Palliative Care: Transforming the Care of Serious Illness

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No Disclosures
Objectives

➔ The case for integrated palliative care strategies
➔ What works to improve quality and subsequently reduce costs for vulnerable people?
Concentration of Risk/$

Health Spending Is Very Highly Concentrated Among the Highest Spenders

Top 1% of spenders account for 23% of spending
Top 5% of spenders account for 50% of spending

NIHM Foundation analysis of data from the 2012 Medical Expenditure Panel Survey.
Concentration of Risk/$

Leading to Staggering Variation in Mean Per-Capita Spending by Spending Group

<table>
<thead>
<tr>
<th>Population Spending</th>
<th>Mean Annual Expenditure Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottom 50%</td>
<td>$234</td>
</tr>
<tr>
<td>Top 50%</td>
<td>$8,386</td>
</tr>
<tr>
<td>Top 30%</td>
<td>$12,951</td>
</tr>
<tr>
<td>Top 10%</td>
<td>$28,452</td>
</tr>
<tr>
<td>Top 5%</td>
<td>$43,038</td>
</tr>
<tr>
<td>Top 1%</td>
<td>$97,859</td>
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</tbody>
</table>

Percent of Civilian Non-Institutionalized Population Ordered by 2012 Health Care Spending

NIHCM Foundation analysis of data from the 2012 Medical Expenditure Panel Survey.
Value = Quality/Cost

Because of the Concentration of Risk and Spending, and the Impact of Palliative Care on Quality and Cost, its Principles and Practices are Central to Improving Value
Mr. B

- An 88 year old man with dementia admitted via the ED for management of back pain due to prostate cancer, spinal stenosis and arthritis.
- Pain is 8/10 on admission, for which he is taking 5 gm of acetaminophen/day.
- Admitted 3 times in 2 months for pain (2x), falls, and altered mental status due to constipation.
- His family (83 year old wife) is overwhelmed.
Mr. B:

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

➔ Mrs. B: “He hates being in the hospital, but what could I do? The pain was terrible and I couldn’t reach the doctor. I couldn’t even move him myself, so I called the ambulance. It was the only thing I could do.”

Modified from and with thanks to Dave Casarett
Before and After

Usual Care

→ 4 calls to 911 in a 3 month period, leading to
→ 4 ED visits and
→ 3 hospitalizations, leading to
→ Hospital acquired infection
→ Functional decline
→ Family distress

Palliative Care

→ Housecalls referral
→ Pain management
→ 24/7 phone coverage
→ Support for caregiver
→ Meals on Wheels
→ Friendly visitor program
→ No 911 calls, ED visits, or hospitalizations in last 18 months
Half of older Americans visited ED in last month of life and 75% did so in their last 6 months of life.

11% of the costliest 5% of patients were in the last 12 months of life. 40% were in the short-term high cost group, and 49% were in the persistent high cost group.
Who are the costliest 2.5%?

- Functional Limitation
- Frailty
- Dementia
- Exhausted overwhelmed family caregivers
- Social + behavioral health challenges
- +/- Serious illness(es)
Functional Limitations as a Predictor of Risk

Figure 4
Among Medicare enrollees in the top spending quintile, nearly half have chronic conditions and functional limitations.

Distribution of enrollees, by groups of enrollees

- **All Enrollees**
  - Chronic conditions & functional limitations: 48% (15% of total)
  - 3 or more chronic conditions only: 31% (12% of total)
  - 1-2 chronic conditions only: 7% (3% of total)
  - No chronic conditions: 7% (3% of total)

- **Top 20% of Medicare Spenders**
  - Chronic conditions & functional limitations: 41% (46% of total)
  - 3 or more chronic conditions only: 7% (7% of total)
  - 1-2 chronic conditions only: 7% (7% of total)
  - No chronic conditions: 1% (1% of total)

- **Top 5% of Medicare Spenders**
  - Chronic conditions & functional limitations: 32% (61% of total)
  - 3 or more chronic conditions only: 1% (7% of total)
  - 1-2 chronic conditions only: 7% (7% of total)
  - No chronic conditions: 7% (7% of total)

Why? Low Ratio of Social to Health Service Expenditures in U.S.

Home and Community Based Services are High Value

→ Improves quality: Staying home is concordant with people’s goals.

→ Reduces spending: Based on 25 State reports, costs of Home and Community Based LTC Services less than $\frac{1}{3}$ the cost of Nursing Home care.
A study published today in Health Affairs found if all 48 contiguous states increased by 1% the number of elderly who got meals delivered to their homes, it would prevent 1,722 people on Medicaid from needing nursing home care. The Brown University study found 26 states would save money because lower Medicaid costs would more than offset the cost of providing the meals.
What is Palliative Care?

→ Specialized medical care for people with serious illness and their families

→ Focused on improving quality of life. Addresses pain, symptoms, stress of serious illness.

→ Provided by an interdisciplinary team that works with patients, families, and other healthcare professionals to provide an added layer of support.

