Palliative Care & Hospice

David Pratt, MD, MPH

Wednesday, Dec. 7
12:15-1:45 PM

Wm. K. Sanford Town Library

625 Albany Shaker Rd., Albany, NY

Today's Presentation Outline

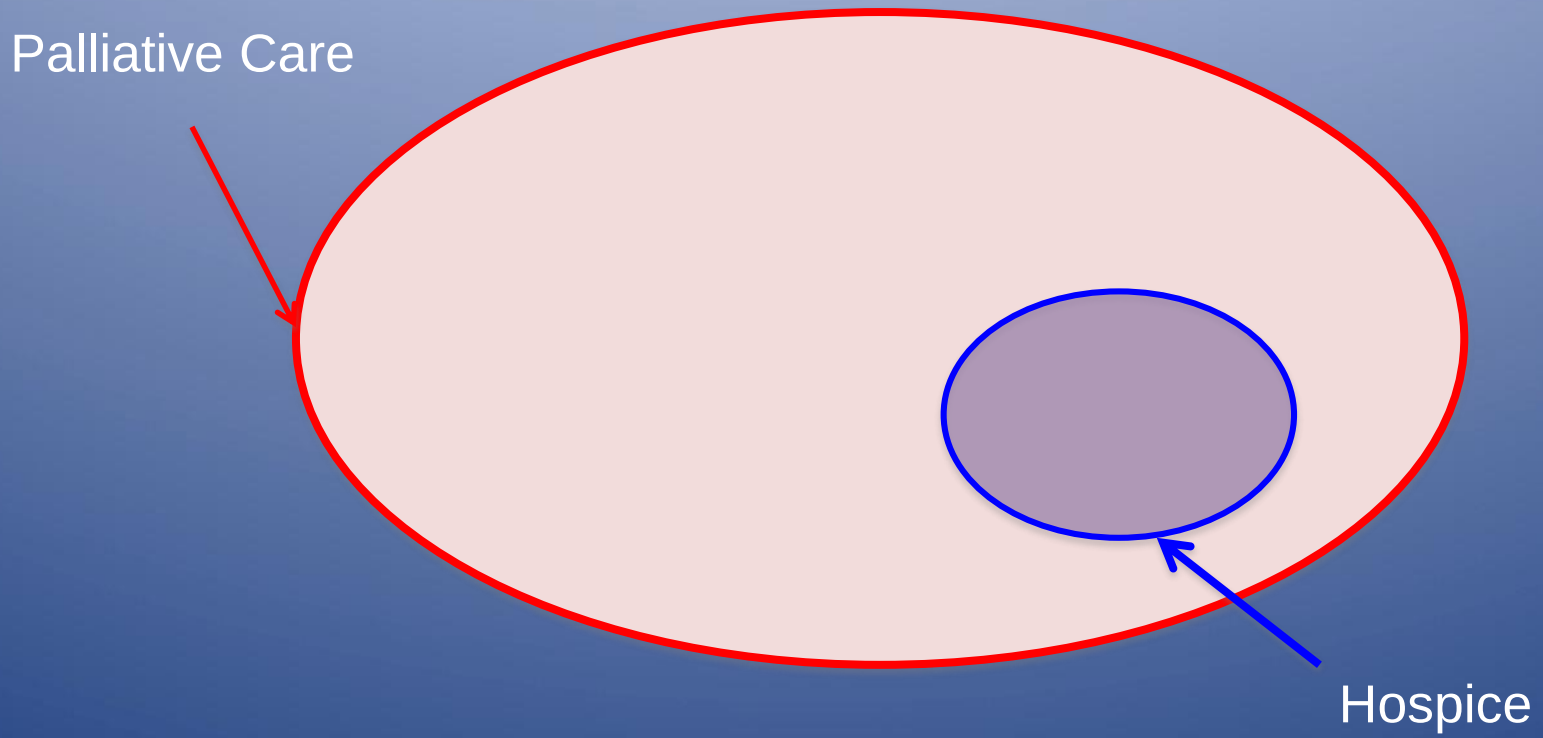
- ✓ Palliative care defined
- ✓ Demography, dollars and reality
- ✓ A (brief) history of palliative care
- ✓ The clinicians' view
- ✓ Efficacy
- ✓ The Benefit
- ✓ Trends
- ✓ Individuals' actions
- ✓ Summary

