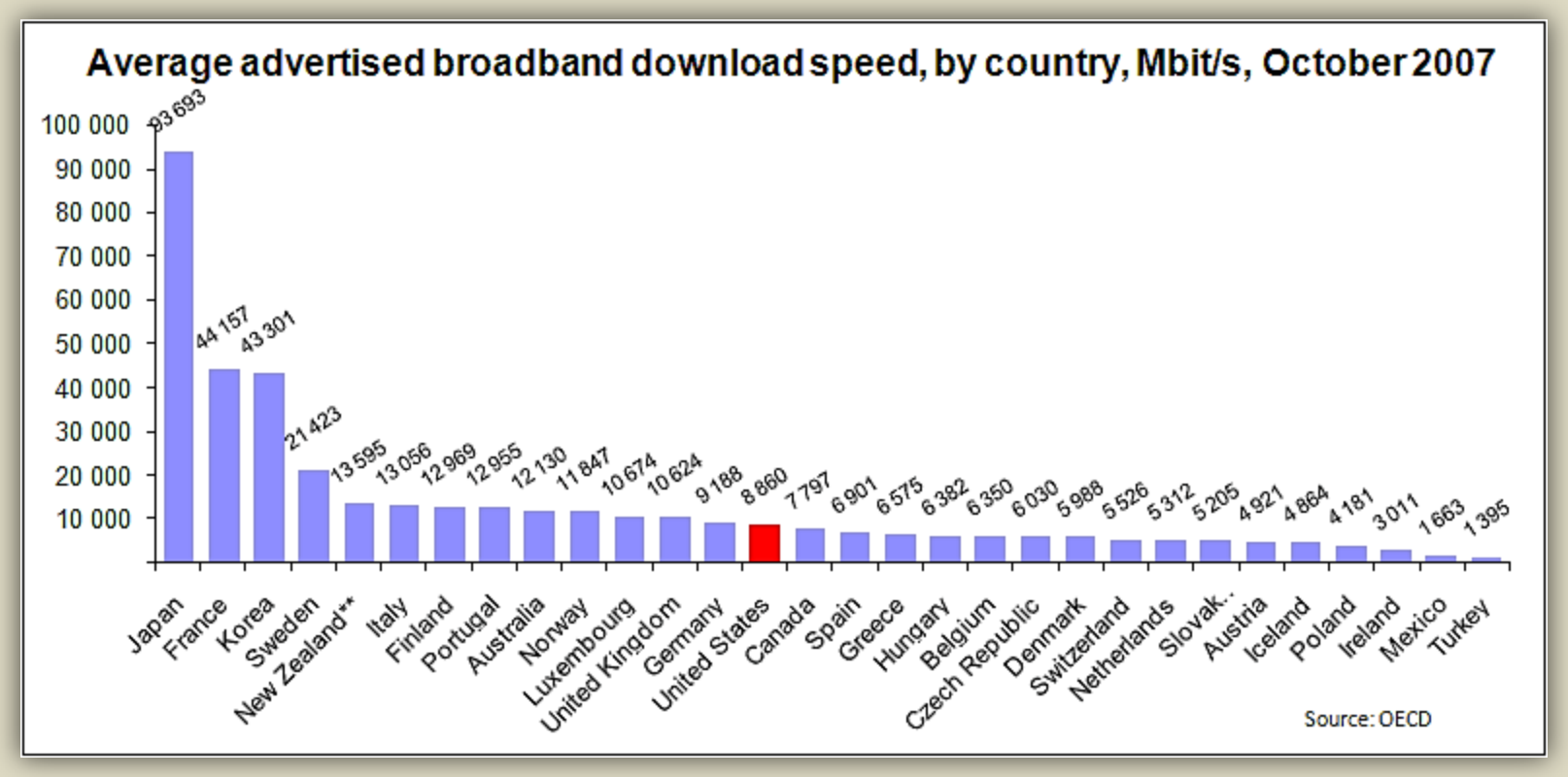
Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
Source: OECD Health Data 2011 (Nov. 2011).

