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Education

# Palliative Care - What Clinicians Need to Know

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- Dr. Leenay is an employee and stockholder with UnitedHealth Group.

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# Objectives

- Identify specific hospitalization rates related to palliative care
- Assess the impact of palliative care on clinical outcomes and medical costs
- Describe the effects of palliative care on patient and caregiver outcomes
- State new and old paradigms for palliative care.
- Explain the tools that can be used to help patients and families transition from the hospital setting.

# End of Life Costs Are Highly Variable

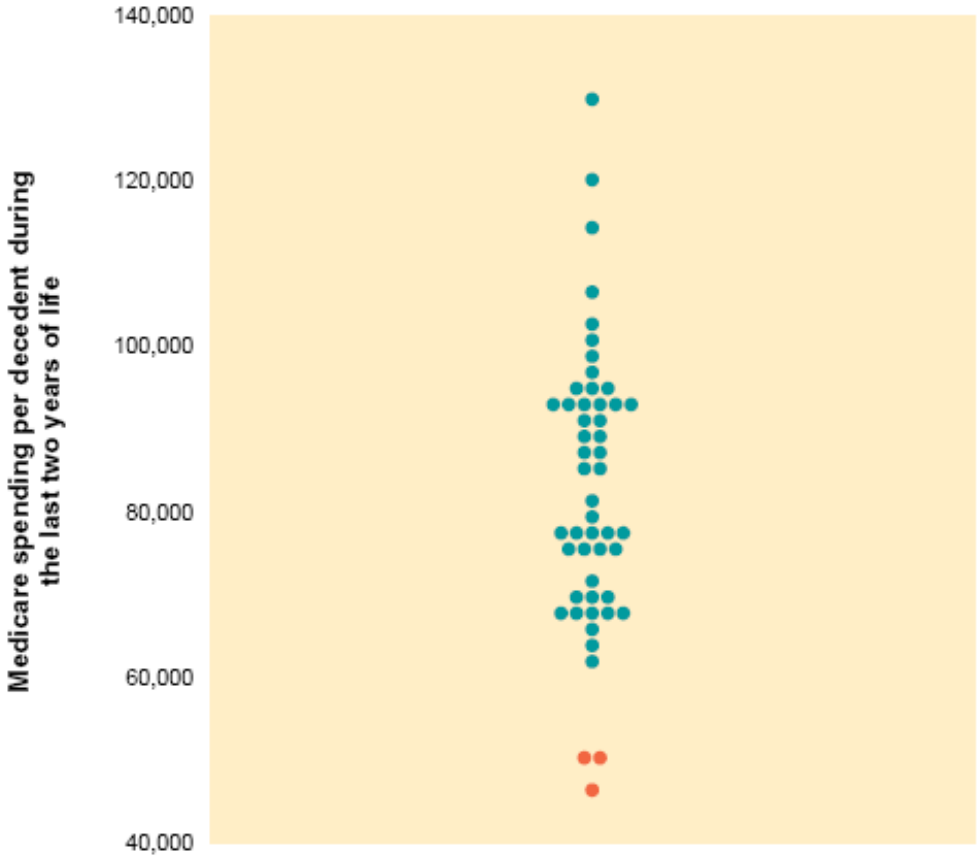
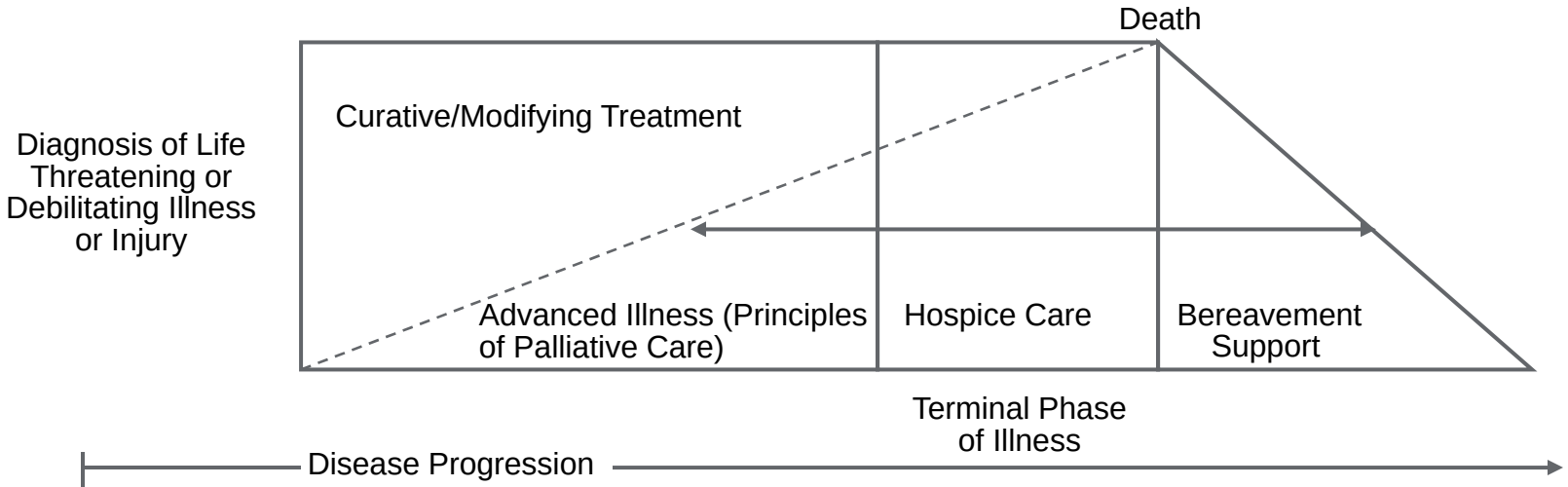



