

Palliative Care: Making the Case



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www.capc.org

www.getpalliativecare.org

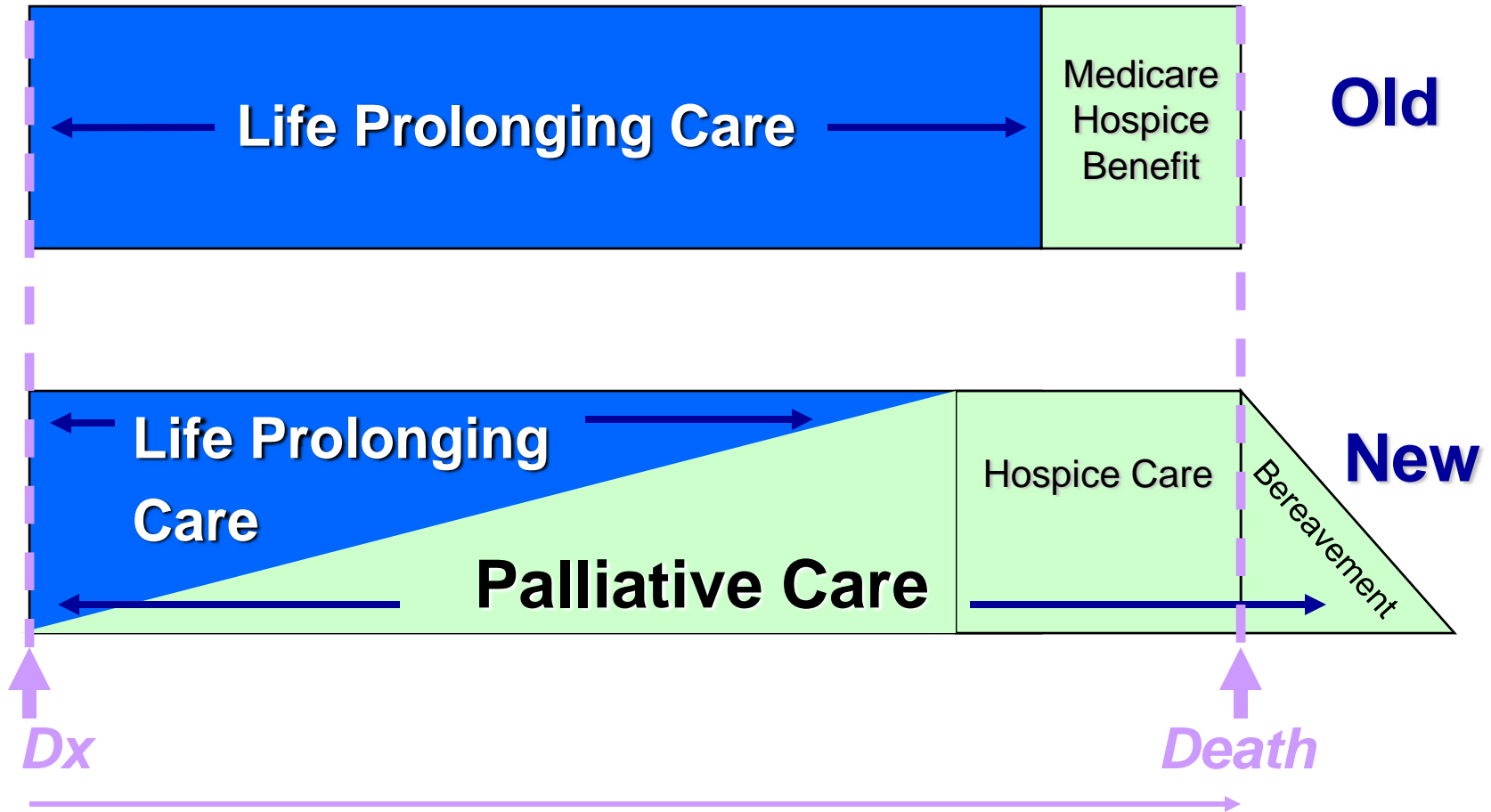
Definition of Palliative Care

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.

73 FR 32204, June 5, 2008

Medicare Hospice Conditions of Participation – Final Rule

Conceptual Shift for Palliative Care



How Does Palliative Care Differ from Hospice?