Health Care Costs



OECD Health Data 2009

Download Speeds



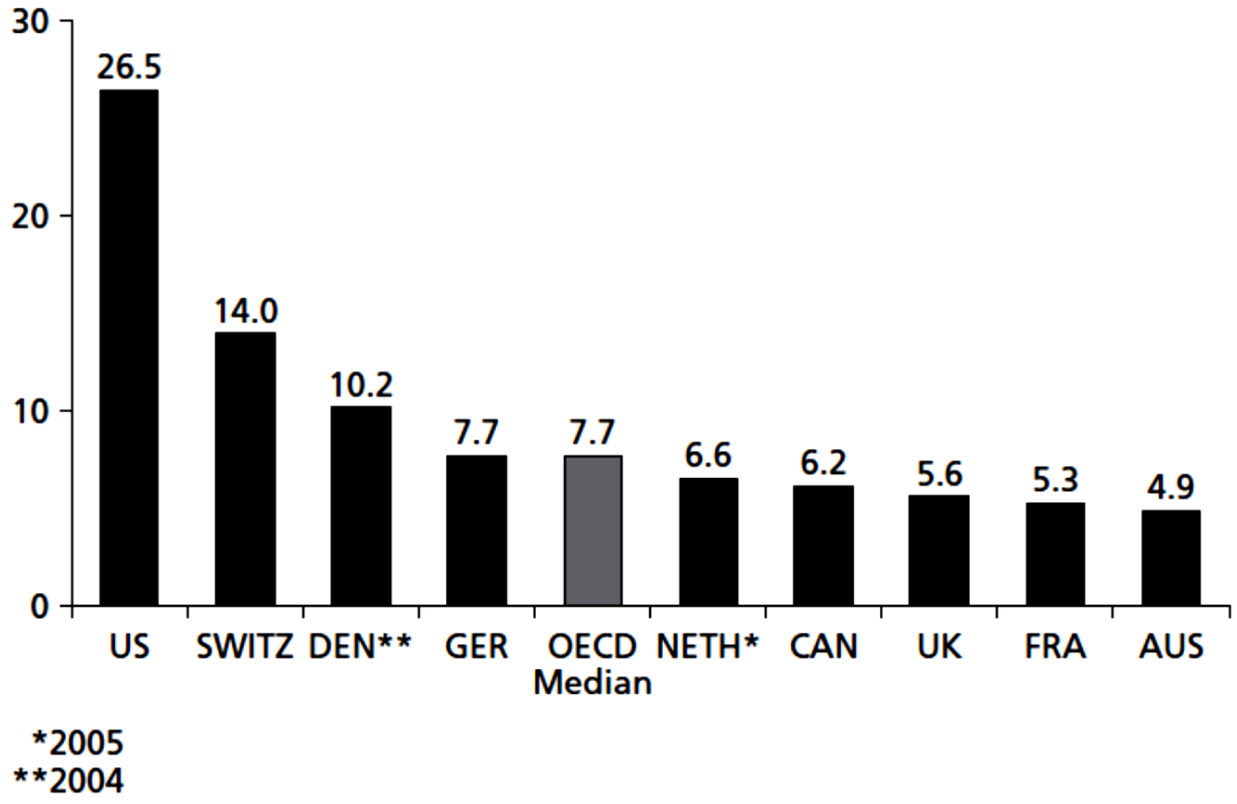
Healthcare Spending and Quality

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

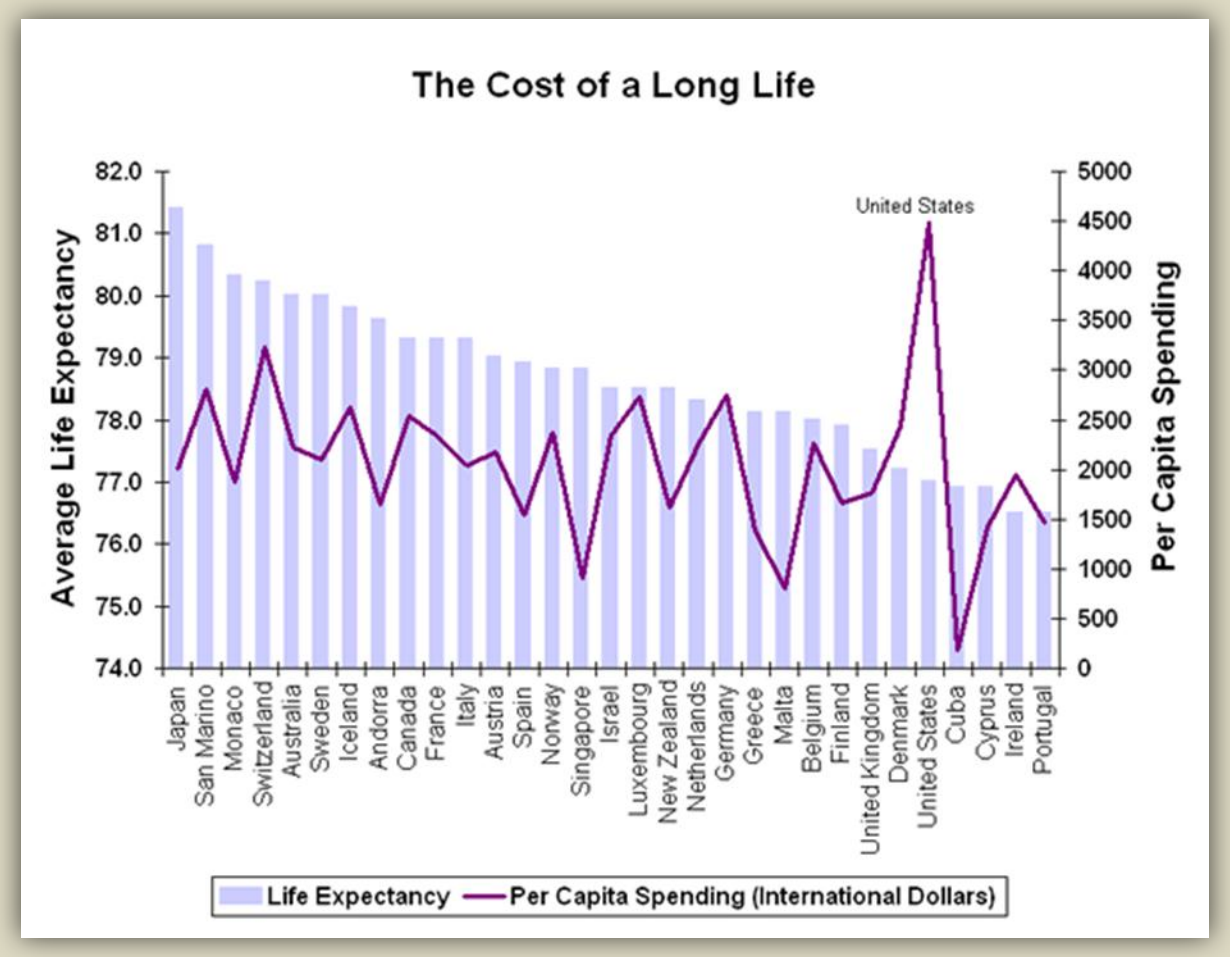
Healthcare Spending

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



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

Healthcare Spending and Quality



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

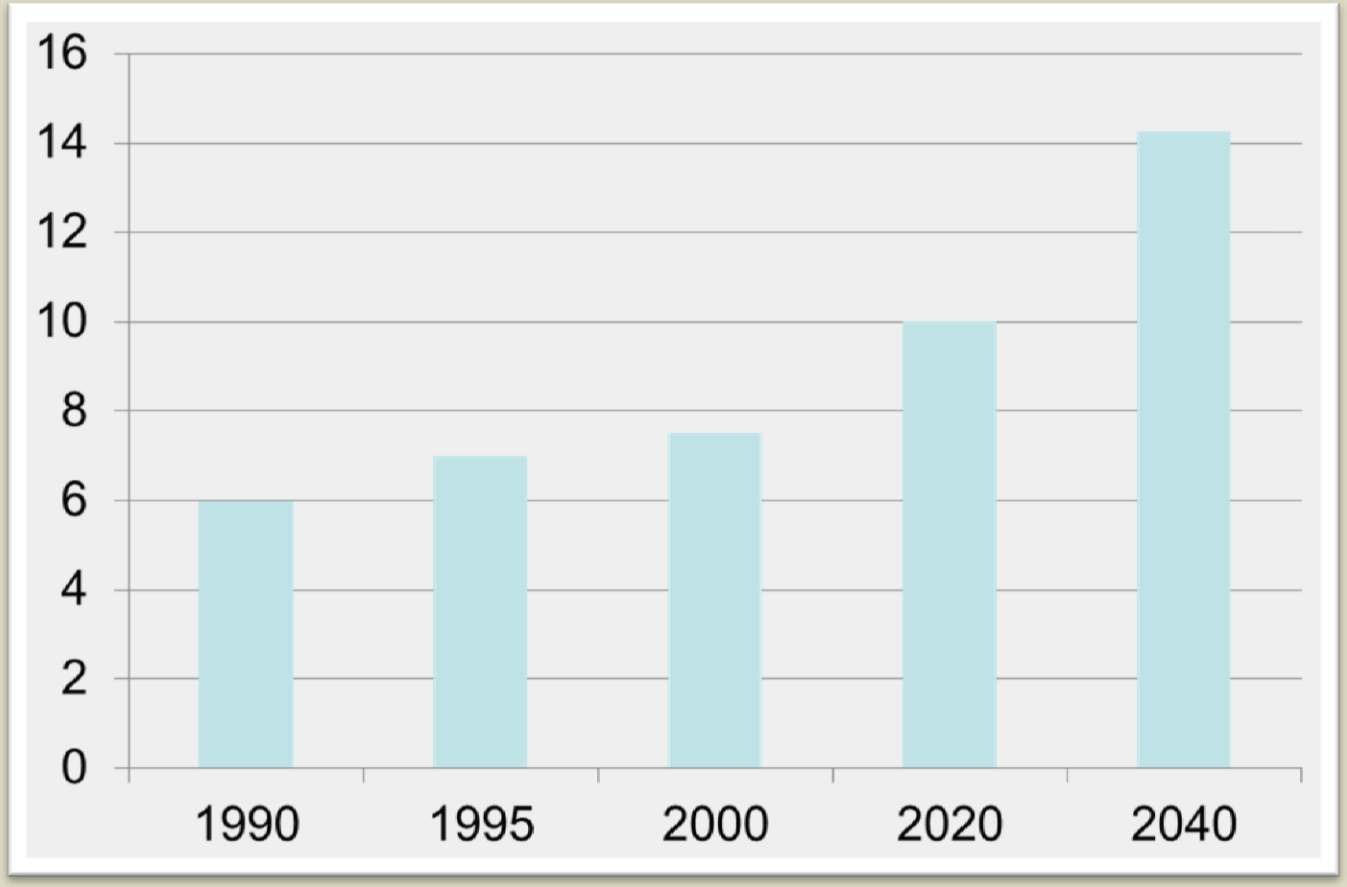
Emanuel et al 2000, Levine 1999, Schulz 1999, Kuhlthau 2010

