Improving Value in Health Care: The Case for Palliative Care

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This Afternoon

The needs of the seriously ill

Palliative Care: A possible solution

Palliative care: What is needed
Concentration of Spending
Distribution of Total Medicare Beneficiaries and Spending, 2011

Total Number of FFS Beneficiaries: 37.5 million
Total Medicare Spending: $417 billion

90%
10%
37%
63%

Average per capita Medicare spending (FFS only): $8,554
Average per capita Medicare spending among top 10% (FFS only): $48,220
Population with Highest 5% of Healthcare Costs

- 49% Population with persistently high costs
- 40% Population with a discrete high-cost event
- 11% Population at the end of life

Source: Aldridge, Kelley, 2013: IOM Commissioned Paper: Epidemiology of Serious Illness and High Utilization of Healthcare
Concentration of Risk and Spending

- Functional Limitation
- Dementia
- Frailty
- Serious illness(es)
- Most are not in last year of life
Mr. Barnes

- 88 year old man with dementia admitted via the ED for exacerbation of emphysema.
- Breathlessness is 8/10 on admission, for which he is taking an inhaler without benefit.
- His 83 year old wife is overwhelmed.
- **Admitted 3 times in 2 months for breathlessness (2x), falls, and confusion.**
Mr. Barnes (continued):

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

• Mrs. B: “He hates the hospital, but what could I do? The breathlessness was terrible. I couldn’t reach the doctor, so I called the ambulance. It was the only thing I could do.”
Palliative Care: A Solution for the Barnes’s

- Specialized medical care for people with serious illnesses to provide an extra layer of support.
- Improves quality of life for patients and the families by addressing the symptoms, pain, and stress of a serious illness - whatever the diagnosis.
- Provided by a team of doctors, nurses, and other specialists.
- Provided together with life-prolonging and curative treatments.
What Do Palliative Care Teams Do?

- **Relieve**
  - Symptoms
  - Distress - emotional, spiritual, practical
  - Uncertainty

- **Communicate**
  - What to expect
  - Treatments that match person + family goals

- **Coordinate**
  - Medical and practical needs across settings
Public Attitudes Towards Palliative Care

Telephone survey of 800 Americans

- **92%** of respondents say they would seek palliative care for a loved one if they had a serious illness.
- **92%** of respondents say palliative care services should be available at all hospitals.
- BUT...Only 8% were knowledgeable about palliative care at the start of the survey
Growth of Palliative Care

Prevalence of U.S. Hospital Palliative Care Teams 2000–2009

Source: Center to Advance Palliative Care, March 2011

Distribution of Palliative Care Programs by Region

Source: Center to Advance Palliative Care, 2011  capc.org/reportcard
Private Sector Payers Are Already Engaging

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 advanced illness.

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

RURAL PALLIATIVE CARE EMERGING AS A HEALTH CARE PRIORITY
Why is Palliative Care the Solution?

- Improves patients quality of life
  - Reduces pain and other symptoms
  - Addresses patients goals
- Improves family satisfaction/well-being
- Reduces resource utilization and costs
  - Matches treatments to goals
  - Allows provision of higher quality care in appropriate, often less costly, settings.
Palliative Care Improves Outcomes For Patients

- 151 advanced lung cancer patients randomized to usual care or usual care + palliative care consultation
- Compared to usual care patients, palliative care patients were observed to have:
  - Significantly improved quality of life
  - Less depression
  - Fewer burdensome treatments
  - Improved survival: + 11 weeks

Temel et al, NEJM 2010
Palliative Care Improves Outcomes for Families

• Caregivers of patients receiving palliative care have:
  – Better quality of life, experience less regret, and show improvements in physical and mental health

• Compared to dying at home with palliative care:
  – Dying in hospital associated with:
    • 9 fold increased risk of prolonged grief disorder in caregivers
  – Dying in an ICU associated with:
    • 5 fold increased risk of posttraumatic stress disorder (PTSD) in caregivers

Wright AA et al, JAMA, 2008; JCO, 2010,
Palliative Care Reduces Unnecessary Treatments