- Non-hospice palliative care is appropriate at any point in a serious illness. It is provided at the same time as life-prolonging treatment. No prognostic requirement, no need to choose between treatment approaches.
- Hospice- a form of palliative care provides care for those in the last weeks-few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible.
(Medicare Hospice Benefit: 84% Medicare, 5% Medicaid, 3% uninsured)

Kaila

- 24 year old recent college graduate
- Uninsured
- Several month gradual onset headache, fatigue, bone pain, shortness of breath
- Delayed care because of \$
- Collapsed at home, brought to Emergency Department
- Diagnosis: acute leukemia
- Severe bone pain, short of breath, depression, worry, devastated parents and 5 siblings
- Emergency Medicaid
- Chemo, bone marrow transplant. Rx > 1 year, mostly in hospital, 3 month stay in ICU- simultaneous care from palliative care service and oncologists throughout.
- Died after 17 days at home with hospice care

Palliative Care: The 4 Main Arguments

1. Quality
2. Patient and family preferences
3. Demographics
4. Finances

Why palliative care?

1. Quality

Defined as care that is:

- beneficial
- patient centered
- efficient
- timely
- safe
- equitable

National Quality Forum (www.qualityforum.org)

Why hospitals?

53% of deaths occur there

Hospitals + Nursing Homes: 77%

Home: 23%

(Teno et al, Brown Site of Death Atlas of the U.S:
www.chcr.brown.edu/dying/usa_statistics.htm 1997 and
National Mortality Followback Survey)

Patient Centered?

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

Singer et al. *JAMA* 1999;281(2):163-168.

And What They Get: Suffering in U.S. Hospitals

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 last 3 days of life.
- 38% of those who died spent >10 days in ICU, in coma, or on a ventilator.

Pain among hospitalized patients with serious illness

% of 5176 patients reporting moderate to severe pain between days 8-12 of hospitalization:

colon cancer	60%
liver failure	60%
lung cancer	57%
MOSF + cancer	53%
MOSF + sepsis	52%
COPD	44%
CHF	43%

More medical care leads 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 Teno et al. JAGS 2005;53:1905-11.

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 Sirovich et al. Annals Intern Med 2006; 144:641-649

Patient Centered?

What Do Family Caregivers Want?

Study of 475 family members 1-2 years after bereavement

- Loved one's wishes honored
- Inclusion in decision processes
- Support/assistance at home
- Practical help (transportation, medicines, equipment)
- Personal care needs (bathing, feeding, toileting)
- Honest information
- 24/7 access
- To be listened to
- Privacy
- To be remembered and contacted after the death

Tolle et al. Oregon report card.1999 www.ohsu.edu/ethics

And What They Get: 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 (pt):	51%
Not enough information about what to expect with the the dying process:	50%
Not enough emotional support (family):	38%
Not enough help with pain/SOB:	19%

The Nature of Suffering and the Goals of Medicine



The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.

Cassell, Eric NEJM 1982;306:639-45.

Why palliative care?

2. Impact of serious illness on patients' families

Family Caregivers: The Numbers

- 2006 United States estimates: 34 million caregivers deliver care at home to a seriously ill relative
 - Mean hours caregiving per week: 21
 - Cost equivalent of uncompensated care: \$297 billion per year (@ \$8/hr)

Levine C. Loneliness of the long-term caregiver

N Engl J Med 1999;340:1587-90.

AARP Caregiving in the U.S. 2006 www.caregiving.org

Report to Congress: Medicare Payment Policy Medpac; March 2006
www.medpac.gov

Caregiver Characteristics

900 family caregivers of seriously ill persons at 6 sites across the U.S.

- Women: 61%
- Work full time: 60%
- Close family member: 96%
- Over age 65: 33%
- In poor health: 33%

Emanuel et al. N Engl J Med 1999;341:956.
Caregiving in the U.S. www.caregiving.org

Caregiving Needs Among Seriously Ill Persons



Interviews with 900 caregivers of seriously ill persons at 6 U.S. sites

- ***need more help: 87% of families***
- transportation: 62%
- homemaking: 55%

Emanuel et al. Ann Intern Med 2000;132:451

Caregiving Increases Mortality

Nurses Health Study: prospective study of 54,412 nurses

- Increased risk of MI or cardiac death: RR 1.8 if caregiving >9 hrs/wk for ill spouse

Lee et al. Am J Prev Med 2003;24:113

Population based cohort study 400 in-home caregivers + 400 controls

- Increased risk of death: RR 1.6 among caregivers reporting emotional strain

Schulz et al. JAMA 1999;282:2215.