Impact of serious Illness on Patient Families

Need large amount of family caregiving	34%
Lost most family savings	31%
Lost major source of income	29%
Major life change for family member	20%
Other family illness from stress	12%
At least one of the above	55%

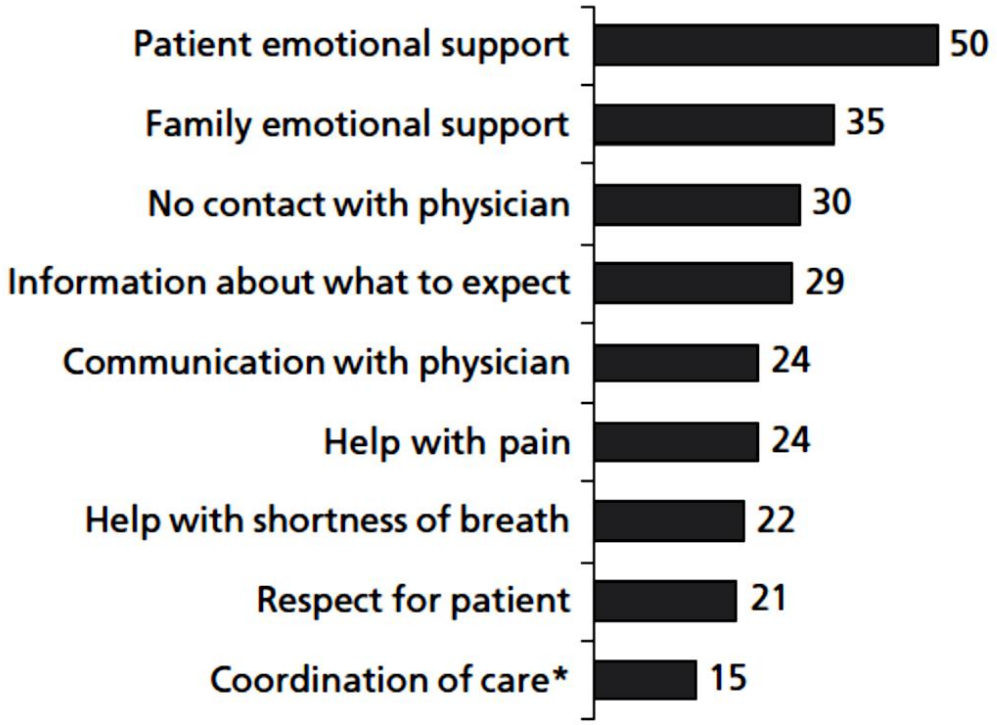
Support
JAMA 1994

Projection of non-institutionalized population Age 65 and over with ADL limitations



Family Satisfaction

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).*



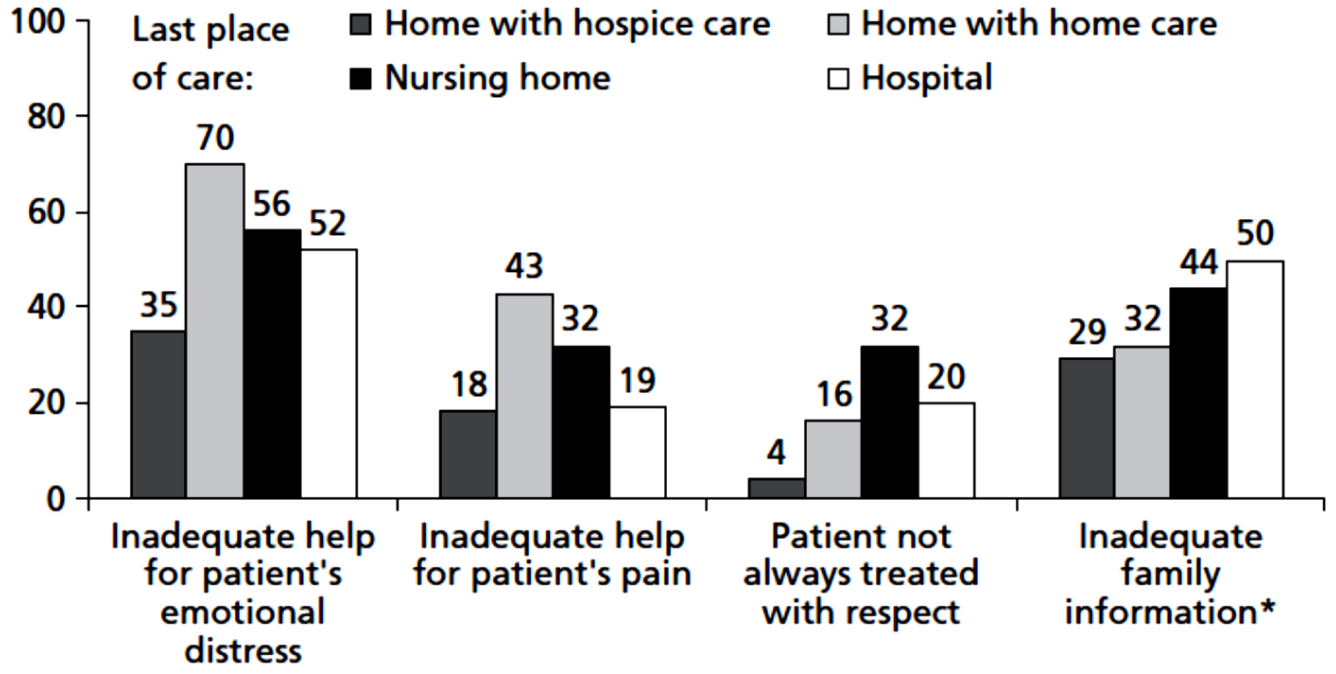
*Staff did not know enough about patient's medical history to provide the best care.

