Palliative Care: Transforming the Care of Serious Illness

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No Disclosures
Objectives

➔ The case for integrated palliative care strategies

➔ What works to improve quality and subsequently reduce costs for vulnerable people?

➔ How to face **outwards** towards needs of:
  – People with serious illness, their families
  – Policy makers, payers, health system leadership
Concentration of Risk/$

Health Spending Is Very Highly Concentrated Among the Highest Spenders

NIHM Foundation analysis of data from the 2012 Medical Expenditure Panel Survey.
Concentration of Risk/$

Leading to Staggering Variation in Mean Per-Capita Spending by Spending Group

<table>
<thead>
<tr>
<th>Population Spending</th>
<th>Mean Annual Expenditure Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottom 50%</td>
<td>$234</td>
</tr>
<tr>
<td>Top 50%</td>
<td>$8,386</td>
</tr>
<tr>
<td>Top 30%</td>
<td>$12,951</td>
</tr>
<tr>
<td>Top 10%</td>
<td>$28,452</td>
</tr>
<tr>
<td>Top 5%</td>
<td>$43,038</td>
</tr>
<tr>
<td>Top 1%</td>
<td>$97,859</td>
</tr>
</tbody>
</table>

156.8M 156.7M 94.0M 31.4M 15.7M 3.1M
$37B $1314B $1218B $892B $675B $307B

Percent of Civilian Non-Institutionalized Population Ordered by 2012 Health Care Spending

NIHCM Foundation analysis of data from the 2012 Medical Expenditure Panel Survey.
Value = Quality/Cost

Because of the Concentration of Risk and Spending, and the Impact of Palliative Care on Quality and Cost, its Principles and Practices are Central to Improving Value
Mr. B

- An 88 year old man with dementia admitted via the ED for management of back pain due to spinal stenosis and arthritis.
- Pain is 8/10 on admission, for which he is taking 5 gm of acetaminophen/day.
- Admitted 3 times in 2 months for pain (2x), falls, and altered mental status due to constipation.
- His family (83 year old wife) is overwhelmed.
Mr. B:

Mr. B: “Don’t take me to the hospital! Please!”

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

Modified from and with thanks to Dave Casarett
Before and After

Usual Care

➔ 4 calls to 911 in a 3 month period, leading to
➔ 4 ED visits and
➔ 3 hospitalizations, leading to
➔ Hospital acquired infection
➔ Functional decline
➔ Family distress

Palliative Care

➔ Housecalls referral
➔ Pain management
➔ 24/7 phone coverage
➔ Support for caregiver
➔ Meals on Wheels
➔ Friendly visitor program
➔ No 911 calls, ED visits, or hospitalizations in last 18 months
The Modern Death Ritual: The Emergency Department

Half of older Americans visited ED in last month of life and 75% did so in their last 6 months of life.

Costliest 5% of Patients


- 49% Last 12 months of life
- 40% Short term high $
- 11% Persistent high $
Who are the costliest 5%?

- Functional Limitation
- Frailty
- Dementia
- Exhausted overwhelmed family caregivers
- +/- Serious illness(es)
<table>
<thead>
<tr>
<th>Disease or condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>95</td>
<td>12.67</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>48</td>
<td>6.4</td>
</tr>
<tr>
<td>Chronic cardiac disease</td>
<td>79</td>
<td>10.53</td>
</tr>
<tr>
<td>Chronic neurological disease</td>
<td>42</td>
<td>5.6</td>
</tr>
<tr>
<td>Chronic hepatic disease</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td>22</td>
<td>2.93</td>
</tr>
<tr>
<td>Dementia</td>
<td>176</td>
<td>23.47</td>
</tr>
<tr>
<td>Advanced frailty</td>
<td>238</td>
<td>31.73</td>
</tr>
<tr>
<td>Other chronic diseases/conditions</td>
<td>24</td>
<td>3.20</td>
</tr>
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</table>
Functional Limitations as a Predictor of Risk

Figure 4
Among Medicare enrollees in the top spending quintile, nearly half have chronic conditions and functional limitations

