Palliative Care in the Age of Health Care Reform

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Attestation

No financial disclosures or conflicts
The Work of Palliative Care

- Focuses on relieving of suffering and stress of serious illness by aggressive pain and symptom management, interdisciplinary psychosocial and spiritual support.

- Strengthens communication, shared decision-making and matching interventions to patient goals.

- Addresses prognosis, fragmentation of care and defines options.

- Facilitates transitions and continuity of care across settings.
Objectives

- Discuss the development and growth of palliative care services
- Distinguish palliative care from hospice
- Discuss the benefits of palliative care for patients/families, clinicians, hospitals and health care systems
- Discuss the future of palliative care in the context of health care reform
Definition of Palliative Care

**Palliative care** means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

CMS: Medicare Hospice Conditions of Participation – Final Rule
Palliative care is interdisciplinary, specialized medical care for people with serious illnesses. It is focused on providing patients (and their families) with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis. The goal is to provide an extra layer of support to improve quality of life for both the patient and the family coping with serious illness.

Palliative care is appropriate at any stage in a serious illness, provided together with curative treatment.

*CAPC.com
Growth of Palliative Care Programs

AHA survey data

CAPC Snapshot 1635 programs 2010
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Growth of Palliative Care
AHA Annual Hospital Survey

- 24.5% (2000) to 63% (2009) of all U.S. hospitals greater than 50 beds report a PC program
- 85% U.S. hospitals with >300 beds report a Palliative Care program
- 100% of VA hospitals
- Florida: 87% of hospitals >350 beds, 62% > 50 beds
- Smaller, for profit and sole community providers < likely to have a PC program
Palliative Medicine
Milestones

- CMS recognition of subspecialty: 2007
- ABIM subspecialty 2008: 11 boards leading to certification in Palliative Medicine
- 2010: 83 accredited fellowship programs (3 in Florida)
- Joint Commission Certification 2011
Hospice Growth and Changes

- 2000-2010: 700,000 to 1.5 million patients/yr
- 1,020,000 died receiving hospice care at some point prior to death (>40% of all decedents in US)
- Over 5000 Hospice providers in US: one in Hillsborough County (Florida CON)
- Changing Population: non-cancer, debility, failure-to-thrive, dementia (60% non-cancer: debility, heart disease, dementia, lung disease, stroke)

NHPCO facts and figures, CMS, MedPAC
Hospice

– Formal benefit of most insurance providers: 90% Medicare, 5% Medicaid, per diem reimbursement, 13 Billion dollars per year
– Prognosis of 6 months or less (if the disease runs its usual course)
– Forgo coverage for curative/life prolonging treatment of their terminal illness.
– 34% died or were discharged in 7 days or less, 12% on hospice for over 180 days
– Median LOS about 18 days (stable), mean LOS 56 days (declining)
Why is Hospice Referral Late

Why is Hospice Referral Late

Conceptual Shift for Palliative Care

Old

Life Prolonging Care

Medicare Hospice Benefit

New

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement

Dx

Death

UNIVERSITY OF SOUTH FLORIDA
WHY SO MUCH GROWTH

- Demographics
- Rise of Chronic Illness
- Quality of Care
- Costs of Care
The Demographic Imperative: Chronically Ill, Aging Population Is Growing

- The number of people over age 85 will double to 10 million by the year 2030.
- The 23% of Medicare patients with >4 chronic conditions account for 68% of all Medicare spending.

CBO High Cost Medicare Beneficiaries May 2005
More seniors are living with two or more chronic conditions 2000-2010

* Seniors are defined as individuals age 65 and older.
Source: Freid, V., et al. (July 2012). *Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years.*
SUPPORT STUDY

National Data on the Experience of Advanced Illness in 5 Tertiary Care Teaching Hospitals:

- 9000 patients with life-threatening illness, 50% died within 6 months of entry
- Half of patients had moderate-severe pain >50% of time last 3 days of life.
- 38% of those who died spent >10 days in ICU, in coma, or on a ventilator
- No effect of advance directive, knowledge of pain, prognosis

SUPPORT JAMA 1995;274:1591-98
Problems with Care of Serious Illness

- Fragmented Care
- High Symptom Burden
- Inadequate advance care planning
- Often limited information sharing
- Expense and care giver burden
What Do Patients with Serious Illness Want?