n=1578

Teno
JAMA 2004

Family Satisfaction

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.

Data Source: The Commonwealth Fund; Study of Care at the Last Place of Care (Teno, J. M. et al. 2004. *JAMA* 291:88-93). Reprinted with permission.

Quality in Advanced Illness

Are values and expectations being fulfilled?

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

Murray MA et at, Oncol Nurs Forum 2009

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

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

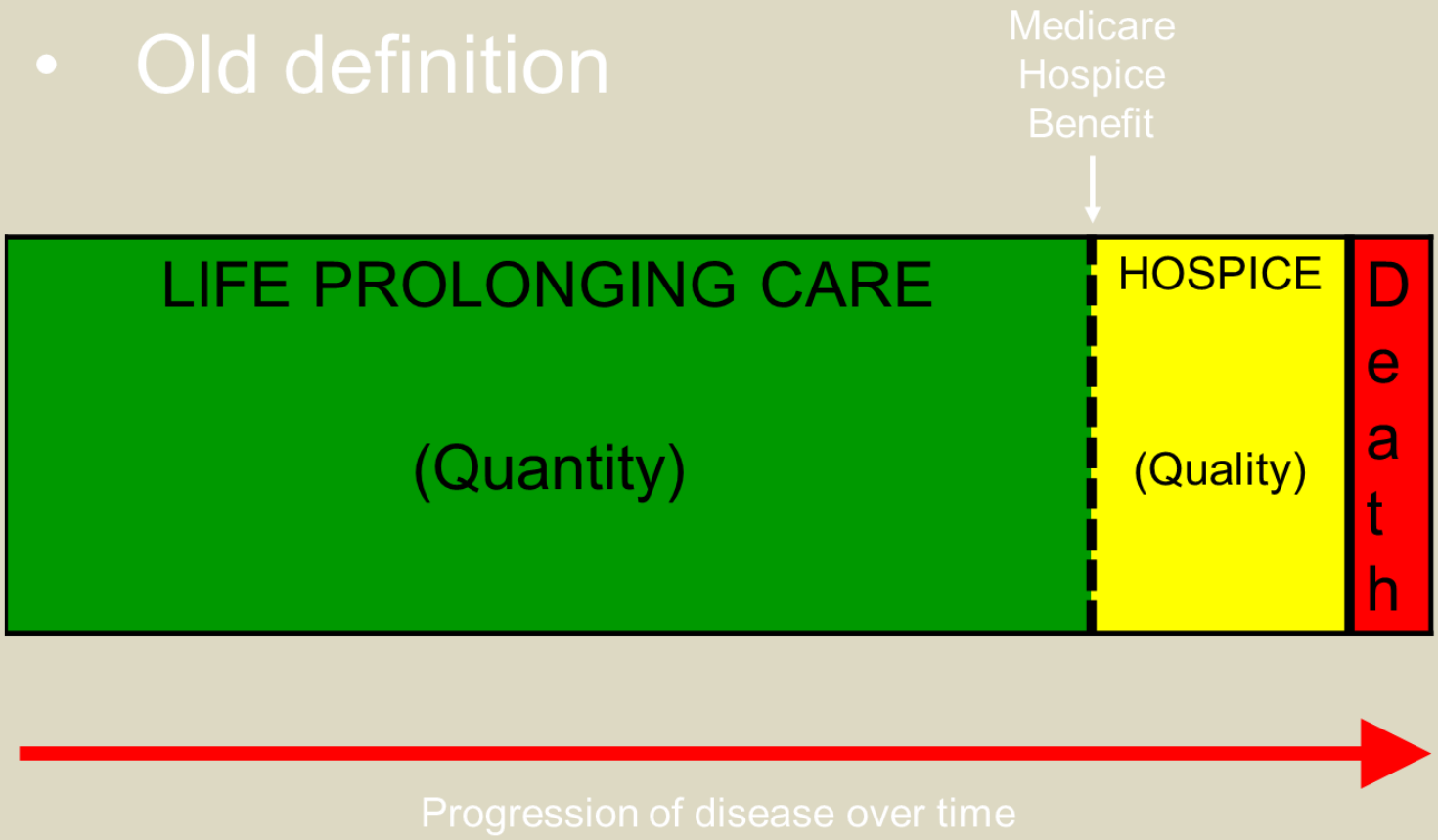
Palliative Care: Key Features

Palliative care promotes:

