Palliative Care Futurist:
Matching Care to Our Patient's Needs

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No Disclosures
Objectives

→ The case for integrating palliative care into treatment of serious illness
→ What works to improve quality and subsequently reduce costs for vulnerable people?

Concentration of Risk/$
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
The Modern Death Ritual: The Emergency Department

Half of older Americans visited the ED in the last month of their life and 75% did so in their last 6 months of life.


Costliest 5% of Patients


- Last 12 months of life: 49%
- Short term high $: 40%
- Persistent high $: 11%
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

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

Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use File.

Dementia As a Predictor of Risk

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>No Dementia</th>
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</thead>
<tbody>
<tr>
<td>Medicare SNF use</td>
<td>44.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Medicaid NH use</td>
<td>21%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Hospital use</td>
<td>76.2%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Home health use</td>
<td>55.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Transitions</td>
<td>11.2</td>
<td>3.8</td>
</tr>
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</table>

Prospective Cohort of community dwelling older adults

Callahan et al. JAGS 2012;60:813-20.

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


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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 health care 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
**Palliative Care Improves Value**

<table>
<thead>
<tr>
<th>Quality improves</th>
<th>Costs reduced</th>
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<tbody>
<tr>
<td>- Symptoms</td>
<td>- Hospital cost/day</td>
</tr>
<tr>
<td>- Quality of life</td>
<td>- Use of hospital, ICU, ED</td>
</tr>
<tr>
<td>- Length of life</td>
<td>- 30 day readmissions</td>
</tr>
<tr>
<td>- Family satisfaction</td>
<td>- Hospitability mortality</td>
</tr>
<tr>
<td>- Family bereavement outcomes</td>
<td>- Labs, imaging, pharmaceuticals</td>
</tr>
<tr>
<td>- MD satisfaction</td>
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**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
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:

1st Independence (76% rank it most important)

2nd Pain and symptom relief

3rd 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.

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’s *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.'”

Page 1 Metropolitan Books, New York, 2014
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

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

NARRATIVE MATTERS

Health Affairs

‘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
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

In Loving Memory
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

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

Center to Advance Palliative Care™
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Friday, October 21, 2016
Online Clinical Curriculum
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- Case-based, interactive
- Compatible on computers, tablets and smartphones
- Comprehensive reporting on course completions

CAPC Online Curriculum

**Safe + Effective Pain Management**

<table>
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<tr>
<th>Comprehensiv Pain Assessment</th>
<th>Matching the Drug Class to the Pain</th>
<th>Patient Factors Influencing Prescribing</th>
<th>Assessing Risk of Substance Use Disorder</th>
<th>Opioid Trials: Design, Efficacy and Safety</th>
<th>Prescribing an Opioid</th>
<th>Prescribing Short-Acting Opioids: 4 Cases</th>
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<tr>
<td>Monitoring for Efficacy, Side Effects</td>
<td>Substance Use Disorder</td>
<td>Opioid Conversions</td>
<td>Advanced Conversions and Opioid Side Effects</td>
<td>Special Populations and Patient-Controlled Analgesia</td>
<td>Managing Patients at Risk for Substance Use Disorder</td>
<td>Pain Management: Putting it All Together</td>
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**Communication Skills**

- Delivering Serious News
- Discussing Prognosis
- Clarifying Goals of Care
- Advance Care Planning
- Running a Family Meeting
2016 Clinical Curriculum

Symptom Management

<table>
<thead>
<tr>
<th>Symptom Management</th>
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<tbody>
<tr>
<td>Shortness of Breath</td>
<td>Constipation</td>
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Whole-Person Care

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<tbody>
<tr>
<td>Care Coordination</td>
<td>Assessing &amp; Supporting the Family Caregiver</td>
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Disease Trajectories (Coming 4th Q ‘16)

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<tr>
<th>Disease Trajectories (Coming 4th Q ‘16)</th>
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</thead>
<tbody>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
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CAPC Curriculum: Symptom Management
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

CAPC Curriculum: Pain Management

Mike's pain has been well-controlled on oxycodone. By what factor should you reduce his equianalgesic morphine dose?

- 0%
- 25%
- 50%
- 75%

>65,000 total course completions in 14 months → 80% by front line clinicians

“I am loving the course. I have an awesome attending physician that has taught me a lot in the past year regarding pain management - the course is not only reinforcing or clarifying material, but I have also learned new things.”

“The learning format (quizzes throughout the course content) is very effective for me.”

“I liked the layout of the communications courses. To present the situation followed by a question and the rationales for the incorrect answers is an excellent learning strategy”

“Well constructed training program. This is an excellent format and review/learning experience.”
Care gaps in current palliative care delivery models


Palliative care boosts ACO results

By Bob Herman | May 9, 2015

In 2005, Dr. Robert Sawicki and his staff at OSF HealthCare, based in Peoria, Ill., decided they needed to do a better job of caring for terminally ill patients. This was nearly 10 years before the Institute of Medicine’s Dying in America report detailed how patients needlessly suffer in their final days, months and years.

But as leaders at the Catholic-based system explored the issue, they discovered palliative care went far beyond helping patients who were close to death. “We very quickly realized you cannot do good end-of-life care if you wait until the end of life,” said Sawicki, OSF’s senior vice president of supportive care who practices family medicine. “You have to start it way upstream.”

OSF launched a palliative-care program that year, and has since made it an integral part of its accountable care organization structure. The program started at a time when palliative care was in its relative infancy as a medical specialty and was often mistakenly equated with hospice care. As experts in the field like to say.
Community-based Palliative Care; Meeting the Needs of the Seriously Ill

Case Study of ACO-Palliative Care Integration
➔ *Sharp HealthCare in California*

Lots of others, for example:
➔ UnityPoint Health System in Iowa
➔ ProHealth, NY
➔ Banner Health System
➔ OSF System in Illinois
➔ Partners Health System in Massachusetts
➔ @HOMe program in Michigan

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**Sharp Outcomes: Hospital + ED Utilization**

- 57% reduction in ED visits
- 54% reduction in admissions

Total count for discharge HF patients (n=155) 2009-2010
Sharp: Total Cost of Care

Impact of home based palliative care in an ACO

Cassel JB et al. JAGS 2016 Sept 2, epub ahead of print.
Predictors of Impact

Assure inclusion of the model characteristics **consistently linked to success** in these studies:

1. Targeting
2. Goal setting
3. Family and social supports
4. Pain and symptom management
5. Flexible “dosing”

Payers Are Bringing the Care Home
Innovative Payer Toolkit
www.capc.org/payertoolkit

→ Predictors of successful payer-ACO-provider initiatives
→ https://www.capc.org/payers/palliative-care-payer-provider-toolkit/

Treating the person beyond the disease.
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…”

"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!!