Palliative Care
(World Health Organization Definition)

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual'

2002

All of Hospice is Palliative Care but not all Palliative Care is Hospice



Venues for Palliative Care

Hospital

Home

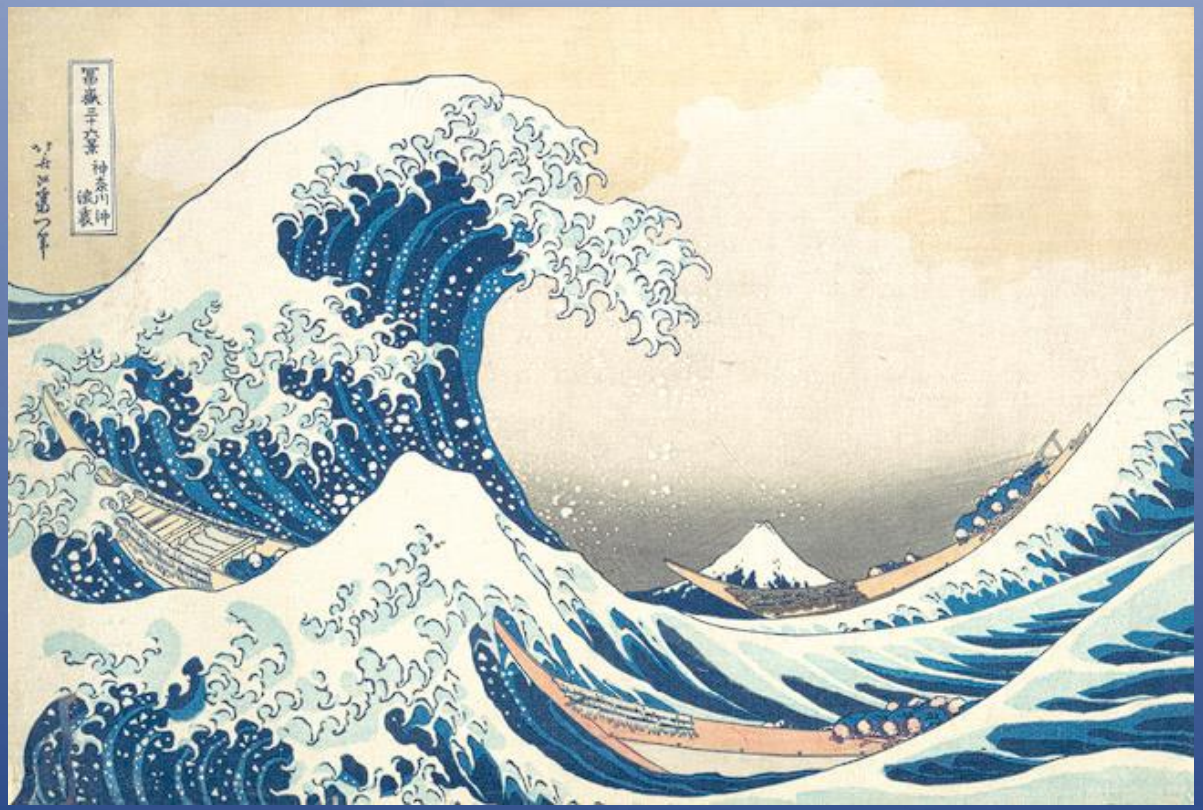
Hospice

Home

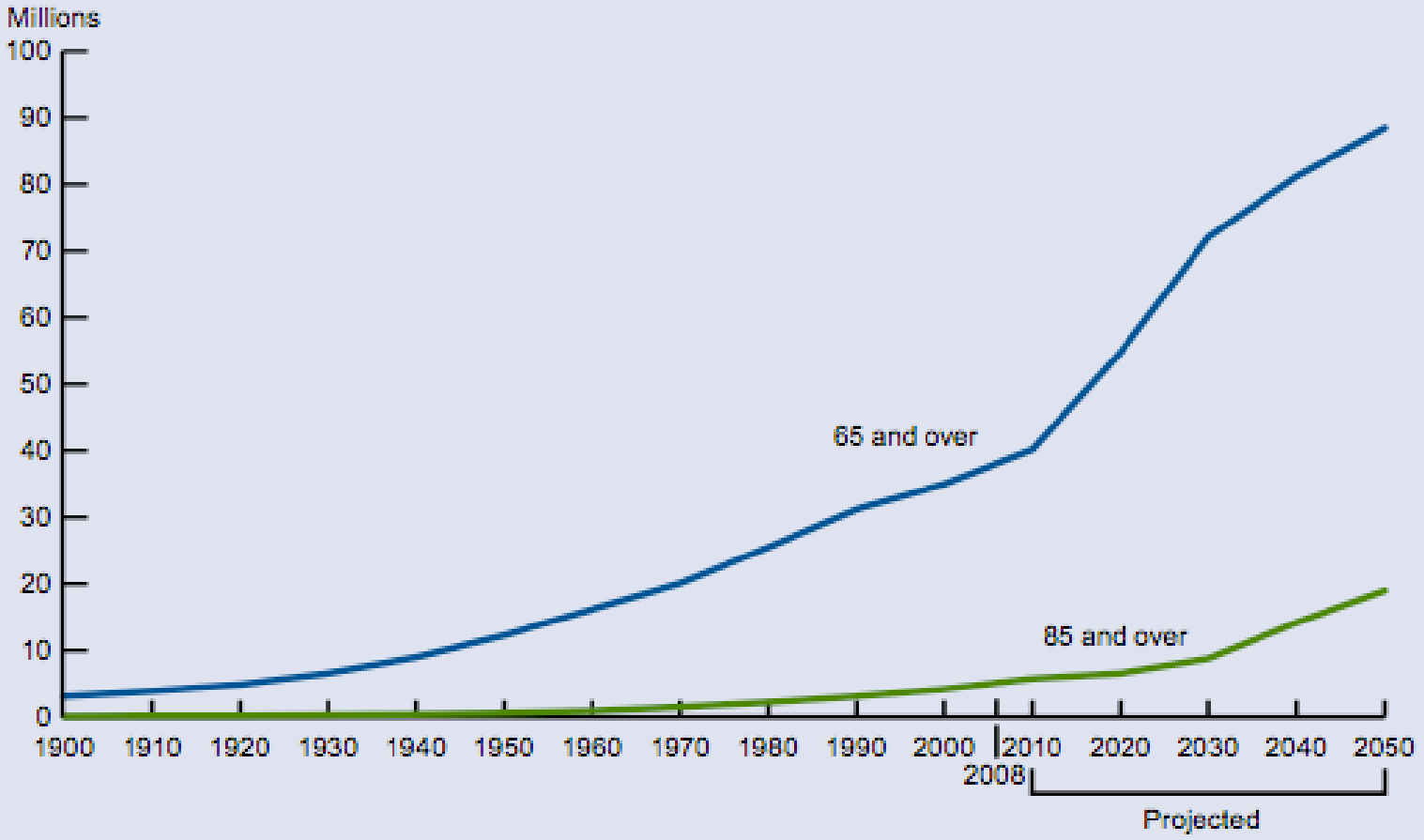
Hospital
or
Community

How Big is the Need?

