Cutting Edge Healthcare: The Emergence of Palliative Care

Diane E. Meier, MD
Director, Hertzberg Palliative Care Institute and
Center to Advance Palliative Care
Professor, Geriatrics and Internal Medicine
Mount Sinai School of Medicine
New York, New York

Judi Lund-Person, MPH
Vice President, Regulatory and State Leadership

Jonathan Keyserling, JD
Vice President, Public Policy and General Counsel
National Hospice and Palliative Care Organization
Alexandria, VA

June 20, 2008
Objectives

1. What is palliative care?
2. Impact of palliative care on quality and cost
3. What states can do
New CMS 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_
How Does Palliative Care Differ from Hospice?

• **Non-hospice palliative care** is appropriate at any point in a serious illness. It can be 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
• 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.
• Died after 2 months at home on hospice
Conceptual Shift for Palliative Care

Old

Life Prolonging Care

Medicare Hospice Benefit

New

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement

Dx

Death
Why is palliative care necessary?

• Suffering
• Overwhelmed family caregivers
• No communication
• Overuse
Families Report Poor Care
Concerns About Quality of Care for Adult Relatives Who Died in 2000
(% Respondents Expressing Concerns)

- Patient emotional support: 50%
- Family emotional support: 35%
- No contact with physician: 30%
- Information about what to expect: 29%
- Communication with physician: 24%
- Help with pain: 24%
- Help with shortness of breath: 22%
- Respect for patient: 21%
- Coordination of care*: 15%

Impact of Palliative Care

- Reduces pain and symptoms
- Supports families
- Communication
- Continuity
- Reduce overuse
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Palliative Care Improves Patient Care

- Mortality follow back survey palliative care vs. usual care
- 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

Overall Satisfaction with Hospice Exceeds 70%
But is Under 50% in All Other Settings

Family Concerns About Quality of Care for Relatives Who Died of a Chronic Illness in 2000 (% with concerns)

Hospice Referral *Lengthens* Life in the Seriously Ill

- Medicare claims data 5% sample
- Cancer + CHF
- 4,493 patients, 1998-2002

**Overall survival longer (average of 29 days) in hospice beneficiaries**

- Subgroup analysis: longer survival seen in CHF, lung, pancreas, and colon cancers, with no difference for breast or prostate cancer. No hospice subgroup had higher mortality.

Summary: Palliative care improves quality

Compared to usual care, palliative care is associated with:

– Reduction in pain and non-pain symptoms
– Improved patient/family satisfaction
– Improved survival!
– Reduced hospital length of stay and overall health costs

Impact of Palliative Care on Costs

Hospital palliative care programs and hospice services demonstrably and substantially decrease health care costs.
“It is thornlike in appearance, but I need to order a battery of tests.”
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

Palliative Care Allows People to Die at Home
Outcomes Among Patients Who Died from CHF, COPD, Cancer Palliative Care versus Usual Care, 1999–2000

# 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Per Day</td>
<td>$867</td>
<td>$684</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,498</td>
<td>$9,992</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,160</td>
<td>$833</td>
</tr>
<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$1,726</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,223</td>
<td>$2,037</td>
</tr>
<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,060</td>
</tr>
<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Costs</th>
<th>Usual Care</th>
<th>Palliative Care</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Day</td>
<td>$1,515</td>
<td>$1,069</td>
<td>$446*</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$23,521</td>
<td>$16,831</td>
<td>$6,690*</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$2,805</td>
<td>$1,772</td>
<td>$1,033*</td>
</tr>
<tr>
<td>ICU</td>
<td>$15,531</td>
<td>$7,755</td>
<td>$7,776***</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$6,063</td>
<td>$3,622</td>
<td>$2,441**</td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,656</td>
<td>$1,475</td>
<td>$181</td>
</tr>
<tr>
<td>Died in ICU</td>
<td>18%</td>
<td>4%</td>
<td>14%*</td>
</tr>
</tbody>
</table>

*p<.001  
**p<.01  
***p<.05

Hospital Palliative Care Reduces Medicaid Costs

• Propensity score matched palliative care consult vs. usual care

• **Died in hospital** (n=639) **direct costs per admission**
  – Palliative care $13,707
  – Usual care $20,457
  – P<.001

• **Discharged alive** (n=6320) **direct costs per admission**
  – Palliative care $7,543
  – Usual care $8,848
  – P<.001
Hospice saves money

- Retrospective case control from Natl. LTC Survey sample 1999-2003
- Costs lower by an average of $2,309 per hospice user
- Greatest savings observed if hospice used for cancer or for last 50-108 days of life (2 – 3 months)

Hospice Reduces Medicaid Spending

• Hospice and non-hospice palliative care save Medicaid $$
  – Study completed by Milliman USA in 2003 concluded that hospice saves Medicaid $7,000 per beneficiary

• Hospice Medicaid benefit is now available in 48 states.

• 2 states without a Medicaid Hospice benefit:
  – New Hampshire
  – Oklahoma
Final Days
Unlikely Way to Cut Hospital Costs: Comfort the Dying

Care, Not Cure
Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

<table>
<thead>
<tr>
<th></th>
<th>NON-PCU</th>
<th>PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and chemotherapy</td>
<td>$2,267</td>
<td>$511</td>
</tr>
<tr>
<td>Lab</td>
<td>1,134</td>
<td>56</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>615</td>
<td>29</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>1,821</td>
<td>731</td>
</tr>
<tr>
<td>Room &amp; nursing</td>
<td>4,330</td>
<td>3,708</td>
</tr>
<tr>
<td>Other</td>
<td>2,152</td>
<td>278</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$12,319</strong></td>
<td><strong>$5,313</strong></td>
</tr>
</tbody>
</table>

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.
Source: Virginia Commonwealth University medical center.
Can patients get palliative care?
U.S. Hospital Palliative Care Programs (AHA Survey 2006)
Hospice Patient Growth
1982 - 2006
Percent of the Dying Served by Hospice is Increasing

36% of all U.S. decedents enrolled in hospice during the last 6 months of life, 2006 (Dartmouth Atlas)
Can Your Constituents Reliably Access Palliative Care?


