The Integration of Palliative and Hospice Care with Complex Medical Conditions.

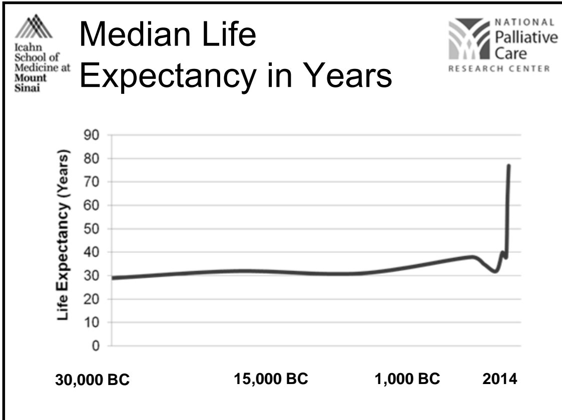
R. Sean Morrison, MD
Co-Director, Patty and Jay Baker National Palliative Care Center
Director, National Palliative Care Research Center
Director, Hertzberg Palliative Care Institute
Hermann Merkin Professor of Palliative Care
Professor, Geriatrics and Palliative Medicine
Brookdale Department of Geriatrics & Palliative Medicine
Icahn School of Medicine at Mount Sinai
New York, NY
sean.morrison@mssm.edu
www.npcrc.org, www.mountsinai.org/palliative

Learning Objectives

At the end of this educational activity, participants should be able to

1. Summarize the challenges healthcare providers are confronted with when treating patients suffering from complex medical conditions
2. Demonstrate strategies and frameworks that integrate palliative and hospice care when caring for seriously ill and dying patients
3. Describe the impact on the patient, family members, and caregivers when patients with complex conditions are integrated into palliative or hospice care services

- *The Needs of The Seriously Ill and the Imperatives for Change*
- *Value in Healthcare*
- *How Does Palliative Care Improve Value*



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Life Expectancy in 2014

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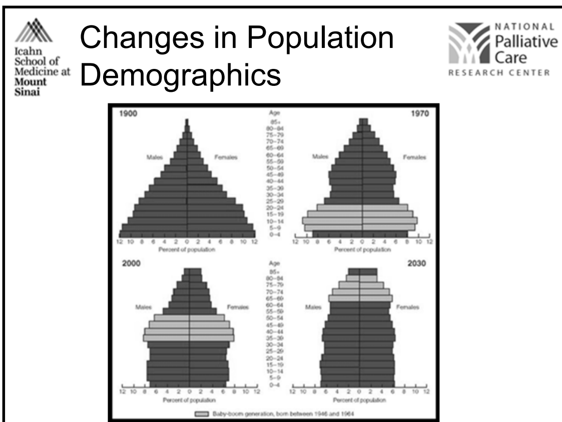
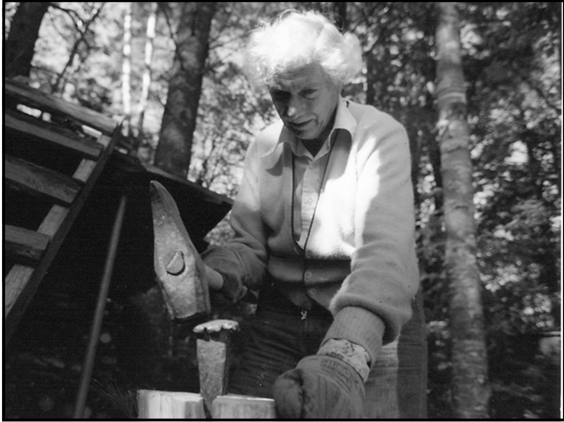
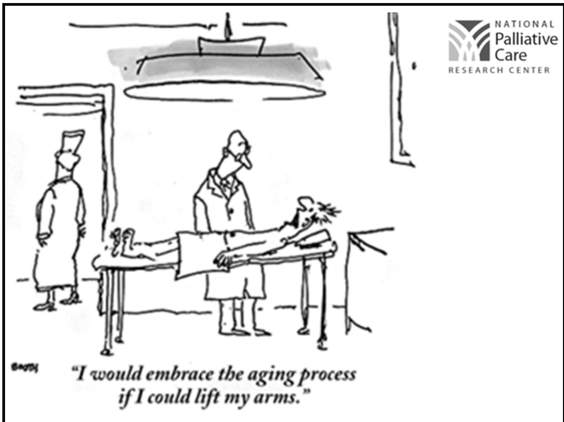
- Median age of death is 78 years
- Among survivors to age 65, median age at death is 84 years
- Among survivors to age 84, median age at death is 88
- Doubling of the population over age 80 by 2030