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Family Satisfaction with Hospitals as the Last Place of Care
2000 Mortality follow-back survey, n=1578 decedents

- Not enough contact with MD: 78%
- Not enough emotional support: 51%
- Not enough information about what to expect with the dying process: 50%
- Not enough emotional support (family): 38%
- Not enough help with pain/SOB: 19%

Medicare Spending Last Year of Life

- 25% of Spending in last stable for last 2 decades
- We spend money on sick people (survivors and decedents)
- 1/3 to 1/2 spending appears unrelated to improvements in quality or longevity
- **Lots of reasons** (prognostic uncertainty, defensive med, unrealistic expectations, fee for service, culture)

- Riley G and Lubitz J. Health Services Research 2010;45:565-
- Neuberg G. 2009. Circulation Cardiovascular Quality and Outcomes 2009;2:127-
Who Benefits from Palliative Care

- Patient and Families
- Clinical Providers
- Hospitals
- Health Care Systems
Benefits of Palliative Care

- Casarett JAGS 2008: mortality f/b study of PC vs UC: 531 family survivors, satisfaction with care markedly improved with PC (p<.001); improvements in pain, psychosocial support, information sharing, access to community services.

- Gelfman: JPSM 2008: 199 families of decedents, after death survey, sig. improvement family satisfaction 65% vs 35%, p<.004), improved psychosocial support.

- Morrison JPM 2008: symptom control following PC consultation in 3491 patients: sig reductions in pain, dyspnea, anxiety, constipation and agitation.

- Gade et al JPM 2008: 11:180- randomized trial PC consult: 517 patients, 3 sites, improve communication, dec ICU admissions, lower costs ($4800), longer hospice LOS, no diff in survival.
151 patients with metastatic NSCLC randomized to usual care +,- palliative care begun at diagnosis

- Improved quality of life, less depression (16% vs 38%, p<.01), less aggressive care at end of life (33% vs 54% p<.05) but

- Longer survival: median survival 11.6 months in group receiving palliative care vs 8.9 months (p<.02) in usual care group

- Longer survival for hospice patients vs. matched non-hospice controls with CHF, lung ca, pancreatic

* Temel et al. NEJM 2010:363:733-42;
**Connor et al JPSM 2007:33:328-246
So From The Patient/Family Perspective

- Diminish high symptom burden with advanced illness
- Navigate a complex and confusing medical system
- Improved satisfaction with care and psychosocial support
- Coordinate care options across settings
- Earlier hospice referral
- Allow simultaneous focus on palliation of suffering with continued treatment
- Longer Survival?
The Clinician Perspective

- Save time by helping to handle repeated, intensive patient-family communications, coordination of care across settings, comprehensive discharge planning
- Bedside management of pain and distress of highly symptomatic and complex cases
- Supporting the treatment plan of the primary physician
- Promote patient and family satisfaction with the clinician’s quality of care
- Growing integration of palliative care guidelines into CCM, oncology, cardiology, surgery, nephrology and pulmonary medicine, JCC
# Hospital Palliative Care Reduces Costs

Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals

<table>
<thead>
<tr>
<th>Costs</th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
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<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
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<tr>
<td>Per Day</td>
<td>$867</td>
<td>$684</td>
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<tr>
<td>Per Admission</td>
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<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,060</td>
</tr>
</tbody>
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Palliative Care and Medicaid

- 2004-2007, four NY hospitals comparing patients who receive palliative care consults versus matched group of those who did not.
- Cost reduction $4000 for those discharged and $7500 for decedents
- Less time in ICU, less likely to die in ICU and more likely to receive hospice