Family Caregivers and the SUPPORT Study

Patient needed large amount of family caregiving:	34%
Lost most family savings:	31%
Lost major source of income:	29%
Major life change in family:	20%
Other family illness from stress:	12%
<i>At least one of the above:</i>	<i>55%</i>

Why palliative care?

3. The demographic imperative

The Demographic Imperative:
**Chronically Ill, Aging Population
Is Growing**



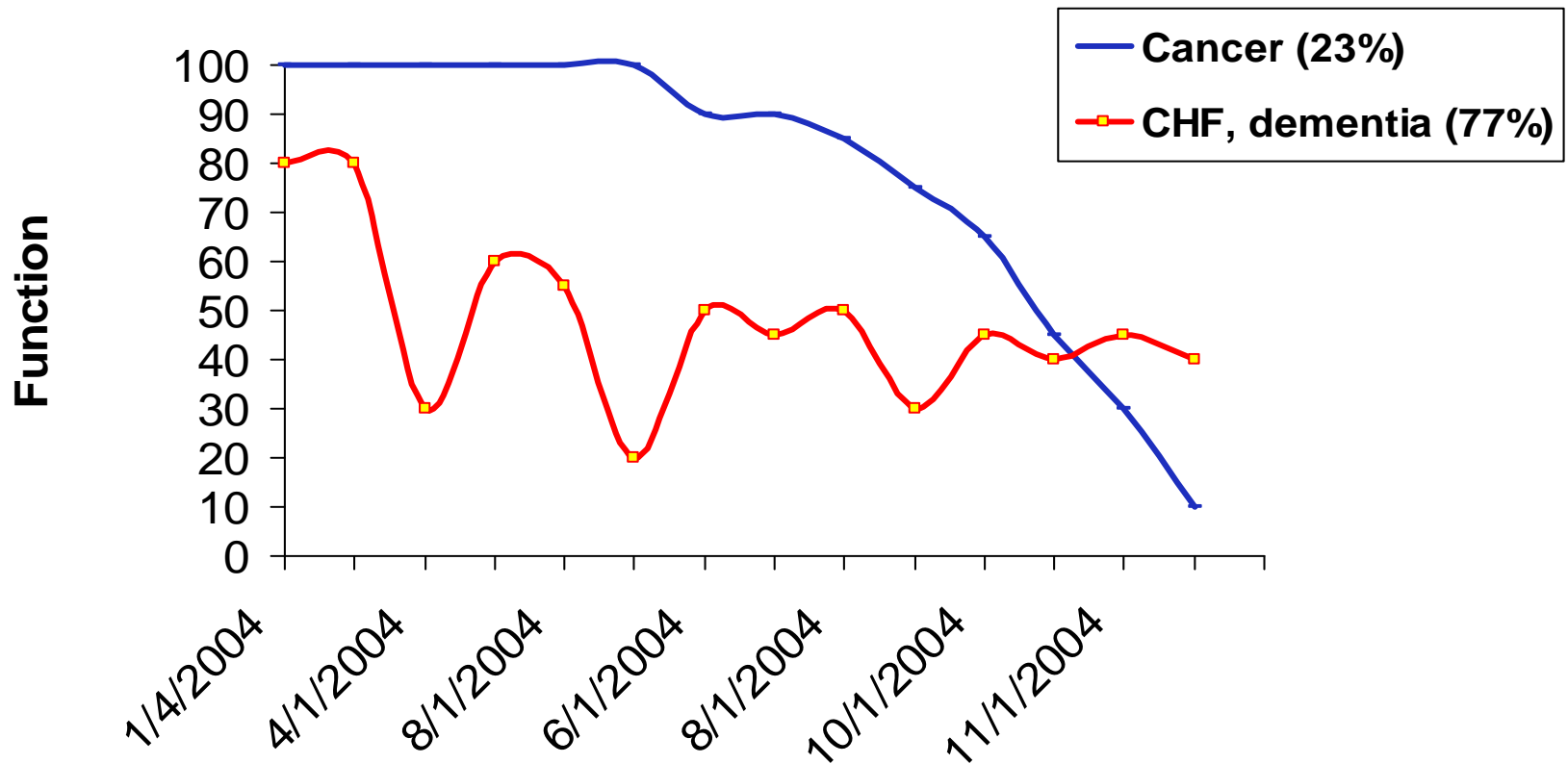
- The number of people over age 85 will double to 10 million by the year 2030.
- The 23% of Medicare patients with >4 chronic conditions account for 68% of all Medicare spending.