CDC



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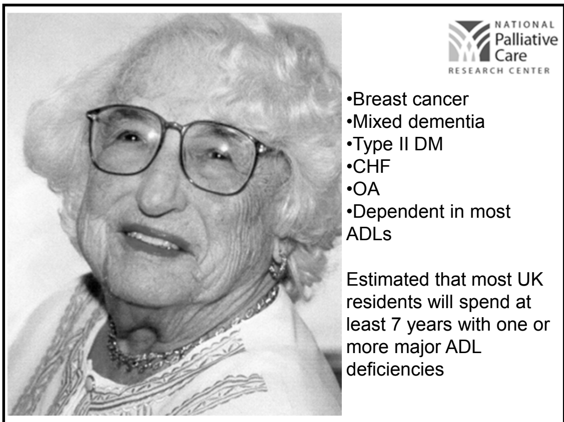
"I would embrace the aging process
if I could lift my arms."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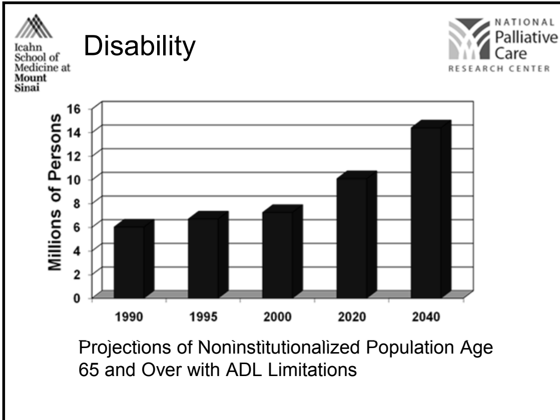
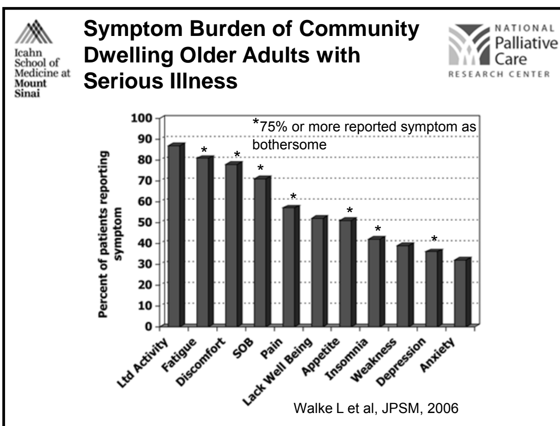
•Breast cancer
•Mixed dementia
•Type II DM
•CHF
•OA
•Dependent in most ADLs
Estimated that most UK residents will spend at least 7 years with one or more major ADL deficiencies





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The Family Burden of Serious Ilness

- 65 million caregivers deliver care at home to a seriously ill relative
  - 40% deliver 20 or more hours of unpaid care
  - 87% state they need more help
  - 33% are in poor health themselves
- Stressed caregivers are at significantly increased risk of death, major depression, reduced quality of life, and loss of work
- Economic costs: $375 billion/year (US)

Emanuel et al. Ann Intern Med 2000, Levine C. N Engl J Med1999, Schulz et al. JAMA 1999; Schulz et al. JAMA 1999;282:2215., Kuhlthau et al, Matern Child Health 2010, Natl Fam Caregivers Assoc, 2010,Buckner & Yeandle, 2011, ONS 2012, Buckner et al

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Family Satisfaction with Hospitals as the Last Place of Care