→ Appropriate at any age, for any diagnosis, at any stage in a serious illness, and provided together with disease treatments.
Conceptual Shift for Palliative Care

Disease-Directed Therapies

Palliative Care

Diagnosis → Time → Death and Bereavement

Medicare Hospice Benefit

Life Prolonging Care

But this

Dx

Death

20
Palliative Care Improves Value

Quality improves
- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- MD satisfaction

Costs reduced
- Hospital cost/day
- Use of hospital, ICU, ED
- 30 day readmissions
- Hospitality mortality
- Labs, imaging, pharmaceuticals
Palliative Care Improves Quality in Office Setting

Randomized trial simultaneous standard cancer care with palliative care co-management from diagnosis versus control group receiving standard cancer care only:

- Improved quality of life
- Reduced major depression
- Reduced ‘aggressiveness’ (less chemo < 14d before death, more likely to get hospice, less likely to be hospitalized in last month)
- **Improved survival** (11.6 mos. vs 8.9 mos., p<0.02)

Palliative Care at Home for the Chronically Ill

Improves Quality, Markedly Reduces Cost

RCT of Service Use Among Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer Patients While Enrolled in a Home Palliative Care Intervention or Receiving Usual Home Care, 1999–2000

KP Study Brumley, R.D. et al. JAGS 2007
46 High Quality Studies 2002-11

Evidence on the cost and cost-effectiveness of palliative care: A literature review

Samantha Smith1
Aoife Brick1
Sinéad O’Hara1
Charles Normand2
46 Studies: Across settings, patient populations, and palliative care delivery models, palliative care improves quality and as a result, reduces costs.

However, despite the wide variation in study type, characteristic and study quality, there are consistent patterns in the results. Palliative care is most frequently found to be less costly relative to comparator groups, and in most cases, the difference in cost is statistically significant. It is also worth noting that there may be complex interactions between costs of care and diagnosis (e.g., cancer/non-cancer distinctions) and groups.
The 5 Key Characteristics of Effective Palliative Care

➔ Target the highest risk people
➔ Ask people what matters most to them
➔ Support family and other caregivers
➔ Expert pain/symptom management
➔ 24/7 access
Goal Setting

→ Ask the person and family, “What is most important to you?”
What is most important?

Survey of Senior Center and Assisted Living subjects, n=357, dementia excluded, no data on function.

Asked to rank order what’s most important:

1\textsuperscript{st} Independence (76\% rank it most important)

2\textsuperscript{nd} Pain and symptom relief

3\textsuperscript{rd} Staying alive.

Fried et al. Arch Int Med 2011;171:1854
Families are Home Alone

➔ 40 billion hours unpaid care/yr by 42 million caregivers worth $450 billion/yr

➔ Providing “skilled” care

➔ Increased risk disease, death, bankruptcy

aarp.org/ppi

http://www.nextstepincare.org/
Families Need Help

➔ Mobilizing long term services and supports in the community is key to helping people stay home and out of hospitals.

➔ Predictors of success: 24/7 meaningful phone access; high-touch consistent personalized care relationships; focus on social & behavioral health; integrate social supports with medical services.

CAPC Center to Advance Palliative Care
Pain and Symptoms

Disabling pain and other symptoms reduce independence and quality of life.
HRS- representative sample of 4703 community dwelling older adults 1994-2006

Pain of moderate or greater severity that is "often troubling" is reported by 46% of older adults in their last 4 months of life and is worst among those with arthritis.

Atul Gawande

Being Mortal

Medicine and What Matters in the End
“I learned about a lot of things in medical school, but mortality wasn’t one of them.”
THE FINALISTS

"Any stiffness?"
Ryan Scott Misener, Tampa, Fla.

"Sorry about the wait."
Bob Howard, Eugene, Ore.

"Any family history with death?"
Stephanie Nilva, New York City
cancer, I thought odd here. Jenny make sure her attention to what her quality of urgent; she was to meet a couple.

She came into the band, looking to the frail geriatric generally see it slender, with a blonde hair, J what I had expected too, was atypical.

She was diagnosed experiencing a time she had a tumor, the diagnosis outside the lung therapy and radiation New York City cancer attack and was managing her too, was atypical.

deep which she and had world, while medical psychology her daughter. With regression of a thought of a not easy each one workable and her own.

‘I Don’t Want Jenny To Think I’m Abandoning Her’: Views On
“I don’t want Jenny to think I’m abandoning her.”

Response to my question asking an oncologist what he hoped to accomplish through intrathecal chemotherapy for a patient with brain metastases from lung cancer.

Meier DE. Health Affairs 2014;33:895-8
Oncologist Offers Intrathecal Chemo (aka most important lesson of my career so far)

- Jenny asks what I think. I tell her I’ll call the oncologist.
- I ask “I don’t have much experience with this procedure. What are you hoping we can accomplish with it?”
- He says “It won’t help her.” Long pause.
- I ask “Do you want me to encourage her to go ahead with it?”
- He says, “I don’t want Jenny to think I am abandoning her.”
Conclusion

➔ Problem?
➔ Lack of Training
➔ Solution?
➔ Training
In Loving Memory
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
5 Recommendations

1. Palliative care everywhere as *standard of practice*

2. and 3. *Required universal* clinician training and certification in palliative care, clinician-patient communication and ACP

4. Policies and payment to *support both medical and social needs*

5. Public education and engagement

How do we work towards the IOM recommendations?

➔ All patients with serious illness should have access to quality palliative care.

➔ To get there we need to:
   – Expand palliative care to home and community care settings
   – Train all clinicians who treat seriously ill patients to provide basic palliative care
We have a lot to do, but, THERE IS REAL PROGRESS
Voices from the 1990’s: Ovarian Cancer and Neuropathic Pain

“I had the most excruciating pain I had ever experienced. The pain medication…did not even begin to penetrate the pain. I thought I was going to die…”

Voices from the 1990’s: Chemo-Induced Neuropathy

“…It felt as if my feet were in too tight ski boots I could not remove. My balance was poor and my feet kept bumping into things. I could not stand for more than 3 or 4 minutes at a time- if I tried my feet ached unbearably. My hands were so numb that if I reached into my purse to get a lipstick, I might come up with a comb or keys instead- I could not tell the difference by feel. My handwriting was so uncontrolled I could not write a marketing list let alone a check or a note…”

“Every day I remind myself that my inner and outer life are based on the labors of other men [and women], living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving.”

Albert Einstein, 1935
The World As I See It
THANK YOU!!