US Census Bureau, CDC, 2003. Anderson GF. NEJM 2005;353:305

CBO High Cost Medicare Beneficiaries May 2005

The Reality of the Last Years of Life: Death Is Not Predictable

(slide courtesy of Joanne Lynn, MD)
Covinsky et al. JAGS 2003;
Lynn & Adamson RAND 2003.
Morrison & Meier N Engl J Med 2002.

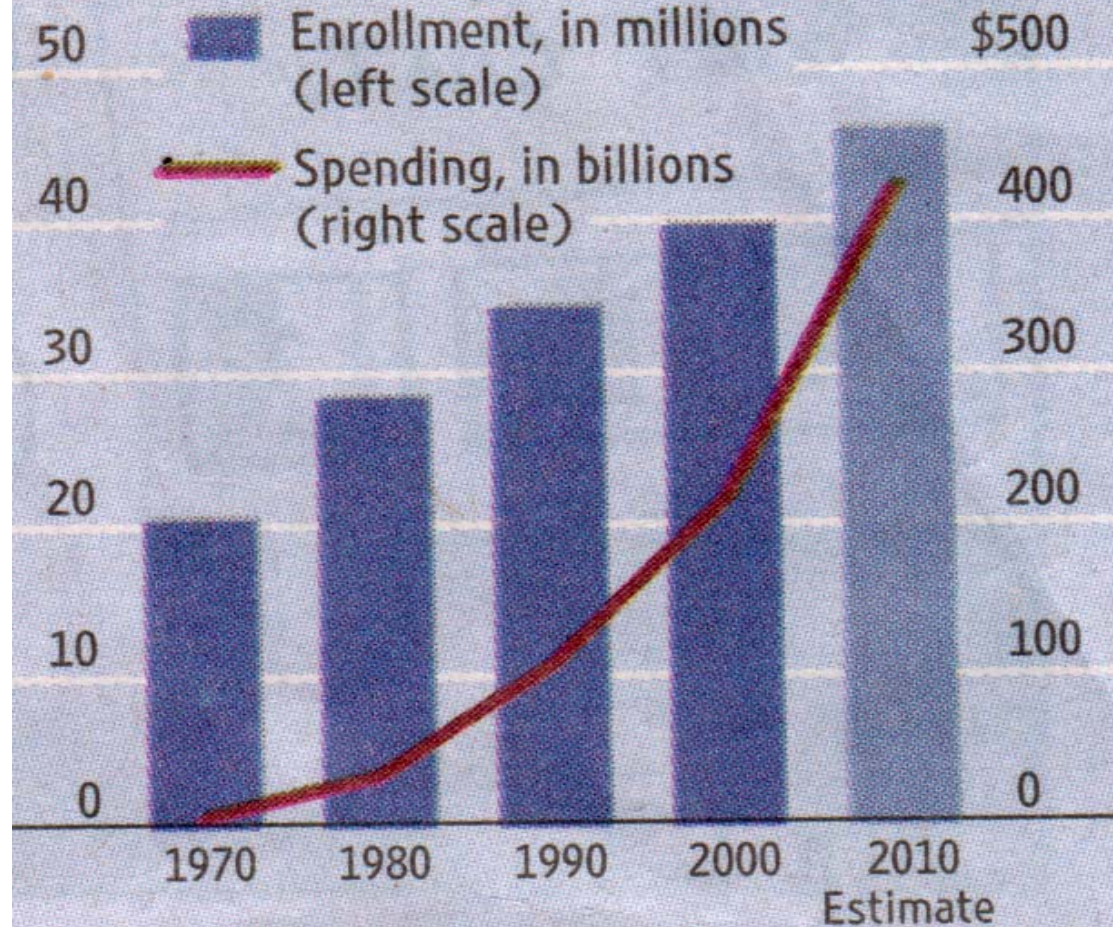


Why palliative care?

4. Efficiency and the financial crisis in healthcare

Burden of Care

Growth in Medicare enrollment
and spending



Sources: Centers for Medicare and Medicaid Services;

Medical Spending in the US: \$2.4 *trillion* in 2008

- 16% GNP, rising to 20% by 2015
- U.S. has more per capita spending than anywhere else in the world, but ranks 20th in quality indices
- The costliest 5% account for 43% of Medicare spending

Medicare Payment Policy: Report to Congress. Medpac 2007 www.medpac.gov
Health Affairs 2005;24:903-14.