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2000 US Mortality follow-back survey, 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 symptoms: 19%

Teno et al. JAMA 2004;291:88-93

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International Comparison of Spending on Health, 1980–2009

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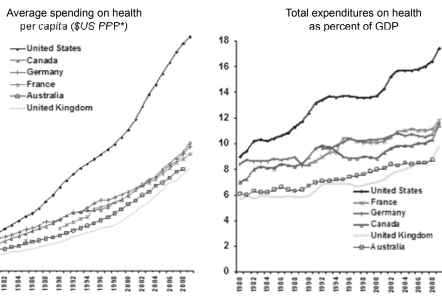

* PPP=Purchasing Power Parity.
Data: OECD Health Data 2011 (database), version 6/2011.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

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Concentration of Healthcare Costs

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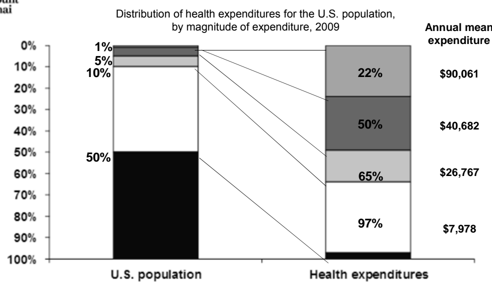
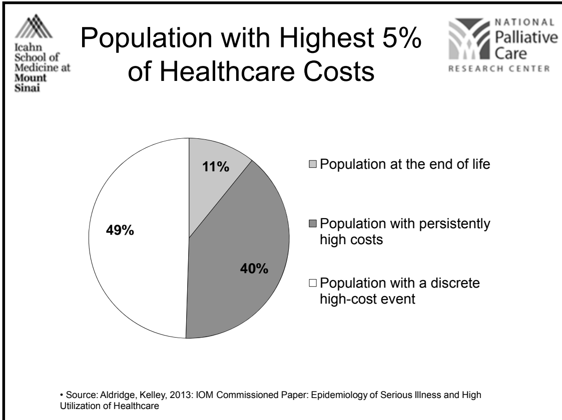


Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.



The Medicare Hospice Benefit

- Enacted in 1982
- Provides palliative care coverage to Medicare beneficiaries who:
  - Relinquish Medicare Part A (coverage for hospitalizations and acute care)
  - Have <6 months to live as certified by a physician and willing to relinquish curative treatments
- Covered by most third party insurances and most state Medicaid plans
- Median length of stay on hospice <3 weeks, less than 40% of all US deaths

Clinical Benefits of Hospice

- Compared to death in usual care, death in hospice is associated with:
  - Enhanced patient comfort
    - Pain, other symptoms, quality of life
  - Improved family outcomes
    - Post-traumatic stress disorder, prolonged grief disorder
  - Similar or greater survival

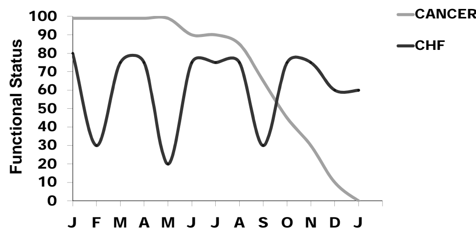
Teno et al JAMA. 2004; Wright et al, J Clin Oncol. 2010 ; Connor et al, J Pain Symptom Manage. 2007.

The Impact of Hospice on Health Care Utilization (3.5 months or less in hospice)

Measures of Utilization	Hospice, Adjusted Means*, (95% CI)	Controls, Adjusted Means*, (95% CI)
Total Expenditures, (2008 USD)	22,083 (20,800, 23,366)	24,644 (23,269, 26,019)**
Total Hospital Days	3.5 (2.2, 4.9)	12.5 (6.6, 18.3)**
Proportion with 30 day Re-admission	0.11 (0.05, 0.17)	0.26 (0.17, 0.35)**
Proportion Dying in the Hospital	0.02 (-0.01, 0.05)	0.42 (0.32, 0.52)**

. *p<0.05; ** p<0.01. Kelley AS, Deb P, Du Q, Morrison RS, Health Affairs, 2013

The Reality of the Last Year of Life



People have an abiding desire not to be dead….