The Silver Tsunami in America



Population age 65 and over and age 85 and over, selected years 1900–2008 and projected 2010–2050



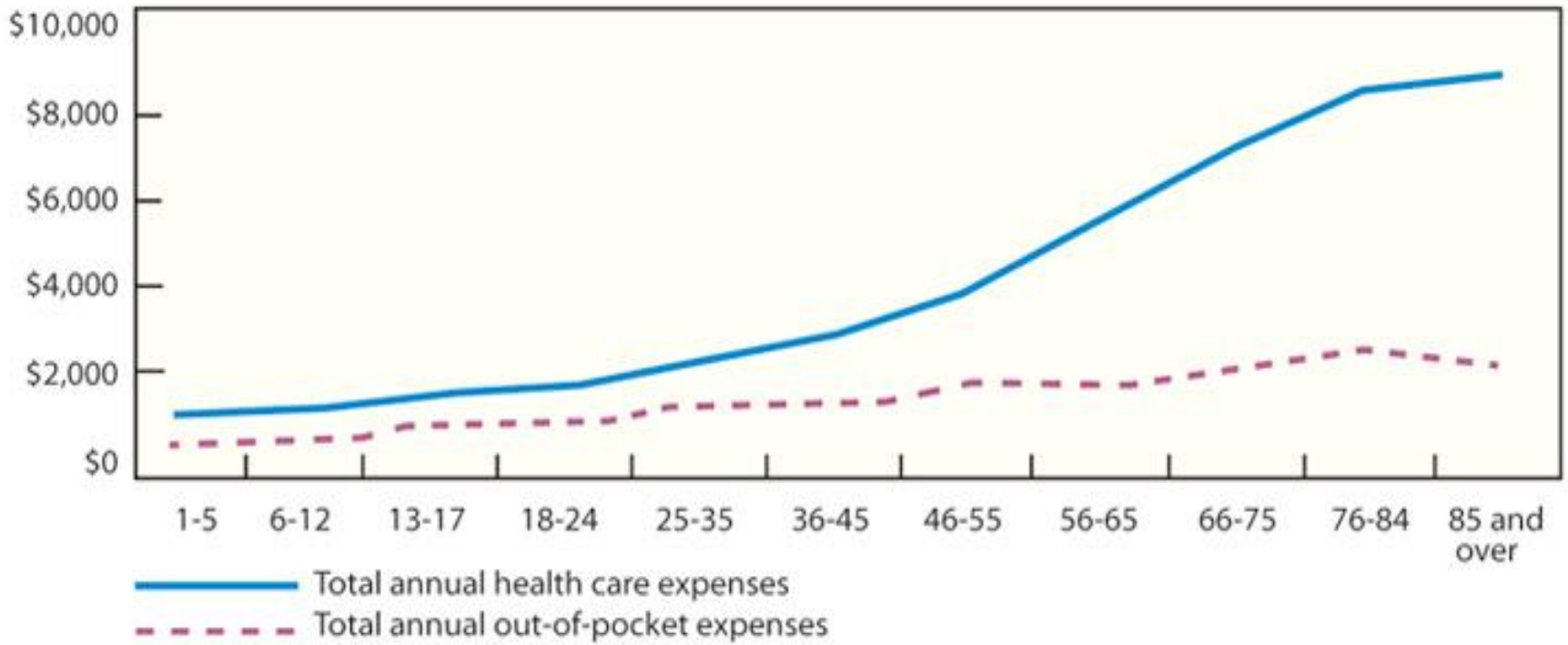
NOTE: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
SOURCE: U.S. Census Bureau, Decennial Census, Population Estimates and Projections.

The Boomers are turning 65 at a rate of 8,000 to 10,000 per day and will do so for 16 additional years.

As We Age We Spend More on Health Care

Figure 3:

A Person's Health Care Spending Increases with Age



Source: U.S. Department of Health and Human Services and Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002.