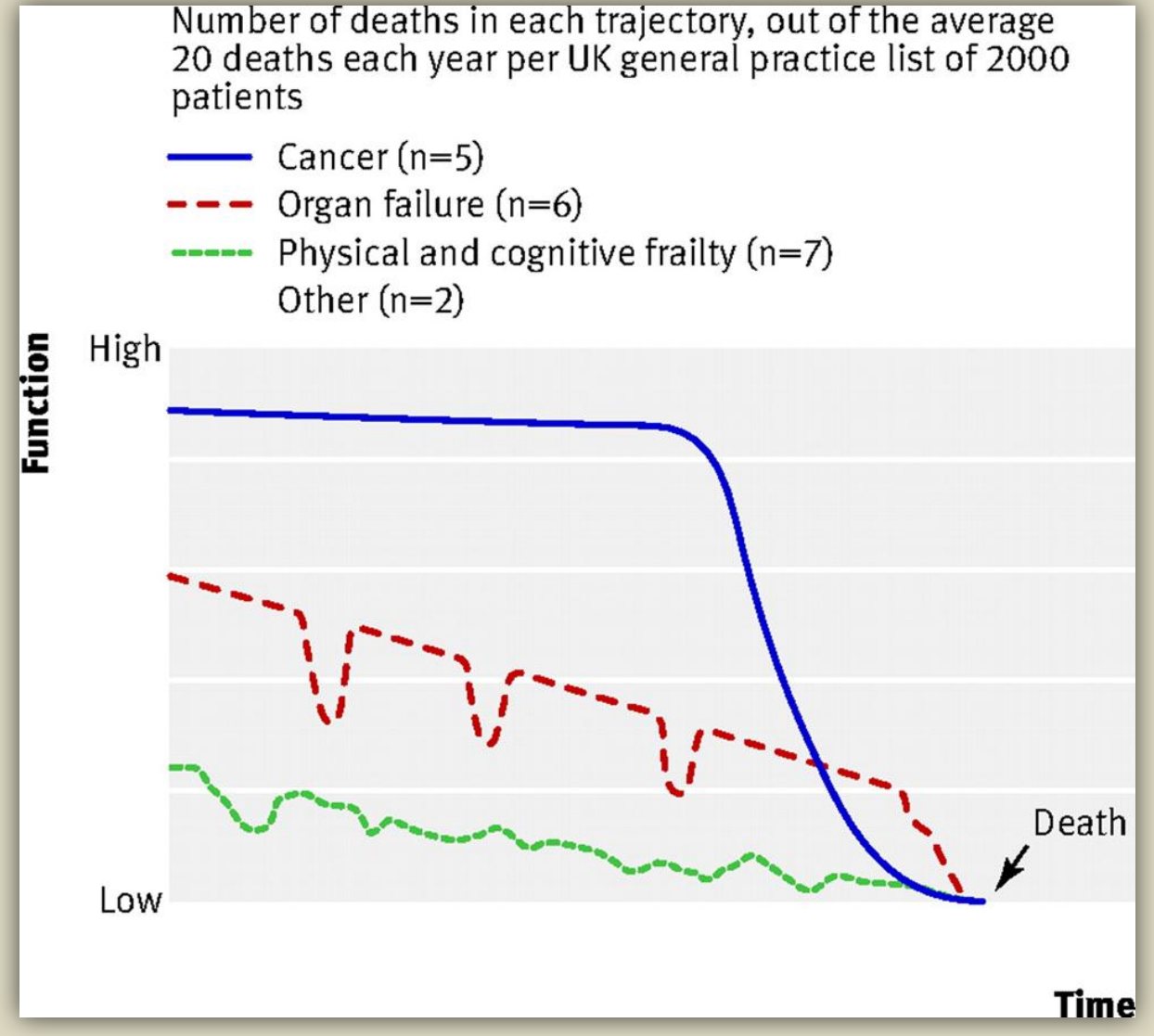
- Comfort through **symptom control**
- Psychosocial and spiritual **distress** management
- Improved **communication** that is patient centered, goal oriented
- Shared **decision making**
- Advanced care **planning**
- Practical help in the **home**
- Expert management of **active dying** and its aftermath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

Palliative Care

- Old definition



Reality of the last year of life



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"

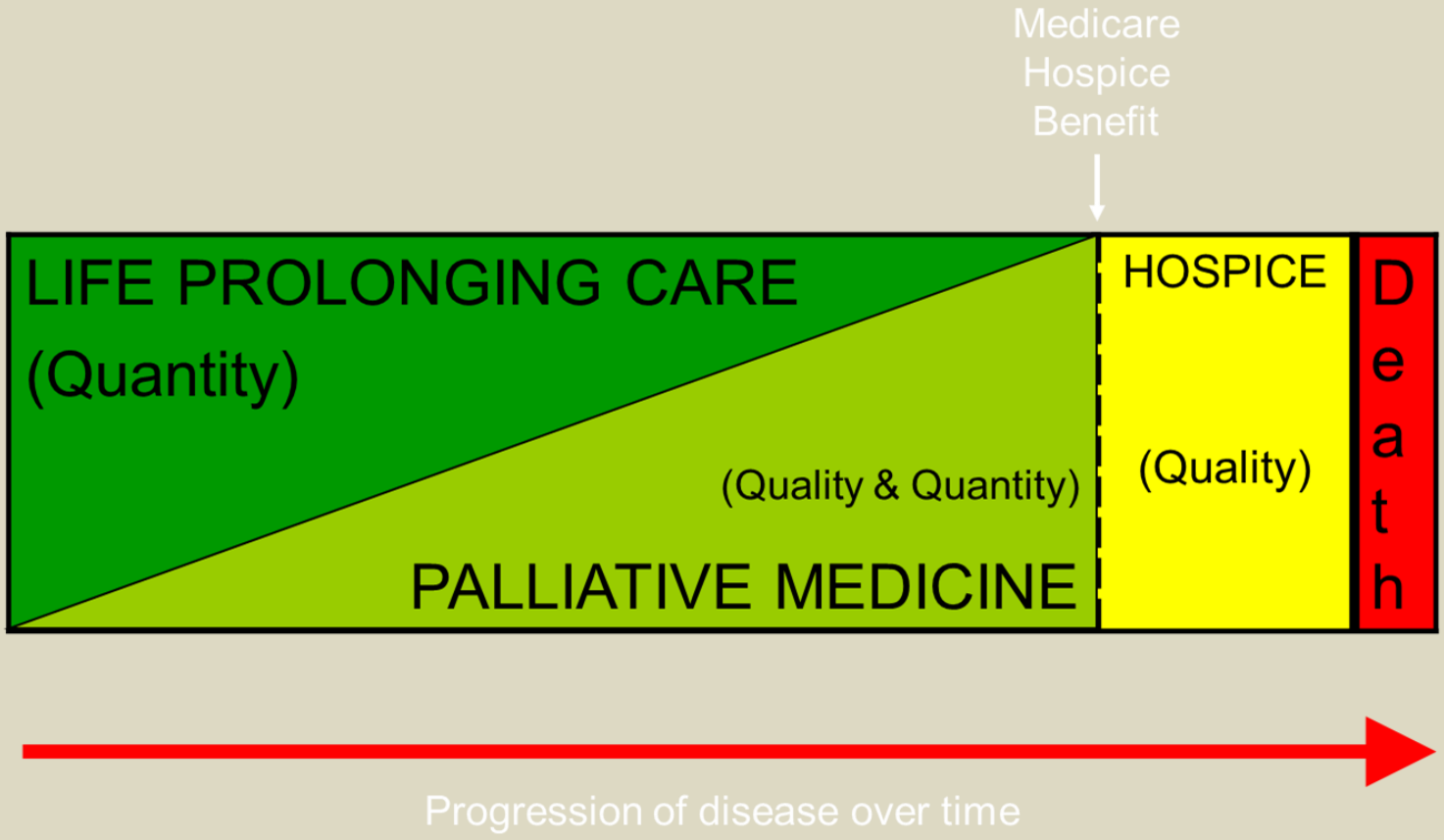
Woody Allen

Death is taboo

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"[13]

Palliative Care



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.