CBO May 2007 High Cost Medicare Beneficiaries www.cbo.gov
nchc.org/facts/cost.shtml

Does Higher Spending Improve Outcomes?

More is Less and Less is More



Higher spending does not lead to better outcomes

Medicare claims data for 4.7 million beneficiaries and 4,300 hospitals

- Dramatic geographic variation in utilization
- Regions of highest utilization (most specialist visits, hospital days, ICU use), have highest mortality and v.v. after risk adjustment.

JAMA 2006; 296:159-160.

www.dartmouthatlas.com/atlas/2006_chronic_care_atlas.pdf

ES Fisher et al Health Affairs 2004; suppl web exclusive: VAR 19-32.

ES Fisher et al. Annals Intern Med 2003; 138:288-98.

Why is palliative care necessary?

- Suffering
- Overwhelmed family caregivers
- No communication
- Extreme overuse and misuse

Is it Beneficial?

Outcomes of Palliative Care

- Reduction in symptom burden
- Improved patient and family satisfaction
- Reduced costs

Palliative Care Is Beneficial

- Mortality follow back survey palliative care vs. usual care
Casarett et al. J Am Geriatr Soc 2008;56:593-99.
- N=524 family survivors
- Overall **satisfaction markedly superior** in palliative care group, $p < .001$
- Palliative 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
 - PTSD symptoms

*Other studies demonstrating benefit of palliative care: Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.
see capc.org/research-and-references-for-palliative-care/citations*

Is it Efficient?

Impact of Palliative Care on Costs

Hospital palliative care programs and hospice services demonstrably and substantially decrease health care costs.

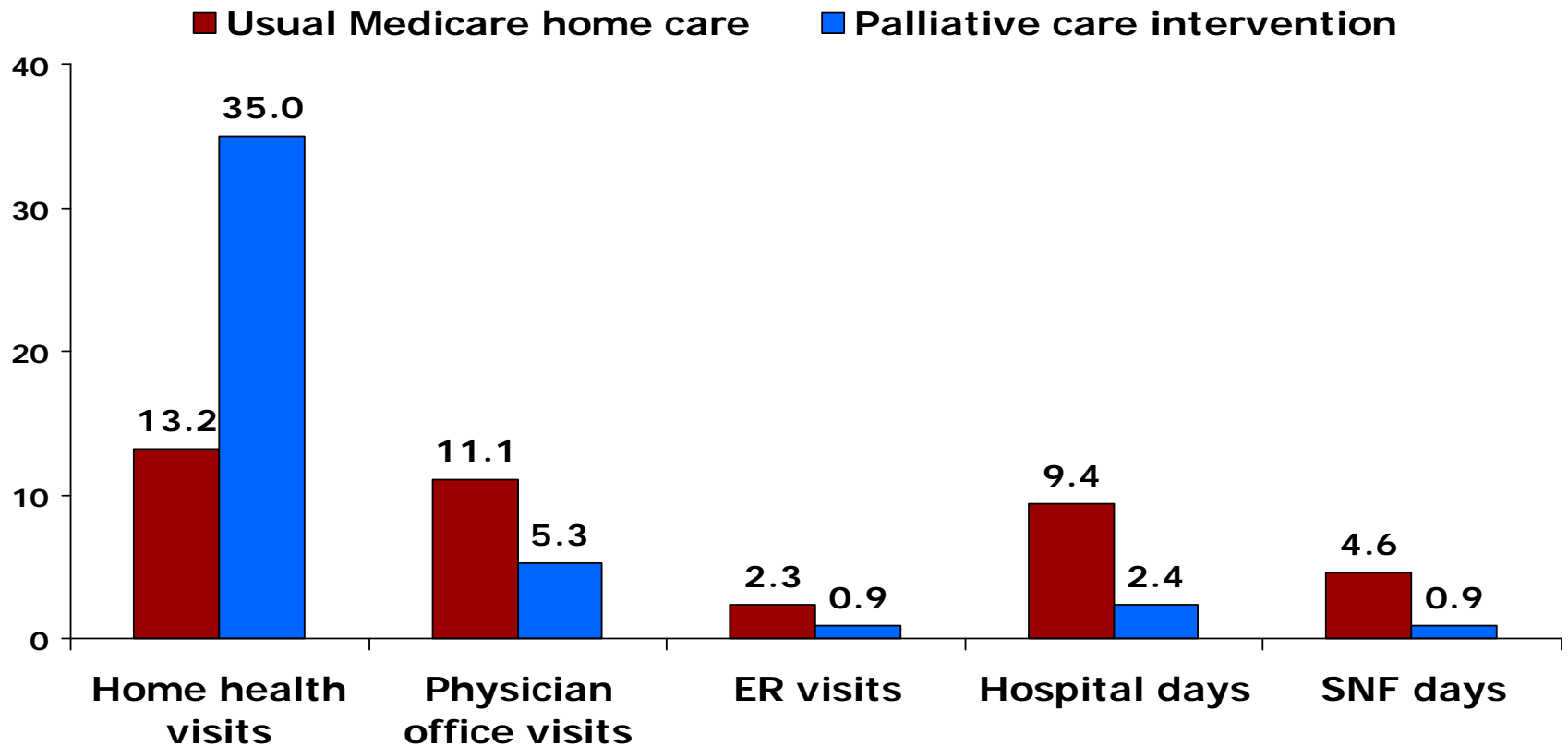
How Palliative Care Reduces Length of Stay and Cost