**Figure 3. Medicare Spending per Decedent During the Last Two Years of Life for Patients with At Least One of Nine Chronic Conditions Among Los Angeles Hospitals and Selected Benchmark Systems (Deaths Occurring 2001–05)**

Source:
*Tracking the Care of Patients with Severe Chronic Illness*
*The Dartmouth Atlas of Health Care 2008*

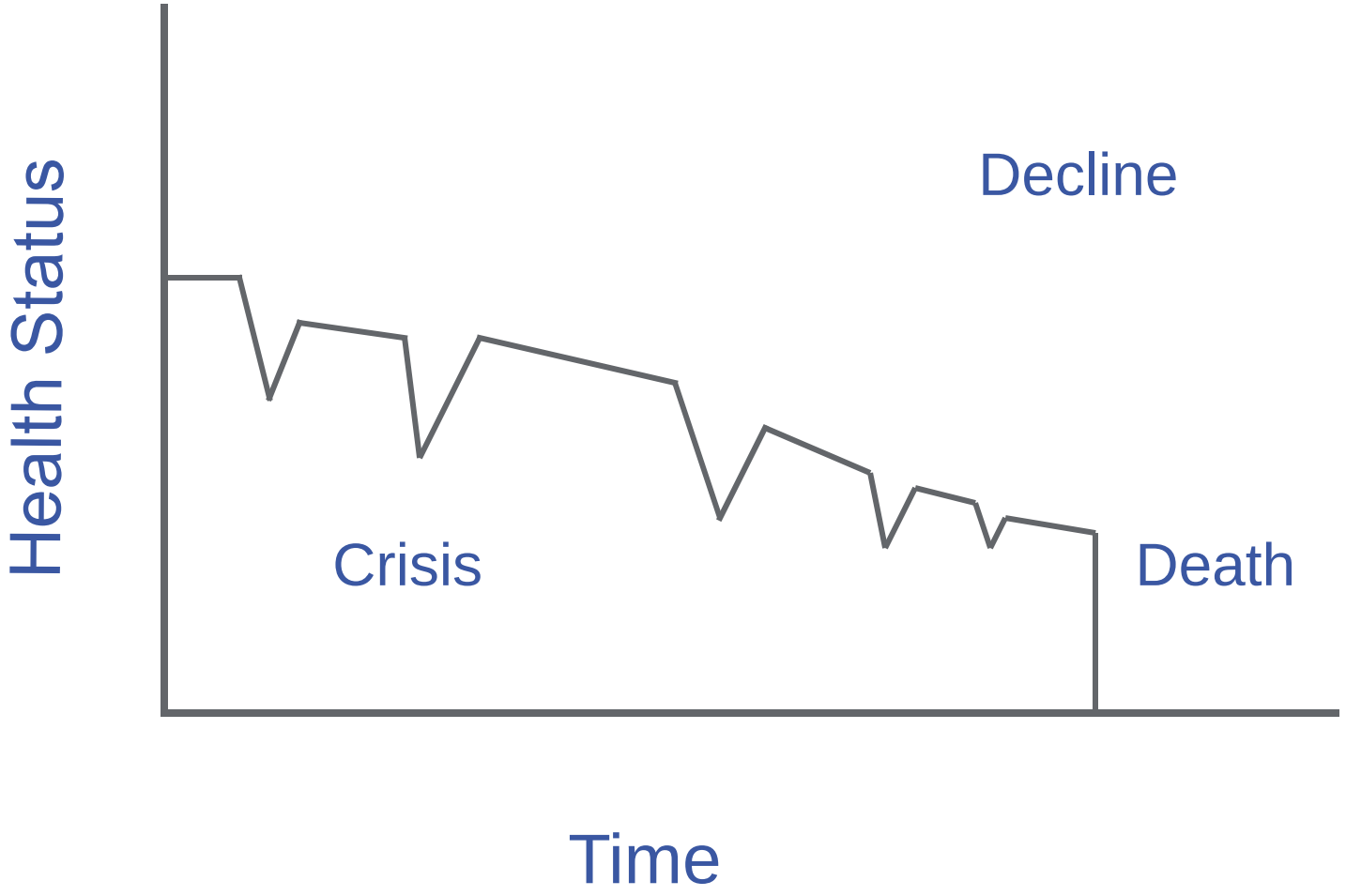
# Advanced Illness

- **Historically an artificial dichotomy between routine medical care and hospice**
- **Advanced Illness typically defined as average life expectancy of one year or less**
  - 12% of overall medical spend
  - 24% of Medicare medical spend
- **Advanced Illness**
  - More neutral term, less resistance from patients and providers
- **Palliative Care**
  - A philosophy of care focused on the reduction of suffering
- **Hospice**
  - An insurance benefit. Many commercial plans have more robust benefits then Medicare. UHG has the most generous of any national health plan. One physician needs to certify that the individual has a life-limiting illness and there is no requirement to forgo curative or life-prolonging therapies.



## Typical Chronic Illness Trajectory

90% of Medicare population dies of an illness from which we could predict their death



# Palliative Care is:

- Interdisciplinary care that aims to reduce suffering and improve quality of life for patients and their families
  - To cure sometimes
  - To relieve often
  - To comfort always

# Palliative Care Best Practice

- Physicians practice palliative care every day
- Patients should expect physicians to relieve suffering
  - Suffering is more global than traditional medical care
- Waiting to exhaust curative interventions delays timely palliative interventions

# Palliative care services

- Palliative care programs
  - Facilitate earlier symptom management
  - Provide supportive care expertise
  - Are appropriate in all settings, but make particular sense on the in-patient side

# Palliative Care is Local

- Most successful clinical models have incorporated face to face interactions
- Most resources therefore must be local and health plan interventions facilitative at best
  - Inpatient palliative care programs
  - Outpatient palliative care programs
  - Hospice
  - HomeCare

# United States Hospice Benefit

- A Medicare Benefit
- Waive standard Medicare Benefits and Elect Hospice Benefit
- Two physicians required to certify patient has a life expectancy of six months or less