"Better to flee from death than feel its grip."

Homer, Greek poet

"The weariest and most loathed worldly life that age, ache, penury, and imprisonment can lay on nature is a paradise to what we fear of death."

William Shakespeare, English playwright

"I don't want to achieve immortality through my work. I'd rather achieve it by not dying."

Woody Allen, American humorist and filmmaker

Concentration of Risk and Spending

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

Palliative Care:

A Possible Solution

What is Palliative Care?

- Specialized medical care for people with serious illnesses.
- Provides patient relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.
- Improves quality of life for both the patient and the family.
- Provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support.
- Appropriate at any age and at any stage in a serious illness, and can be provided together with 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

Palliative Care 2014

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 Enhances Value

Value = <u>Quality</u>
Cost

Palliative Care Improves Outcomes For Patients and Families

- 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:
  - Improved quality of life (p=.03)
  - Fewer depressive symptoms (p=.02)
  - Fewer burdensome treatments (p=.05)
  - Improved survival: 11.6 months versus 8.9 months for usual care group (P=.02)

Temel et al, NEJM 2010

Palliative Care Assists Families

- Compared to care at home with hospice.
  - Hospital deaths associates with:
    - Heightened risk for prolonged grief disorder (AOR, 8.83; P=.02),
  - ICU deaths associated with:
    - Greater physical and emotional distress and worse QoL (all P≤.03)
    - Heightened risk for posttraumatic stress disorder in caregivers, AOR, 5.00; P=.02),

Wright AA et al, JCO, 2010

Palliative Care Assists Families

- Families of patients with better quality of death were found:
  - To have better quality of life
  - To experience less regret
  - To show improvements in self-reported health, physical functioning, and mental health during the bereavement period

Wright AA et al, JAMA, 2008

The Impact of Effective Communication: Cancer

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

	No. (%)			Adjusted OR (95% Confidence Interval)[a]	*P* Value
		End-of-Life Discussion			
	Total (N=332)	Yes	No		
Medical care received in the last week	332	123 (37.0)	209 (63.0)		
ICU admission	31 (9.3)	5 (4.1)	26 (12.4)	0.35 (0.14-0.90)	.02
Ventilator use	25 (7.5)	2 (1.6)	23 (11.0)	0.26 (0.08-0.83)	.02
Resuscitation	15 (4.5)	1 (0.8)	14 (6.7)	0.16 (0.03-0.80)	.02
Chemotherapy	19 (5.7)	5 (4.1)	14 (6.7)	0.36 (0.13-1.03)	.08
Feeding tube	26 (7.9)	11 (8.9)	15 (7.3)	1.30 (0.55-3.10)	.52
Outpatient hospice used	213 (64.4)	93 (76.2)	120 (57.4)	1.50 (0.91-2.48)	.10
Outpatient hospice ≥1 wk	173 (52.3)	80 (65.6)	93 (44.5)	1.65 (1.04-2.63)	.03

Abbreviation: ICU, intensive care unit; OR, odds ratio.
[a] The 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.

Wright AA et al, JAMA, 2008

Palliative Care Teams Reduce Unnecessary Expenditures

- Palliative care teams establish patients goals of care and match treatments to goals
  - Reduce miss-utilization and improve hospital efficiency
  - Right care to the right patients at the right place at the right time.
- Palliative care teams facilitate transition planning by coordinating care for the most complex and vulnerable patient populations.
  - Ensure that patients are discharged to safe environments, prevent readmissions, and prevent unwanted incident admissions

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ORIGINAL INVESTIGATION

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 Lithe, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

	Live Discharges			Hospital Deaths		
Costs ($)	Usual Care (n=18,2347)	Palliative Care (n=2,630)	Δ	Usual Care (N= 2,124)	Palliative Care (2,278)	Δ
Per Day	830	666	174*	1,484	1,110	374*
Per Admission	11,140	9,445	1,696**	22,674	17,765	4,908**
ICU	7,096	1,917	5,178*	14,542	7,929	7,776*
Died in ICU	X	X	X	18%	4%	14%*