Palliative care:

- Clarifies goals of care with patients and families
- Helps families to select medical treatments and care settings that meet their goals
- Assists with decisions to leave the hospital, or to withhold or withdraw death-prolonging treatments that don't help to meet their goals

Palliative Care Shifts Care Out of Hospital to Home

Service Use Among Patients Who Died from CHF, COPD, or Cancer Palliative Home Care versus Usual Care, 1999–2000



Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of \$1696 in direct costs per admission ($P = .004$) and \$279 in direct costs per day ($P < .001$) including sig-

nificant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of \$4908 in direct costs per admission ($P = .003$) and \$374 in direct costs per day ($P < .001$) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients. Two confirmatory analyses were performed, including mean costs per day before palliative care and before a comparable reference day for usual care patients in the propensity score models resulted in similar results. Estimating costs for palliative care patients assuming that they did not receive palliative care resulted in projected costs that were not significantly different from usual care costs.

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

Arch Intern Med. 2008;168(16):1783-1790

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Group Information: The Palliative Care Leadership Centers' Outcomes Group is listed at the end of this article.

ADVANCES IN DISEASE PREVENTION, disease-modifying therapies, and medical technology in combination with the aging of the population have resulted in a dramatic growth in the number of adults living with serious illness.¹ Despite enormous expenditures, patients with serious illness receive poor quality medical care, characterized by untreated symptoms, unmet personal care needs, high caregiver burden, and low patient and family satisfaction.²

Palliative care is the interdisciplinary specialty that focuses on improving quality of life for patients with advanced illness and for their families through pain and symptom management, communication and support for medical decisions concordant with goals of care, and assurance of safe transitions between care settings.³ Until a decade ago, palliative care in the United States was typically available only to patients living at home and enrolled in hospice. Now, palliative care programs targeting acutely ill patients are found increasingly in hospitals. As of 2005, 30%

of US hospitals and 70% of hospitals with more than 250 beds reported the presence of a palliative care program—an increase of 96% from 2000.⁴ Unlike hospice, hospital palliative care is provided simultaneously with all other appropriate disease-directed treatments.⁵

Hospital palliative care programs have been shown to improve physical and psychological symptom management, caregiver well-being, and family satisfaction,^{2,3,6} and small, single-site studies suggest that palliative care programs may reduce hospital and intensive care unit (ICU) expenditures by clarifying goals of care and assisting patients and families to select treatments that meet those goals.¹⁰⁻¹² This study was undertaken to estimate the effect of palliative care consultation programs on hospital costs.

METHODS

We used hospital administrative data to compare hospital costs of patients receiving palliative care consultation matched by propensity score¹³⁻¹⁶ with patients receiving usual care from 2002 through 2004.