Wright AA et al, JAMA, 2008

Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion

<table>
<thead>
<tr>
<th></th>
<th>No. (%)</th>
<th>Adjusted OR (95% Confidence Interval)</th>
<th>P Value</th>
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<tbody>
<tr>
<td></td>
<td>Total (N=332)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>End-of-Life Discussion</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Medical care received in the last week</td>
<td>332</td>
<td>123 (37.0)</td>
<td>209 (63.0)</td>
</tr>
<tr>
<td>ICU admission</td>
<td>31 (9.3)</td>
<td>5 (4.1)</td>
<td>26 (12.4)</td>
</tr>
<tr>
<td>Ventilator use</td>
<td>25 (7.5)</td>
<td>2 (1.6)</td>
<td>23 (11.0)</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>15 (4.5)</td>
<td>1 (0.8)</td>
<td>14 (6.7)</td>
</tr>
<tr>
<td>Outpatient hospice used</td>
<td>213 (64.4)</td>
<td>93 (76.2)</td>
<td>120 (57.4)</td>
</tr>
<tr>
<td>Outpatient hospice ≥1 wk</td>
<td>173 (52.3)</td>
<td>80 (65.6)</td>
<td>93 (44.5)</td>
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</tbody>
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Abbreviation: ICU, intensive care unit; OR, odds ratio.

aThe propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients’ treatment preferences, desire for prognostic information, and acceptance of terminal illness.
<table>
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<th>Live Discharges</th>
<th>Hospital Deaths</th>
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<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Costs ($)</td>
<td>(n=18,2347)</td>
<td>(N= 2,124)</td>
</tr>
</tbody>
</table>
| Per Day              | 830             | 1,484           | 374*  
|                      | 666             | 1,110           |  
| Per Admission        | 11,140          | 22,674          | 4,908** |  
| ICU                  | 7,096           | 14,542          | 7,776* |  
| Died in ICU          | X               | X               | 18%    | 4%     | 14%* |

*P<.001  **P<.01  ***P<.05
Palliative Care Reduces Readmissions

• Involvement of hospital palliative care reduces readmissions by 50%.
• Discharge to hospice or palliative care associated with a 4-6 fold reduction in readmissions as compared to discharge to:
  – home (home health or no home care)
  – nursing home (without hospice)

Our Goals

• All patients and families will know to request palliative care in the setting of serious illness.
• All healthcare professionals will have the knowledge and skills to provide palliative care.
• All healthcare institutions in the US will be able to support and deliver high quality palliative care.
Palliative Care Across the Continuum

Hospital Consult Service

- Inpatient Unit
- Outpatient Clinic
- Home Care
- Nursing Homes
- Home Medical Program
- Cancer Center
What is Preventing Us From Reaching Our Goal?

• Infrastructure
• Workforce
• Knowledge gaps
• Public awareness and demand
Infrastructure

• Not enough to have access to palliative care in hospitals:
  – >1, 900 programs but of highly variable quality, penetration, staffing, and resources

• Most illness outside of hospitals – nursing homes and home
  – Models need to be developed and disseminated without regard to prognosis or goals of care

• Inadequate quality metrics
What is Needed?

- Regulatory and accreditation requirements
- Quality measures linked to payment incentives
- System redesign – checklists and pathways coupled with clinician education
- Integration into new delivery models
- Benefit design
Work Force

- 1 palliative medicine MD for every 1,700 persons with serious illness
- 20 states provide no post-graduate fellowship training programs in palliative medicine
- Most fellowship programs in academic medical centers are supported through philanthropy
- No mandatory training and limited incentives for continuing medical education

Morrison et al, IOM, 2011
What Is Needed?

• Palliative medicine fellowship training
• “Generalist level” palliative care training
  • Undergraduate and graduate medicine, nursing, social work, chaplain training
  • Mid-career continuing education and training: Pain and symptom management, Communication
• Quality measures, transparency, and public reporting
Evidence Base

Research Publications:
- Oncology
- Palliative Care

Research Funding

• 0.2% of all NIH grants focus on palliative care
• By institute
  – NCI: 0.4% of all grants funded
  – NINR: 7.6% of all grants funded
  – NIA:NIA 0.8% of all grants funded
  – NIMH 0.04% of all grants funded
  – NHLBI, NIDDK: <.01% of all grants funded

Gelfman, Du, Morrison, JPM, 2012
The Result:

• Current palliative care practice is guided by:
  – Data from other populations
  – Results form small series of patients from single institutions
  – Anecdote and hearsay

• Is this the type of care that we want for our parents or for ourselves?
78% of the American public literally have no idea what palliative care is!

Not At All Knowledgeable 70%

Somewhat Knowledgeable 14%

Knowledgeable 3%

Very Knowledgeable 5%

Don’t Know 8%

*Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.
Pending Legislation

- HR 1339/S 641: Enhances workforce through specialist and generalist training and centers of excellence
- HR 1666: Enhances research capacity and funding, promotes public awareness
Summary

• High cost of care ≠ High quality of care
• Palliative care impacts on the value of health care by improving quality
• Better quality reduces need for acute, high cost hospital/ER/ICU care
• Palliative care integration in health systems is essential for improved care of the seriously ill