*P<.001 **P<.01 ***P<.05

ARCH INTERN MED/VOL 168 (NO. 16), SEP 8, 2008 WWW.ARCHINTERNMED.COM
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THE CARE SPAN

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

Total cost per day ($): 3,000; 2,500; 2,000; 1,500; 1,000; 500; 0

● Palliative care group
● Usual care group

-6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6

Days before and after palliative care consultation

Morrison R S et al. Health Aff 2011;30:454-463

HealthAffairs

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Palliative Care Reduces Readmissions

- Mandatory hospital palliative care consultations via standardized triggers halved oncology readmissions
- Discharge to hospice or palliative care associated with a 4-6 fold reduction in readmissions as compared to:
  - home (home health or no home care)
  - nursing home (without palliative care)

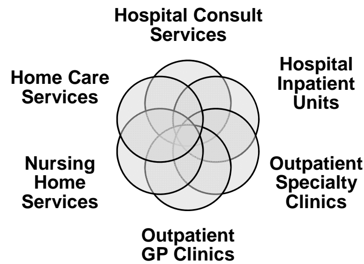
Nelson et al, Perm J, 2011; Enguidanos, JPM 2012, Adelson et al, ASCO 2013

Palliative Care Improves Value

Quality improves
- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- Care matched to patient centered goals

Costs reduced
- Hospital costs decrease
- Need for hospitalization/ICU decreases

Palliative Care Across the Continuum: The Future



Hospitals

- Expected volume: 5-10% of discharges for an average hospital
- Consultation services
  - Interdisciplinary teams:
    - MD, APN ,SW Chaplain
  - Respond to requests/triggers
  - 60 minutes per new consultation/30 min per follow-up
- Co-management services
  - Relatively new
  - Palliative care professional (MD or APN) joins existing specialty team with high volume of serious illness to provide co-management
  - Existing models: oncology, cardiology (VAD), ICU

Hospitals (continued)

- Inpatient units
  - Dedicated (more common) or float beds
  - Typically seen in more mature/larger programs with increased penetration and patient volume
  - Associated with greater costs savings and enhanced patient outcomes as compared to consultation teams
  - However
    - Less opportunity for hospital staff education, integration
    - Difficulty maintaining volume if not an active clinical service
    - Upfront construction costs

Practice Based Models

- Palliative care consultation clinics
  - Interdisciplinary teams
  - Provide co-management of patients with serious illness
  - Early models have been focused primarily on cancer
  - Models in active development in response to ACA
- Palliative care co-management
  - Similar to hospital model
  - Palliative care professionals embedded in specialty practice (e.g., oncology)

Home Care Models

- Open access hospice
  - Provide hospice services to patients who want palliative care but do not meet Medicare eligibility criteria
  - Receive hospice services while simultaneously retaining access to disease-directed medical treatments
  - Limited availability
- Palliative home-based care
  - Interdisciplinary pyramid teams provide patients with an individualized mix of disease-directed and comfort care
  - Focus on transitions from the hospital to home and education and support for patients/caregivers to optimize symptom management, prevent crisis, and keep patients at home
  - Base tends to be payers, home care agencies

Long-Term Care

- Hospice partnerships
  - Associated with decreased use of invasive therapies and hospitalizations, improved pain and symptom management, and higher family satisfaction with care
  - 6 month prognostic requirement is a major barrier
- Palliative care consultation
  - Consultant (MD or APN) provides recommendations to the NH clinicians and bills under Medicare Part B
  - Relies on NH staff to screen for need and implement assessments

Long-Term Care (continued)

- Facility based palliative care teams/units
  - Present in about 25% of nursing homes
  - Demonstrated outcomes include:
    - Improved rates of preference concordant care, enhanced staff satisfaction and reduced turnover, less observed resident discomfort, and lower costs

Summary

- The needs of an aging society demand changes in how we deliver healthcare
- Palliative care impacts on the value of heath care by improving quality
- Better quality reduces need for acute, high cost care
- Palliative care integration in health systems is essential for improved care of the seriously ill