- Mandated interdisciplinary team management
  - Nurse
  - Social Worker
  - Chaplain
  - Volunteer
  - Medical Director

- Most States parallel the Medicare benefit for Medicaid Benefits
- Private insurance varies but usually is less restrictive than the Hospice benefit

# United States Home Care Benefit

- A Medicare Benefit
- Must be “homebound”
- Must require skilled services
- “Restorative” services only, not for maintenance therapy

- Virtually all Medicaid agencies and private insurance mirrors the Medicare benefit

# Outpatient Palliative Care Teams

- Medicare, Medicaid, and Private Health insurance don't cover beyond core outpatient care that they would cover for anyone
  - Physician visits to the house
  - Nurse practitioner home visits
  - Occasionally social worker visits
  - If they are Homecare but not hospice eligible

# Inpatient consult teams

- Advance Practice Nurse
- Chaplain
- Licensed Clinical Social Worker
- Physician
- TLC team offers
  - Symptom management expertise
  - Address changing goals of care
  - Enhance patient and family support
  - Assist with alternative sites of care

# Curative vs. Palliative model

| Curative model | Palliative model |
|---|---|
| Primary goal is cure | The primary goal is relief of suffering |
| The object of analysis is the disease process | The object of analysis is the patient and the family |
| Symptoms are clues to underlying disease | Symptoms treatment prioritized over diagnostic assistance |
| Primary value is placed on measurable data | Both measurable and subjective data are valued |
| Devalues subjective, immeasurable and unverifiable data | Value placed on patients illness experience |
| Therapy is medically indicated if it eradicates or slows the progression of disease | Therapy is indicated for controlling symptoms and relief of suffering |
| The patients body is differentiated from the mind | Patient is a complex being with physical, emotional, social and spiritual dimensions |
| Patients are viewed as collections of parts, little need to know whole person | Treatment is congruent with the values, beliefs, and concerns of the patient and family |
| Death is the ultimate failure | Enabling patient to live fully and comfortably until death is a success |

# What Happens Without Appropriate Advanced Illness Care?

Clinicians have long recognized when we focus on the right things for the patient, the right outcomes result.