Morrison et al 2010 Health Affairs

Hospital Payment Shortfall Relative to Costs for Medicare and Medicaid, 1997 – 2007

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2007, for community hospitals.
Hospital Perspective  
(value=quality/cost)

– Effectively treat the growing number of people with complex advanced illness
– Increase patient and family satisfaction
– By Product of Palliative Care: rationalize the use of hospital resources, avoid costs
– Increase bed/ICU capacity
– Meet JC quality standards
– America’s Best Hospitals, JCAHO
Concentration of Health Care Spending in the U.S. Population, 2009

Percent of Population, Ranked by Health Care Spending

(≥$51,951) (≥$17,402) (≥$9,570) (≥$6,343) (≥$4,586) (≥$851) (<$851)

Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care and pharmacies; health insurance premiums are not included.

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2009

- **Enrollees**
  - Total = 62.6 million

- **Expenditures**
  - Total = $346.5 billion

**Top 5%**
- Children 3.7%
- Adults 1.9%
- Disabled 30.4%
- Elderly 18.6%

**Bottom 95%**
- Children 0.3%
- Adults 0.2%
- Disabled 2.5%
- Elderly 2.0%

**Source:** KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.
Costs of each episode of care rise with the number of a beneficiary's chronic conditions.


* MS-DRG 470.
Medicare Spending per Beneficiary, 2005

Not populated

$5,200 to $6,900

$6,900 to $7,800

$7,800 to $8,600

$8,600 to $10,300

$10,300 to $13,900
Variations in Medicare Spending Growth

- 1992-2006: 3.5 % national average increase in Medicare spending, adjusted for general inflation (FFS)
- Miami 5%, Tampa 3.75%, San Fran:2.49%
- Savings of $1.5 trillion over 10 years if all growth at San Francisco rate
- Organized systems of care, payment reform

Dartmouth Health Atlas Feb 2009 (www.dartmouthatlas.org)
Higher intensity May Lead to Lower Satisfaction with Care

Family members of decedents in high-intensity hospital service areas report lower quality of:
- Emotional support, shared decision-making, Information about what to expect, respectful treatment
  

Physicians practicing in high health care-intensity regions report more difficulty:
- Arranging elective admissions, Obtaining specialty referrals, maintaining good doctor-patient relations, delivering high quality care

Changes in End-of-Life Care for Medicare Beneficiaries

Retrospective cohort study of Medicare decedents in 2000-2009

- Dying in hospital: 32 to 24%
- Hospice use: 22 to 42%
- ICU in last month of life: 24 to 29%
- Hospitalization last 90 days: 62 to 69% (10% with > 3 hosp. stays)
- Transitions in last 3 days: 10 to 14% (17% COPD)

Teno, J et al. JAMA: Feb 6 2013
Health Care Reform and Palliative Care

- Bundling
- ACO
- Medical Home
- SNP
- Medicaid Managed Care
- Concurrent Care
- Dually Eligible Patients
- Post Acute Care reform
Benefits of Outpatient Palliative Care

- Advance Illness Management Model: palliative care services: 185 patients: PC vs usual home care: 68% decrease in hospitalization in high risk patients, 30% increase in hospice use, diminished symptom burden
  
  Health Affairs 2011;30:390-

- Aetna: expands hospice eligibility to one year, 50% increase in hospice use, sig decrease in hospitalization last year

  JPM 200912:827-
Volume-Based

- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration
Value-Based

- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- Re-aligned incentives, encouraged coordination
To do this work....

- Know the patient’s story
- Understand the body, its limits and possibilities in illness over time
- Know the system in which you practice
- Know yourself
- Courage
We Never Withdraw Care

- “As sickness progresses toward death, measures to minimize suffering should be intensified. Dying patients require palliative care of an intensity that rivals that of curative efforts...”

Eric Cassels 1989 NEJM “The Nature of Suffering and the Goals of Medicine”