Follwell, et al. JCO January 10, 2009 vol 27 no. 2 206-213

Palliative Outcomes

"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)

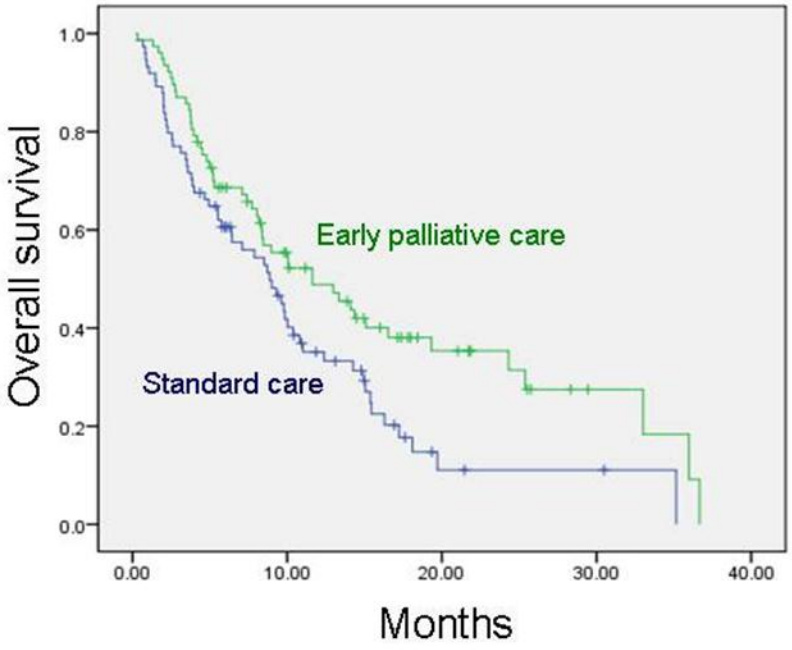
Palliative-care patients were also less likely to receive aggressive end-of-life care. The authors reported that 33% of patients receiving palliative care had aggressive end-of-life care versus 54% of the standard-care group (P=0.05).

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).

Temel JS, et al. New England Journal of Medicine 363 (8) (August 19 2010): 733-742.

Palliative Outcomes

Survival Analysis

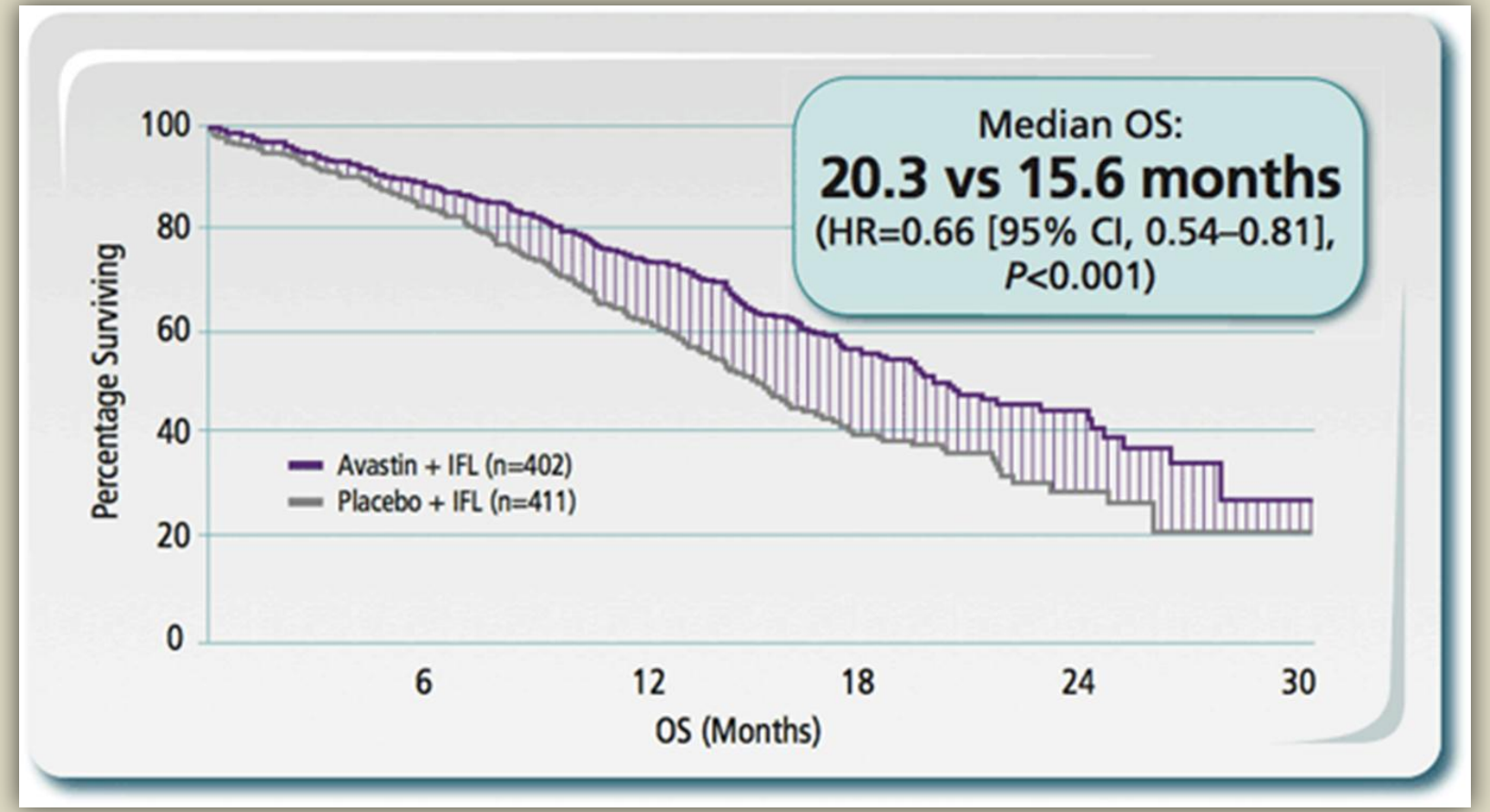


Median Survival
Early palliative care 11.6 mo
Standard care 8.9 mo
p=0.02

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

Temel, ASCO 2010, #7509

Palliative Outcomes



What about aflibercept?