- Literature identifies the *greatest driver of avoidable admissions and unnecessary care* is attributed to the lack of clarity of stakeholders regarding disease progression and personal values about quality of life.

- Individuals often do not clearly understand disease progression and prognosis. *This leads to inappropriate utilization and cost, while increasing suffering and reducing quality of life.*

# Challenges to Member Engagement

- Physicians drive the interaction with the patient, but typically have discussions late in the course of disease
- Individuals do not understand that they have clinical conditions that will take their life and that many of the clinical interventions are palliative
- Administrative data does not meet the needs of pro-active identification
  - Claims costs climb nine months prior to death in the Medicare population, and later in the commercial population
  - Claims based identification tools typically identify a minority of individuals likely to die and very late in the course of their illness
- Clinical tools to predict death rely on disease specific criteria and functional status, but require administration by a clinician

# How to Identify the Patient Population

- The first step in providing care is patient identification. You need to identify those patients best suited to this care.

➢ By using evidence-based criteria, you can evaluate each patient and determine if they're appropriate for advanced illness care.

➢Each individual should be evaluated on the basis of key indicators:

➢"Would you be surprised if your patient dies within the next two years/24 months?

➢Core indicators such as functional status (best predictor), utilization of acute services, and general health status.

➢Palliative Performance Scale (PPS) score

➢Disease specific indicators

➢Physician consultation and referral for flagged cases

Even if prognosis is wrong, these discussions add value – so engage!

# Advanced Illness Long Term Strategy

- Facilitate discussions with family and physicians
  - Advanced Directive community strategy
  - Advance Directive Availability for all members
- Robust commercial Hospice benefit
  - Exceeds that Medicare
- Steerage
  - Assure oncology centers have palliative care programs
- Case management
  - Advanced Illness Case Management
- Bereavement services

# Utilization Variation in the Last Six Months

The Dartmouth Atlas of Health Care, 2006 reports the following regarding utilization variation by state in the last six months of life:

- The care of people with chronic illness accounts for more than 75% of all U.S. health care expenditures, but Medicare spends much more per enrollee in some states and regions than it does elsewhere.
- The differences in spending provide important insights into the causes of waste in our current health care system, and the opportunities to improve both the quality and efficiency of care.
- Resource utilization variation by state in the last six months of life:
  - Days spent in hospital last year 7.3 – 16.4
  - Days spent in ICU 1.5 – 4.7
  - Total MD visits 17.0 – 41.5
  - Percentage of patients seeing 10 or more MDs 10.8% - 38.7 %
  - Percentage of deaths occurring during a hospitalization with an ICU stay 11.7% - 25.1%
  - Hospice utilization 6.8% - 44.7%
- The extra spending, resources, physician visits, hospitalizations and diagnostic tests provided in high spending states, regions and hospitals doesn't buy longer life or better quality of life.
- In fact, those with chronic illnesses who live in high rate regions have slightly shorter life expectancies and less satisfaction with their care than those in regions with lower rates of spending.
- If the resource utilization of efficient providers managing people with severe chronic illness was implemented nationally, it would reduce Medicare spending for patients in the last two years of life by 30%

# Current Models of Care

- 4700 Hospice providers are available in most communities, is rapidly growing, and care for over 40% of deaths in America
  - Median LOS over 20 days, Average LOS over 67 days
  - 95.6% paid and delivered as routine home care
  - Should be considered a product

- Palliative care programs exist within many facilities, organizations, and plans
  - Providers believe they provide palliative care, but data repeatedly finds that discussions occur late and that individuals suffer
  - Palliative care programs were created to reduce medical spend and improve clinical outcomes and paid for through existing payment methodologies or cost avoidance calculations
    - 53% of hospitals with 50 or more beds (varies by state from 10% - 100%) have programs with variability in capacity and approach
    - Outpatient programs are lean due to low utilization, and challenges of reimbursement systems
    - Health plan experience is mixed with face to face programs being the only intervention repeatedly demonstrating value