Hospital Palliative Care Reduces Costs

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

	Live Discharges			Hospital Deaths		
Costs	Usual Care	Palliative Care	Δ	Usual Care	Palliative Care	Δ
Per Day	\$867	\$684	\$183*	\$1,515	\$1,069	\$446*
Per Admission	\$11,498	\$9,992	\$1,506*	\$23,521	\$16,831	\$6,690*
Laboratory	\$1,160	\$833	\$327*	\$2,805	\$1,772	\$1,033*
ICU	\$6,974	\$1,726	\$5,248*	\$15,531	\$7,755	\$7,776***
Pharmacy	\$2,223	\$2,037	\$186	\$6,063	\$3,622	\$2,441**
Imaging	\$851	\$1,060	-\$208***	\$1,656	\$1,475	\$181
Died in ICU	X	X	X	18%	4%	14%*

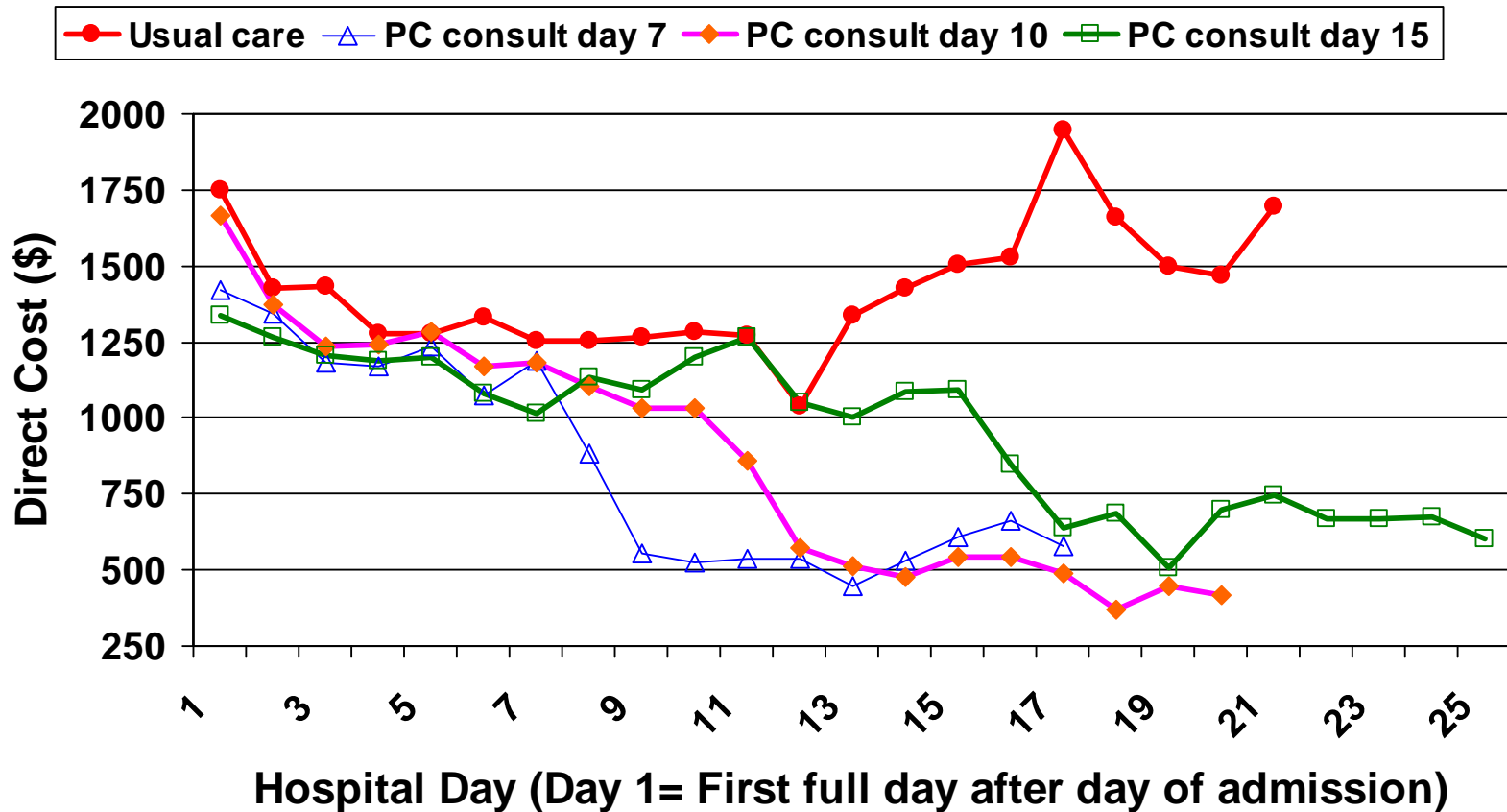
*p<.001

**p<.01

***p<.05

Morrison, RS et al. Archives Intern Med 2008;

Mean direct costs/day for patients who died and who received palliative care consultation versus matched usual care patients