ASCO

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)

Gelfman
JPSM 2008

Palliative care outcomes

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

Casarett et al, J Am Geriatr Soc 2008

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

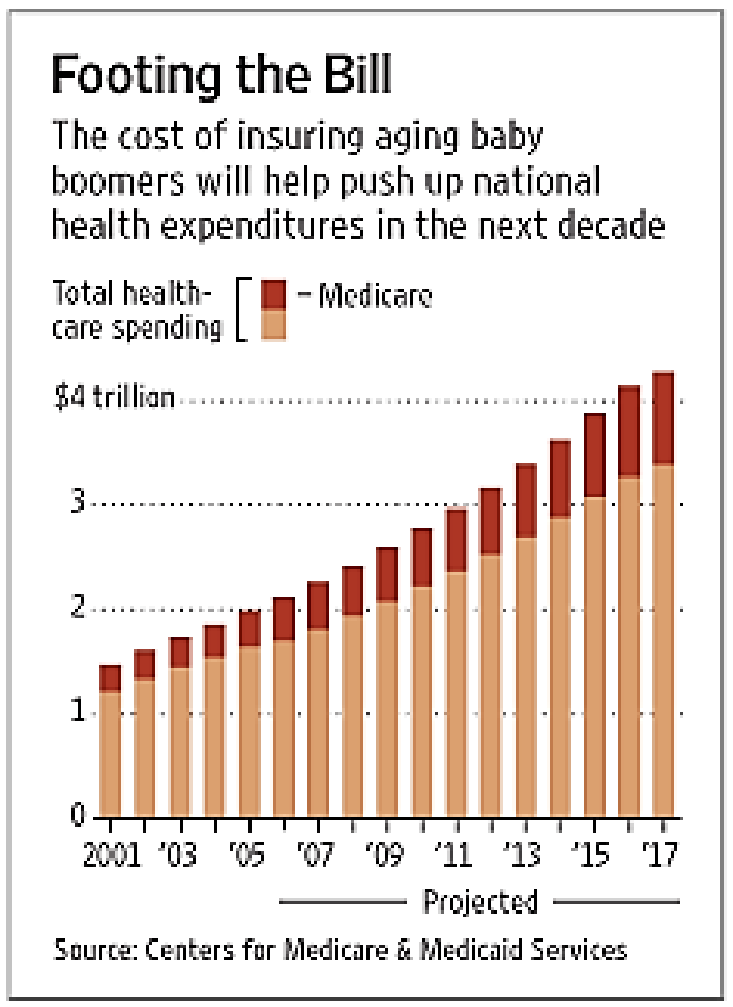
How does palliative care address the health care crisis?

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



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)

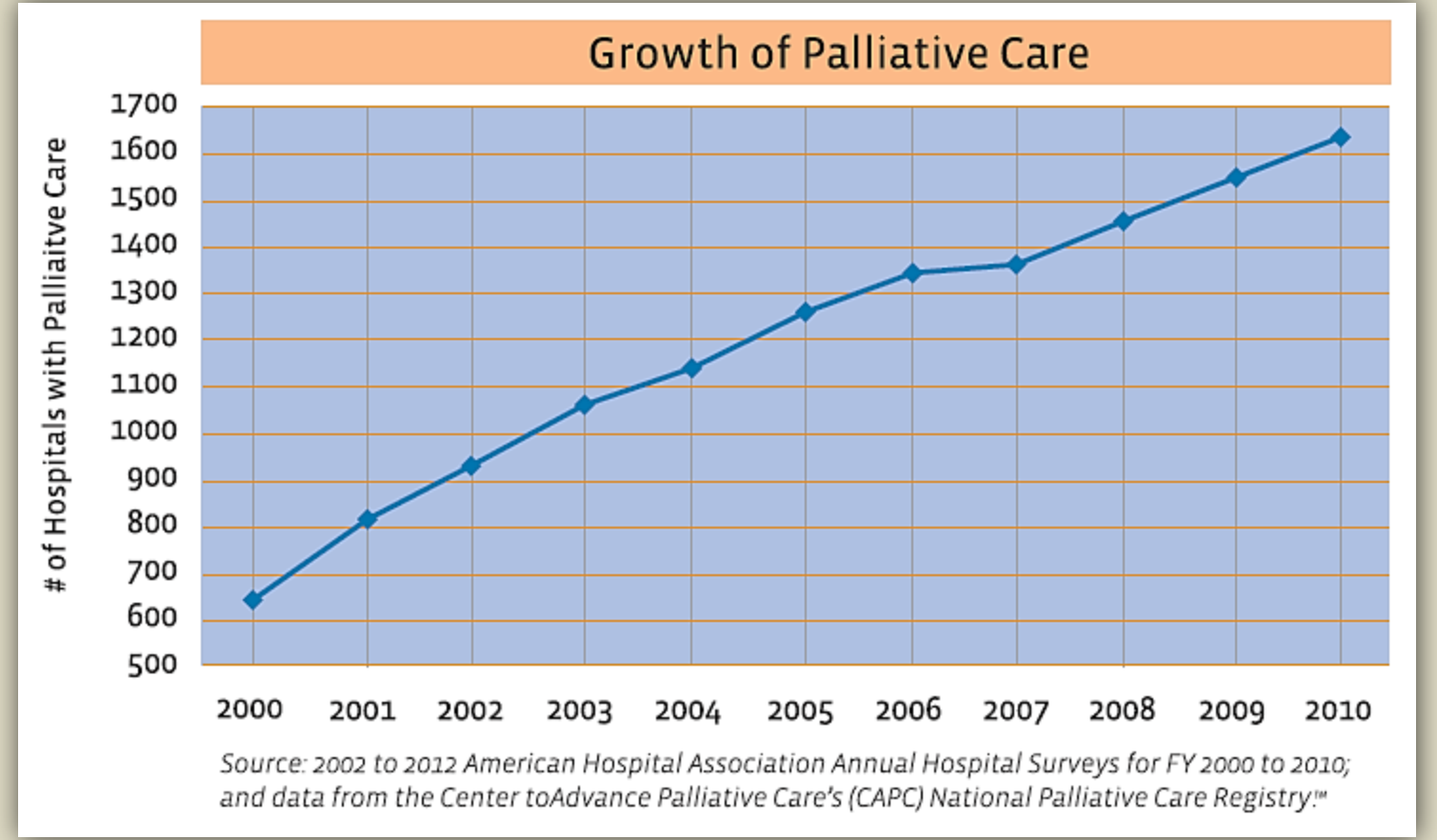
Death discharge saved $374 / day ($5000/admission) – (P 0.003)

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.