# A Successful End of Life Care Intervention within Hospitals

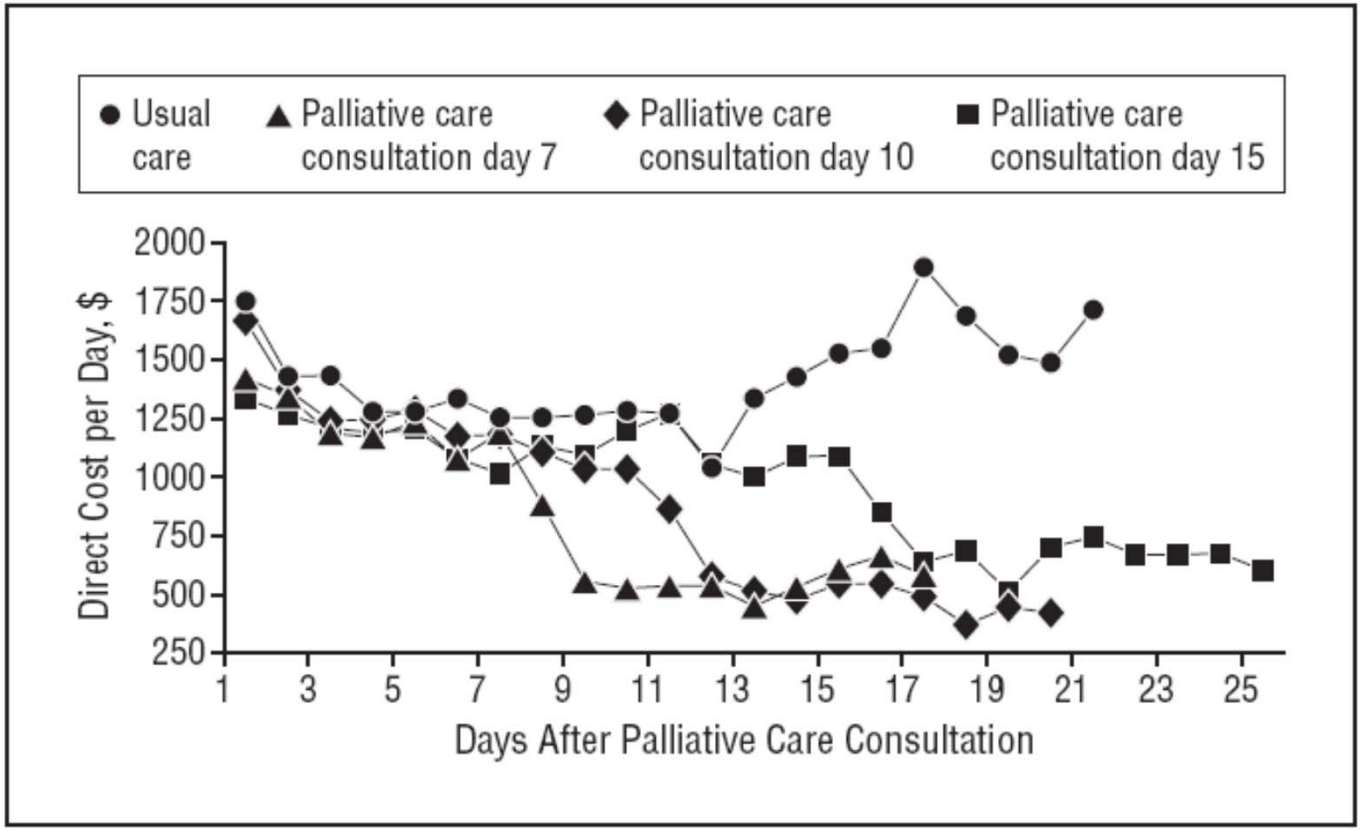
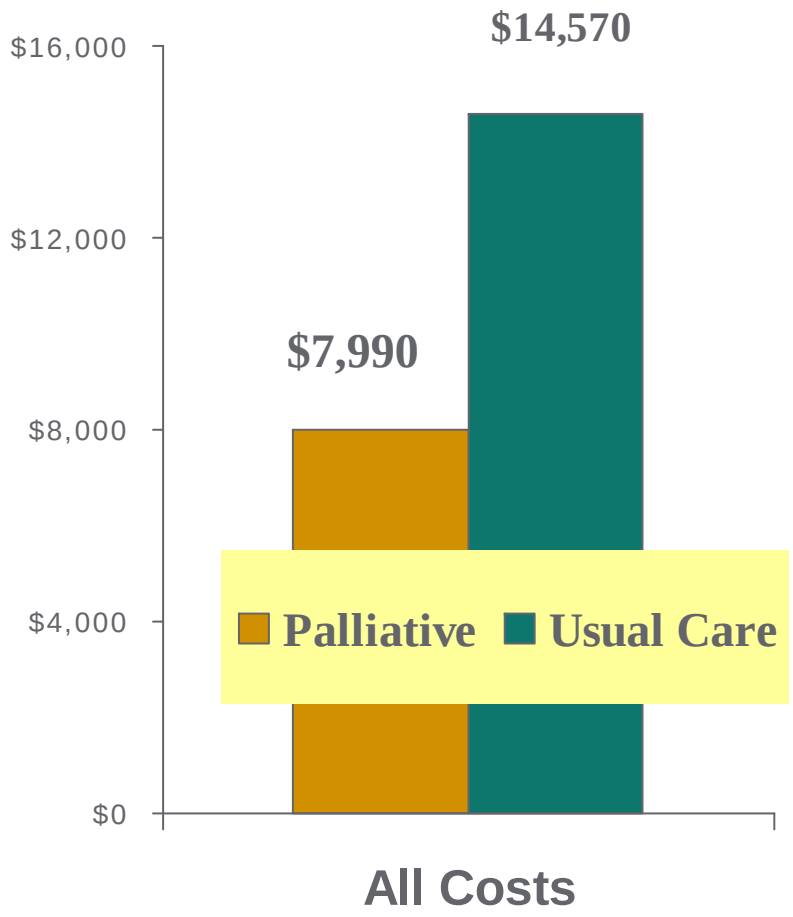