Building a Hospital-Based Palliative Care Program

Making the Case for Hospital-Based Palliative Care

Designing a Program

Financing a Program

Estimating Program Volume

Forecasting Future Patient Volume

Estimating Cost Savings

Estimating Hospital Revenue Enhancement

Estimating Hospital Billing Revenues

Estimating Revenues from Physician Billing

Palliative Care and Philanthropy

Estimating Costs

Implementing a Program

Measuring Quality & Impact of Programs

Hospice & Palliative Care Across the Continuum

Tools for Palliative Care Programs

Research and Resources on Palliative Care

SEARCH GO

Financing the Palliative Care Program

Demonstrating how the program contributes to the hospital's financial viability is necessary to secure administrator support. It is recommended that the team partner with colleagues familiar with the hospital's financial systems and accounting practices. However, the team may still need to conduct its own data collection and analysis to present the financial case for palliative care.

Financing a Program presents an overview of principles and select spreadsheets useful to conducting financial analyses in support of palliative care programs.

- [Estimating Program Volume, LOS and Daily Census](#)
- [Forecasting Future Patient Volume](#)
- [Estimating Cost Savings](#)
- [Estimating Hospital Revenue Enhancement](#)
- [Estimating Hospital Billing Revenues](#)
- [Estimating Revenues from Physician Billing](#)
- [Palliative Care and Philanthropy](#)
- [Estimating Costs](#)

For more assistance on estimating volume and impact, as well as sample budget formats, view this [comprehensive tutorial](#).

CAPC's [Guide to Building a Hospital-Based Palliative Care Program](#) expands the information on this website and provides the rationale, detailed steps and tools for conducting a range of financial analyses.

We CAN do better-

Dr. M, an 89 y.o. practicing psychoanalyst

- Admitted to the hospital for scleroderma and new onset kidney failure.
- Declined hemodialysis. Palliative care consult called to assess patient's capacity to refuse dialysis and to assure that she was not suicidal.
- Discharged home with hospice on day 5 of hospital stay.
- Did well at home for 4 months, remained in active clinical practice.
- Said good bye to her patients, her son, and her friends, then died quietly at home 3 days later.

Dr. M- How does palliative care deliver quality?



- She received good hospital palliative care- *goals of care assessment and development of a care plan that met her goals, symptom management.*
- Transitioned effectively to, and received good care from, hospice at home- *Meticulous symptom management, psychosocial support from hospice RN, SW, MD + primary doc to patient and her distressed family and friends. Assured a peaceful dignified death at home.*

Demonstrates how the palliative care quality continuum works well from the perspective of the patient and family, the providers, and the payers.

How Does Palliative Care Work?

-Consultation model

-Client = referring MD

-Interdisciplinary team

-Focus on 3 domains:

- Relieve physical and emotional suffering
- Improve patient-physician-family communication and decision-making
- Strengthen transition management and continuity of care across settings



“There’s no easy way I can tell you this, so I’m sending you to someone who can.”

Use Guidelines to Assure Quality and Standardization of Palliative Care

- National Consensus Project for Quality Palliative Care – 2009 2nd ed.
nationalconsensusproject.org
- National Quality Forum *Framework and Preferred Practices for Hospice and Palliative Care* - 2007

The National Quality Forum

A National Framework and Preferred Practices for Quality Palliative and Hospice Care

Based on National Consensus Project

38 Preferred Practices within 8 Domains:

Examples:

- Preferred Practice 2: Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, 7 days a week.
- Preferred Practice 5: Hospice care and specialized palliative care professionals should be appropriately trained, credentialed, and/or certified in their area of expertise.

Summary: *Making the Case*

- Palliative care improves quality of care for our sickest and most vulnerable patients and families.
- Universal human experience and universal health professional obligation.

Life is pleasant. Death is peaceful. *It's the transition that's troublesome.*

- Isaac Asimov

US science fiction novelist & scholar (1920 - 1992)

Art Buchwald, Whose Humor Poked the Powerful, Dies at 81

By RICHARD SEVERO

Published: January 19, 2007, New York Times

As he continued to write his column, he found material in his own survival. *"So far things are going my way,"* he wrote in March. *"I am known in the hospice as The Man Who Wouldn't Die. How long they allow me to stay here is another problem. ...But in case you're wondering, I'm having a swell time — the best time of my life."*

Although the world is full of suffering, it is also full of the overcoming of it.

Helen Keller

Optimism 1903