Distribution of enrollees, by groups of enrollees

- All Enrollees: 15% Chronic conditions & functional limitations, 48% 3 or more chronic conditions only, 31% 1-2 chronic conditions only, 7% No chronic conditions
- Top 20% of Medicare Spenders: 46% Chronic conditions & functional limitations, 41% 3 or more chronic conditions only, 12% 1-2 chronic conditions only, 7% No chronic conditions
- Top 5% of Medicare Spenders: 61% Chronic conditions & functional limitations, 32% 3 or more chronic conditions only, 1% 1-2 chronic conditions only, 7% No chronic conditions

## Dementia As a Predictor of Risk

**Prospective Cohort of community dwelling older adults**

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>No Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare SNF use</td>
<td>44.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Medicaid NH use</td>
<td>21%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Hospital use</td>
<td>76.2%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Home health use</td>
<td>55.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Transitions</td>
<td>11.2</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Callahan et al. JAGS 2012;60:813-20.
Dementia and Total Spend

➔ 2010: $215 billion/yr
➔ By comparison: heart disease $102 billion; cancer $77 billion
➔ 2040 estimates > $375 billion/yr

Hurd MD et al. NEJM 2013;368:1326-34.
Why? Low Ratio of Social to Health Service Expenditures in U.S.

Surprise! Home and Community Based Services are High Value

➔ Improves quality: Staying home is concordant with people’s goals.

➔ Reduces spending: Based on 25 State reports, costs of Home and Community Based LTC Services less than 1/3rd the cost of Nursing Home care.
A study published today in Health Affairs found if all 48 contiguous states increased by 1% the number of elderly who got meals delivered to their homes, it would prevent 1,722 people on Medicaid from needing nursing home care. The Brown University study found 26 states would save money because lower Medicaid costs would more than offset the cost of providing the meals.
What is Palliative Care?

- Specialized medical care for people with serious illness and their families.
- Focused on improving quality of life as defined by patients and families.
- Provided by an interdisciplinary team that works with patients, families, and other healthcare professionals to provide an added layer of support.
- Appropriate at any age, for any diagnosis, at any stage in a serious illness, and provided together with disease treatments.

Conceptual Shift for Palliative Care

Disease-Directed Therapies

Palliative Care

Diagnosis

Time

Death and Bereavement
Palliative Care Improves Value

Quality improves
– Symptoms
– Quality of life
– Length of life
– Family satisfaction
– Family bereavement outcomes
– MD satisfaction

Costs reduced
– Hospital cost/day
– Use of hospital, ICU, ED
– 30 day readmissions
– Hospitality mortality
– Labs, imaging, pharmaceuticals
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 Nursing Homes

A REPORTER AT LARGE

THE SENSE OF AN ENDING
An Arizona nursing home offers new ways to care for people with dementia.
BY REBECCA MEAD
MAY 20, 2013
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
Evidence on the cost and cost-effectiveness of palliative care: A literature review

Samantha Smith1
Aoife Brick1
Sinéad O’Hara1
Charles Normand2
46 Studies: Across settings, patient populations, and palliative care delivery models, palliative care improves quality and in so doing, reduces costs.

However, despite the wide variation in study type, characteristic and study quality, there are consistent patterns in the results. Palliative care is most frequently found to be less costly relative to comparator groups, and in most cases, the difference in cost is statistically significant. It is also worth noting that there may be complex interactions between costs of care and diagnosis (e.g., cancer/non-cancer distinctions), age groups...
The 5 Key Characteristics of Effective Palliative Care

➔ Target the highest risk people
➔ Ask people what matters most to them
➔ Support family and other caregivers
➔ Expert pain/symptom management
➔ 24/7 access
Target those with:

- Functional Limitation
- Frailty
- Dementia
- Exhausted overwhelmed family caregivers
- +/- Serious illness(es)
Goal Setting

“Don’t ask what’s the matter with me; ask what matters to me!”

Ask the person and family, “What is most important to you?”
What is most important?

Survey of Senior Center and Assisted Living subjects, n=357, dementia excluded, no data on function. Asked to rank order what’s most important:

1st Independence (76% rank it most important)

2nd Pain and symptom relief

3rd Staying alive.