**Figure 2.** Mean direct costs per day for patients who died and who received palliative care consultation on hospital days 7, 10, and 15 compared with mean direct costs for usual care patients matched by propensity score. Hospital day 1 is the first full day after the day of admission.

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

# Improved Care at a Reduced Cost




## Kaiser Permanente

- Average $6,580 (45%) reduction in costs for Palliative Care or Advanced Illness Care patients
- p<.001 F=35.93
- Locus of care shifted from inpatient to home, result is lower costs

Meier, D. Planning a hospital-based palliative care program: A primer for institutional leaders. www.capc.org

# Financial Impact

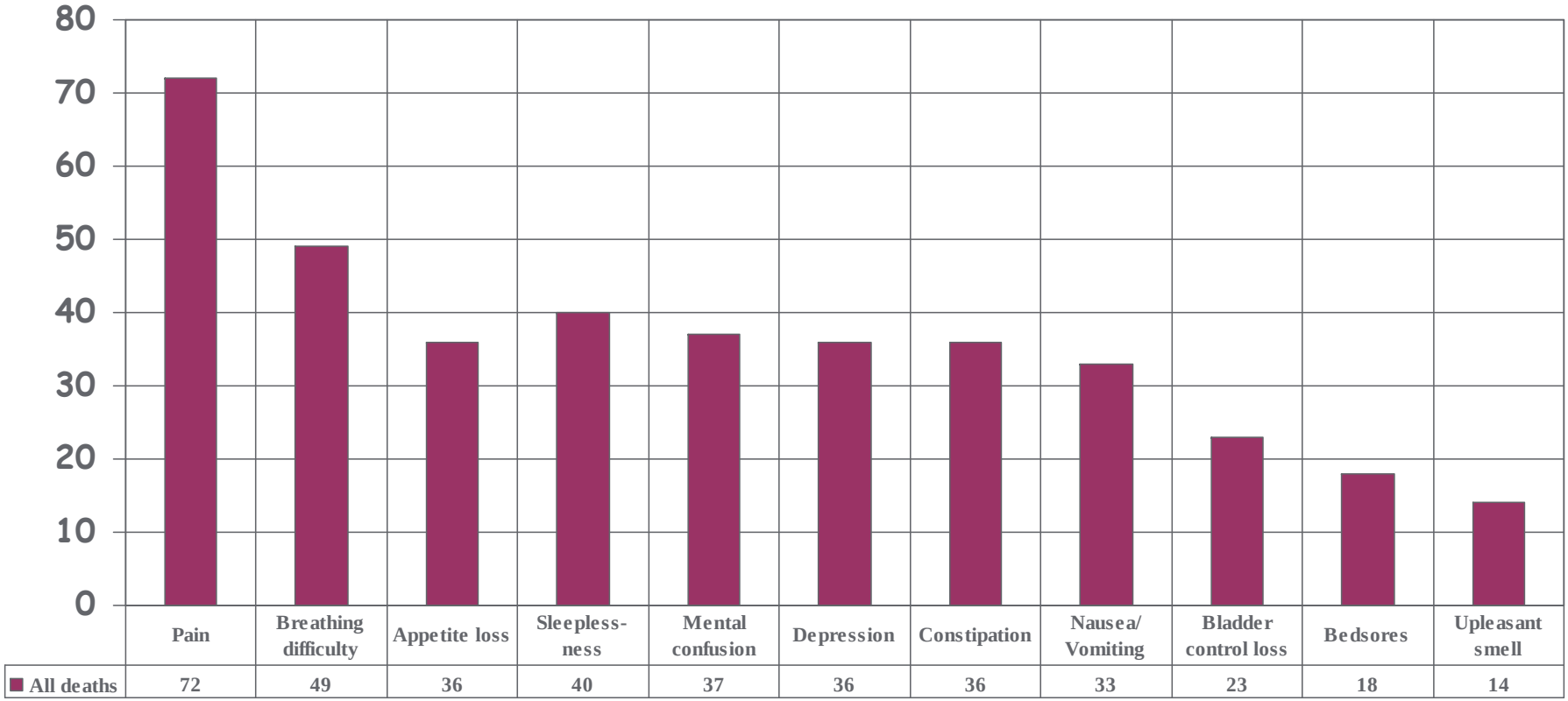
- Kaiser
  - Curative and Home Hospice Care were applied simultaneously to patients who had a year to live
    - 87% died at home vs. 57% of controls
    - Costs were 45% lower than controls
- University of Michigan
  - Prostate cancer patients received both chemotherapy and hospice care
    - $19,790 for treatment alone
    - $12,682 for chemotherapy with hospice