• Check out www.getpalliativecare.org for a listing of all hospital palliative care programs in your state

• Hospice penetration also highly variable, see www.nhpco.org for directory

• Geography is destiny - How does your state rank?
Wide State-by-State Variation in Hospice Use

% Using Hospice During Last 6 Months of Life
Fee-for-Service Medicare Beneficiaries with
Severe Chronic Illnesses Who Died During 2000–2003

Data: Dartmouth Atlas Project 2006. Adapted with permission. Rates were adjusted for differences in age, sex, race, and prevalence of 12 chronic illnesses. Excludes Medicare beneficiaries enrolled in managed care plans.
Palliative Care Initiatives at the State Level
State Licensure Issues as Barriers to Palliative Care

- 44 states have hospice licensure laws and regulations
- Palliative care for non hospice patients cannot be provided in some states by hospice providers
  - **Tennessee:** Legislation now allows hospices to provide palliative care to non-hospice patients (2007)
  - **South Carolina:** State has determined that hospices can only provide non-hospice palliative care with a home health license. Home health requires a CON.
  - **Georgia:** Hospices worked to change the definition of hospice in GA to allow a hospice to do palliative care. State opposed the change because of staff resource limitations for surveys. Governor signed it but cannot be implemented until the state had enough FTE’s to survey a hospice that had a palliative program.
Examples of Palliative Care Initiatives at the State Level

- **New York, Massachusetts**: State Palliative Care Resource Councils- technical assistance, resources, training
  
  Examples: [http://assembly.state.ny.us/leg/?bn=S00597&sh=t](http://assembly.state.ny.us/leg/?bn=S00597&sh=t)  
  http://www.mass.gov/Ihqcc/docs/annual_report.doc

- **Colorado**: Building Blocks to Health Care Reform (2/13/08) includes an area called the Center for Improving Value in Health Care. Governor set up as an Executive Order and includes the vision that all Coloradans would live well at the end of life or in serious illness, and none would suffer needlessly.

- **POLST**
- Health professional education
- Pediatrics
**POLST: Physician Orders for Life Sustaining Treatment**

- Instructions to guide care before the crisis
- POLST/MOLST legislation
  [www.health.state.ny.us/professionals/patients/patient_rights/molst](http://www.health.state.ny.us/professionals/patients/patient_rights/molst)
- Began in Oregon, now also NY, WV, others
- The National Quality Forum has identified the POLST Paradigm as a preferred practice for quality end-of-life care
State-Mandated Training Requirements

• Palliative Care Training Requirements
  – **West Virginia:** WV requires 2 hours of continuing education in end-of-life care including pain management for all newly licensed physicians, nurses, physician assistants, and pharmacists during the first 2 years of their licensure.
  – **California:** continuing education requirement for physicians
Workforce Investments: Education for Healthcare Professionals

- **Minnesota:** Funding for educating faculty in palliative care (for all health care professionals), and for students to pursue education in hospice and palliative care—purpose is to strengthen workforce in order to alleviate the acute shortage of qualified people trained to work in palliative care programs.
Pediatric Palliative Care

- Washington State - Pediatric Palliative Care program, part of Medicaid, and covered by the two major health insurers.
- Massachusetts legislature approved and funded a pediatric palliative care program
- Similar program in CA
- Expanded definition of eligibility for pediatric hospice beyond the terminally ill with 6 month prognosis—medically fragile children often not expected to reach adulthood. (Same expansion of eligibility for the seriously chronically ill needed for all ages!)
What Can State Legislatures Do?

• Policies to improve *access* to palliative care
• Policies to improve *quality* of palliative care
How can we ensure that all seriously ill Americans have access to quality palliative care?

Supportive policies:

1. **Assure access to care** - Invest in workforce, incent providers, nursing homes, and hospitals to deliver palliative care, reduce policy barriers to hospice, drive public demand through outreach

2. **Assure quality of care** - Populate all medical-nursing schools with trained faculty, invest in palliative care workforce, require quality measures, and standards in all care settings
State Policies to Improve **Access** to Palliative Care

1. **P4P**: Financial incentives to doctors+nurses who provide or refer to palliative care
2. **P4P**: Financial incentives to hospitals that provide palliative care (Norway model)
3. Require palliative care for hospital, SNF accreditation
4. Provide technical assistance resources to providers via partnership with state’s hospital, hospice, and LTC organizations
5. Reduce regulatory and payment barriers to hospice care
State Policies to Improve Quality of Palliative Care

1. **Palliative Care Training**: Increase numbers of palliative care faculty at your state’s medical and nursing schools. Federal legislation example: http://www.govtrack.us/congress/bill.xpd?bill=s109-1000

2. **Post graduate training**: Support palliative medicine fellowships and palliative care nurse practitioner programs - workforce pipeline.

3. **Palliative Care Program Certification**: Help hospitals strengthen quality via Joint Commission Certification programs.
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. I don’t know where I’d go now, or if people would still want to see me if I weren’t in a hospice. 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
For more information

Center to Advance Palliative Care
www.capc.org
www.getpalliativecare.org
diane.meier@mssm.edu

National Hospice and Palliative Care Organization
www.nhpco.org
jlundperson@nhpco.org
jkeyserling@nhpco.org