Fried et al. Arch Int Med 2011;171:1854
Families are Home Alone

➔ 40 billion hours unpaid care/yr by 42 million caregivers worth $450 billion/yr

➔ Providing “skilled” care

➔ Increased risk disease, death, bankruptcy

aarp.org/ppi
http://www.nextstepincare.org/
Families Need Help

➔ Mobilizing long term services and supports in the community is key to helping people stay home and out of hospitals.

➔ Predictors of success: 24/7 meaningful phone access; high-touch consistent personalized care relationships; focus on social & behavioral health; integrate social supports with medical services.
Pain and Symptoms

Disabling pain and other symptoms reduce independence and quality of life.

HRS- representative sample of 4703 community dwelling older adults 1994-2006

Pain of moderate or greater severity that is "often troubling" is reported by 46% of older adults in their last 4 months of life and is worst among those with arthritis.

It’s Not Only Pain

*75% or more reported symptom as bothersome

Walke L et al, JPSM, 2006
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
Atul Gawande’s *Being Mortal: Medicine and What Matters in the End*

“I learned about a lot of things in medical school, but mortality wasn’t one of them.”

Page 1 Metropolitan Books, New York, 2014
Going to scale

1. Workforce Training
   ➔ Not even close to enough clinicians with specialty training to meet the needs
   ➔ Therefore, we need to:

   – Train every clinician and help community providers to step-up
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
2. Public awareness: We need a positive vision of the good to drive demand and policy change.
Treating the person beyond the disease.
Going to scale

How can we help families help patients stay home?

Partner with payers.
Keeping Patients Out of Hospitals: A Private-Sector Approach to Health Reform

By Adam Wolfberg

Hospitalization alone costs $3,000 to $4,000 per day. By aligning incentives, a California practice is thriving, saving money, and keeping people in their homes and community.
Payers Are Bringing Palliative Care Home

Highmark Introduces Advanced Illness Services Program

Beginning Jan. 1, 2011, Highmark will offer the Advanced Illness Services (AIS) program as part of its Medicare Advantage plans. The program will provide 100 percent coverage for as many as 10 outpatient care visits by AIS network hospice and/or palliative care providers to promote quality of care for members with progressive, life-limiting illness.

Stratis Health

Leading collaboration and innovation in health care quality and safety

RURAL PALLIATIVE CARE EMERGES AS HIGH PRIORITY

Insurer Begins Huge Palliative Care Program

By Marissa Evans | June 17, 2014
Clinicians, talk to your payers!

But first, read this:

Predictors of successful payer-ACO-provider initiatives

Case studies

Checklists, worksheets
Palliative Care is a National Priority
Palliative care is essential to quality.

Common denominator: Stop suffering.
“Dying” in America 2014 IOM Report

1. Person-centered, family-oriented palliative care everywhere as *standard of practice*

2. and 3. *Required universal* clinician training and certification in palliative care, clinician-patient communication and ACP

4. Policies and payment to *support both medical and social needs*

5. Public education and engagement

How do we work towards the IOM recommendations?

➔ All patients with serious illness should have access to quality palliative care.

➔ To get there we need to:
  – Expand palliative care to home and community care settings
  – Train all clinicians who treat seriously ill patients to provide basic palliative care
The Role of the Center to Advance Palliative Care

→ Provides *tools, training, and technical assistance* to front-line clinicians

→ Drives public, professional, payer and policy-maker *awareness*

→ Advocates in support of payment, accreditation, and regulatory standards to *drive quality and access*
In 2013, hospital programs served >6MM patients each year.

Palliative care prevalence and # of patients served tripled since 2000.

100% of the U.S. News 2014 – 2015 Honor Roll Hospitals Have a Palliative Care Team.

100% of the U.S. News 2014 – 2015 Honor Roll Children’s Hospitals Have Palliative Care Teams.
Where are the opportunities to go to scale? Follow IOM Priorities

➔ Workforce training
➔ Strengthen quality
➔ Access beyond hospitals
➔ Public awareness
➔ Inform public policy
Although the world is full of suffering, it is full also of the overcoming of it.

Helen Keller

*Optimism, 1903*