# Is Palliative Care a Solution

- Do clinical outcomes improve?
  - Suffering, symptoms and quality of life
  - Ethical issues
- Do financial outcomes improve?
- Does satisfaction improve?
  - Patients
  - Families
  - Physicians
  - Staff

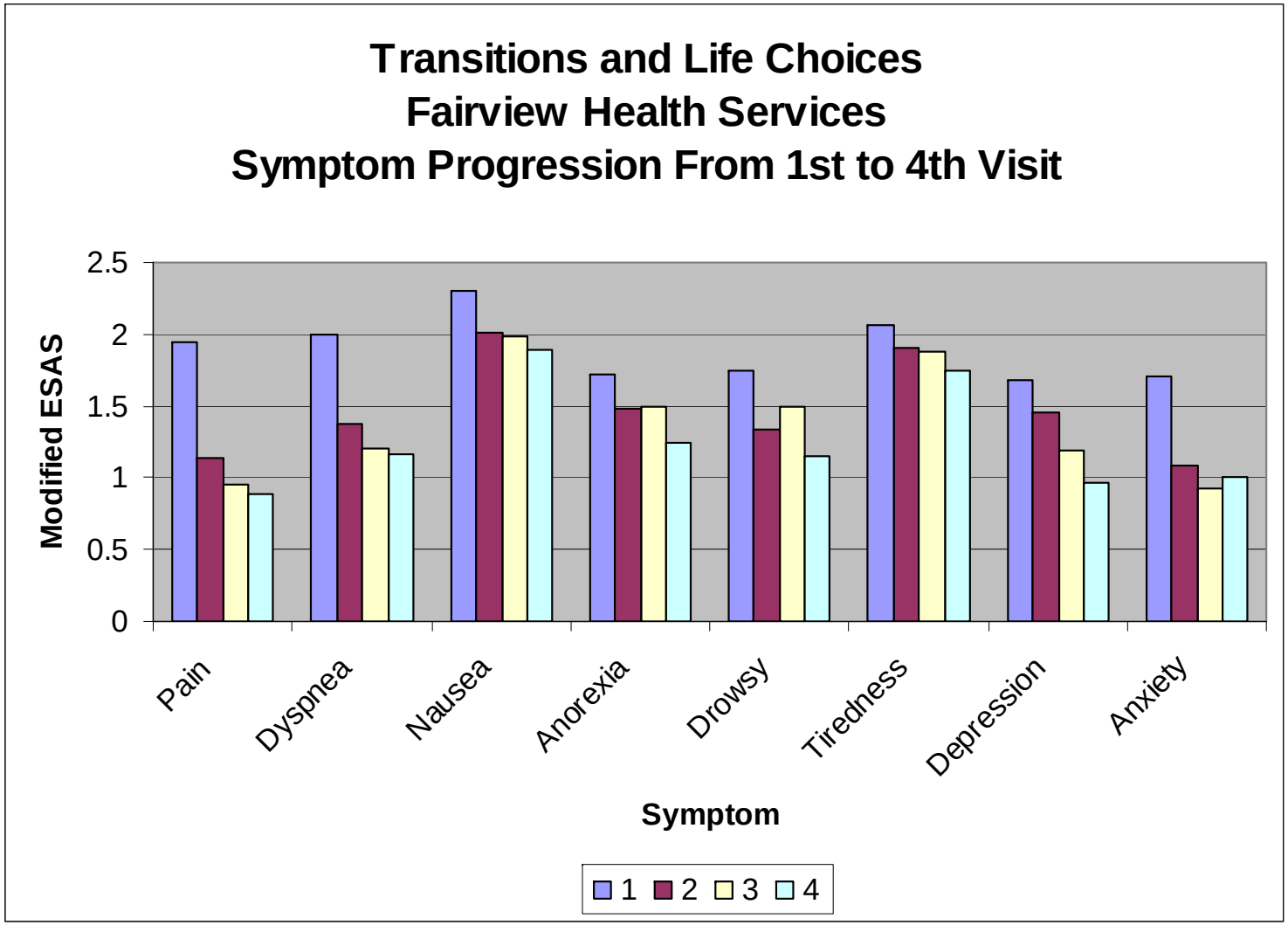
# Symptom prevalence

Prevalence of symptoms in dying patients reported by family members regardless of location of death




| | Pain | Breathing difficulty | Appetite loss | Sleepless-ness | Mental confusion | Depression | Constipation | Nausea/ Vomiting | Bladder control loss | Bedsores | Upleasant smell |
|---|---|---|---|---|---|---|---|---|---|---|---|
| All deaths | 72 | 49 | 36 | 40 | 37 | 36 | 36 | 33 | 23 | 18 | 14 |

# Symptom progression



# Mortality Illustration
## DRG 127 Heart Failure and Shock

Average total costs were 2.5 times higher in episodes where patients died

| | FUMC | | FSH | |
|---|---|---|---|---|
| | Cases DC'd Alive | Cases Expired | Cases DC'd Alive | Cases Expired |
| Cases | 204 | 7 | 394 | 17 |
| Quantity of Charges | 38963 | 3813 | 59006 | 7611 |
| Total Charges | $2,985,807 | $299,261 | $4,949,745 | $546,581 |
| **Average Charge per Case** | $14,636 | $42,752 | $12,563 | $32,152 |