R. Sean Morrison, et al. Arch Intern Med. 2008;168 (16):1783-1790

Palliative Growth



Palliative Growth

Prevalence (2000-2010)			
Data Year	# of Teams in Hospitals	Total # of Hospitals	% of Prevalence
2000	658	2,686	24.5%
2001	805	2,648	30.4%
2002	946	2,658	35.6%
2003	1,082	2,683	40.3%
2004	1,150	2,569	44.8%
2005	1,265	2,509	50.4%
2006	1,357	2,452	55.3%
2007	1,373	2,505	54.8%
2008	1,486	2,517	58.5%
2009	1,568	2,489	63.0%
2010	1,635	2,489	65.7%
Change in palliative care teams 2000 to 2010			**148.5%**

Palliative Growth

Region 2010

Region	# of Teams in Hospitals	Total # of Hospitals in Region	% of Teams in Region
Northeast	339	447	75.8%
Midwest	459	609	75.4%
West	310	434	71.4%
South	527	999	52.7%

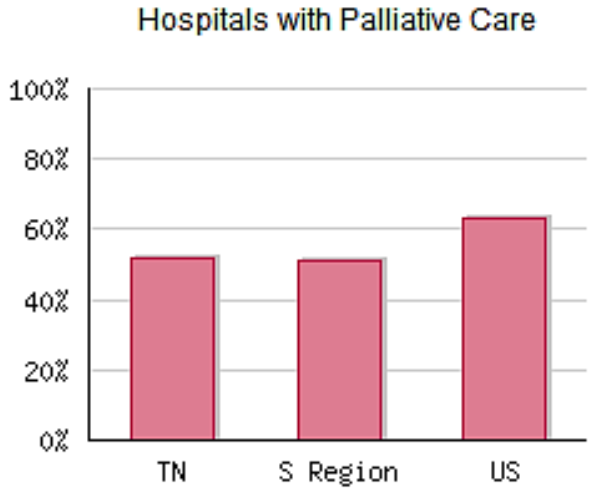
Size (2010)

Bed Size[1]	# of Teams in Hospitals	Total # of Hospitals by Bed Size	% of Teams by Bed Size
300+ [2]	639	727	87.9%
50 to 299	996	1,762	56.5%
Under 50	347	1,492	23.2%

Palliative Growth - TN

STATE RANKINGS

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



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

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

Palliative vs. Hospice

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

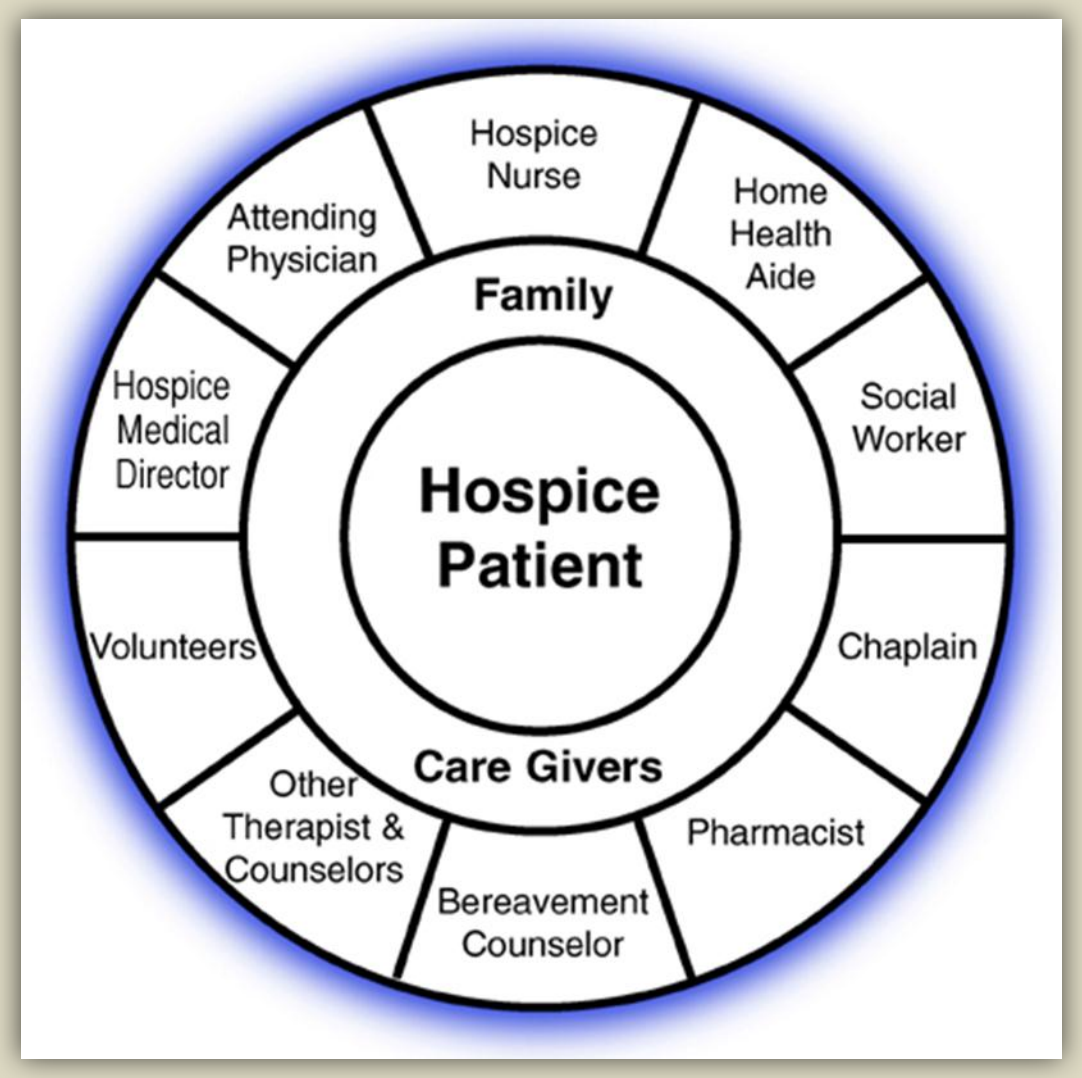
Regulations do not limit disease-modifying treatments unless it affects eligibility

- Agencies may limit coverage

Extensive data shows high satisfaction with care and health cost reductions

- 71% Excellent Satisfaction

Hospice Team



Hospice Survival

NHPCO *Original Article*

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

Hospice Savings

What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?

Donald H. Taylor Jr[a,*], Jan Ostermann[a], Courtney H. Van Houtven[b], James A. Tulsky[c], Karen Steinhauser[c]

[a]*Terry Sanford Institute of Public Policy, Duke University Durham, Durham, NC, USA*
[b]*Duke University and Durham Veterans Administration Medical Center, USA*
[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

Patient Protection and Affordable Care Act "ACA" (Public Law 111-148)

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

Patient Protection and Affordable Care Act "ACA" (Public Law 111-148)

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