| Variable Direct Cost | $831,145 | $88,726 | $968,726 | $110,999 |
| Total Cost | $1,573,263 | $154,777 | $1,917,230 | $211,936 |
| **Average Cost per Case** | $7,712 | $22,111 | $4,866 | $12,467 |

CHF Patients [ DRG 127 Heart Failure & Shock ]
Source = Eclipsys Decision Support (TSI)

# Inpatient Utilization Over Two Years at Fairview Southdale, Minneapolis

Of the 17 patients at Southdale who died, 9 had an average of 3.6 prior inpatient admissions within the FV system in 2 years prior to inpatient death

| | Unique Persons | Total Inpt Admissions | Total Inpt Days | Avg Days / Pt | ALOS | Avg Charges | Avg Total Cost | Avg Net Revenue | Avg Profit / Person |
|---|---|---|---|---|---|---|---|---|---|
| **Admission w/ Death** | 17 | 17 | 158 | 9.29 | 9.29 | $ 32,152 | $ 12,467 | $ 8,020 | $ (4,447) |
| **Inpatient Admissions in 2 yrs Prior to Death** | 9 | 32 | 212 | 23.56 | 6.63 | $ 53,156 | $ 23,130 | $ 19,229 | $ (3,902) |
| | | | | | | | | | |
| **TOTAL** | 17 | 49 | 370 | 21.76 | 7.55 | $ 60,293 | $ 24,712 | $ 18,199 | $ (6,513) |

CHF Patients [ DRG 127 Heart Failure & Shock ]
Source = Eclipsys Decision Support (TSI)
Inpatient stays in 2 years prior to death

Questions & Answers

Thank You.

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