The Case for Palliative Care

Demography → Demand

Demand → Dollars

This logic explains the growing interest
from the government and
private insurance companies in palliative care

A Snapshot: Dementia and Total Expenditures

- 2010: $215 billion/yr
- By comparison: heart disease $102 billion; cancer $77 billion
- 2040 estimates> $375 billion/yr

Hurd MD et al. NEJM 2013;368:1326-34.

The Decline Ritual: Via the ED and the ICU

- Half of older Americans visited ED in last month of life and 75% did so in their last 6 months of life.
- 90% of ED visits in those >65 due to symptom distress.
- 50% increase in ICU admissions from ED in people >85 years.

Smith AK et al. Health Affairs 2012;31:1277-85.

Pines JM et al. JAGS 2013;61:12-17.

Mullins et al. Acad Emerg Med 2013;20:479-86.

A British estimate is that 65%

of all those who die each year

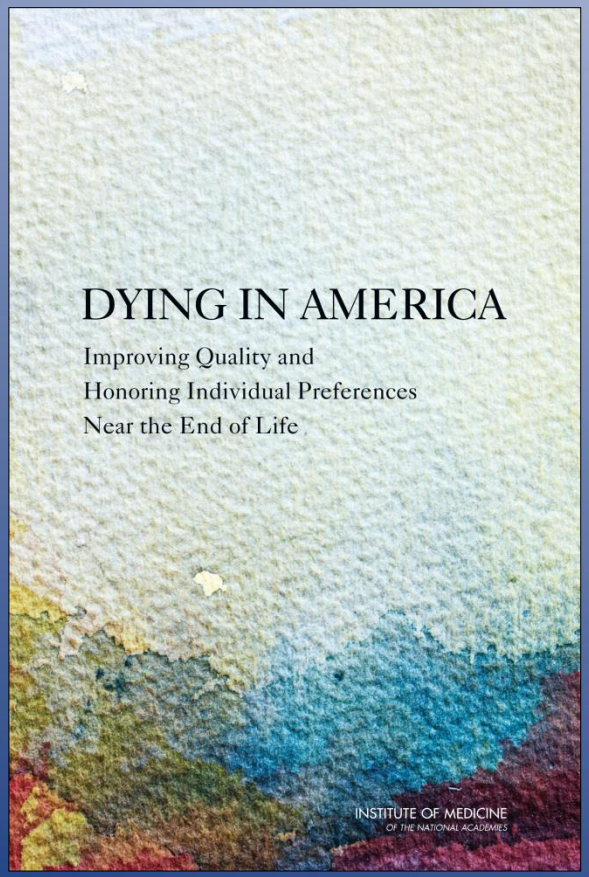
would be better served

if palliative care was involved.

Palliative Medicine 2014, Vol 28(1) 49–58

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

www/iom.edu/endoflife



INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

Key Findings and Recommendations

1. Person-centered, family oriented care – continuum
2. Communication and Advance Care Planning
3. Professional Education and Development
4. Policies and Payment Systems
5. Public Education and Engagement

www.iom.edu/reports

A (brief) Palliative Care History

History of Palliative Care

- Antiquity: caring for each other
- Middle Ages: convents, hostels, hospitality inns - Martigny CH
- Early years of medicine: symptom management, comfort, sitting bedside
- Modern era: treatment and cure over comfort
- Modern Hospice Movement 1970's
  - Dame Cicely Saunders in the United Kingdom

History of Palliative Care

- Hospice in the USA
  - Volunteer Team to provide supportive care for cancer patients, in their homes: late 1970's, early 1980's.
  - Medicare Hospice Benefit: 1980's
    - Non-Cancer diagnoses now more frequent than cancer diagnosis for hospice care.
- Palliative Medicine: recognized specialty for
  - physicians
  - nurse practitioners, nurses
  - Certified Nurse Assistants

How do US Experts Define Palliative Care?

- **Specialized or generalist medical** care for people and their families with serious illness
- Focused on **improving quality of life** as defined by patients and families.
- 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 is provided together with curative and life-prolonging treatments.

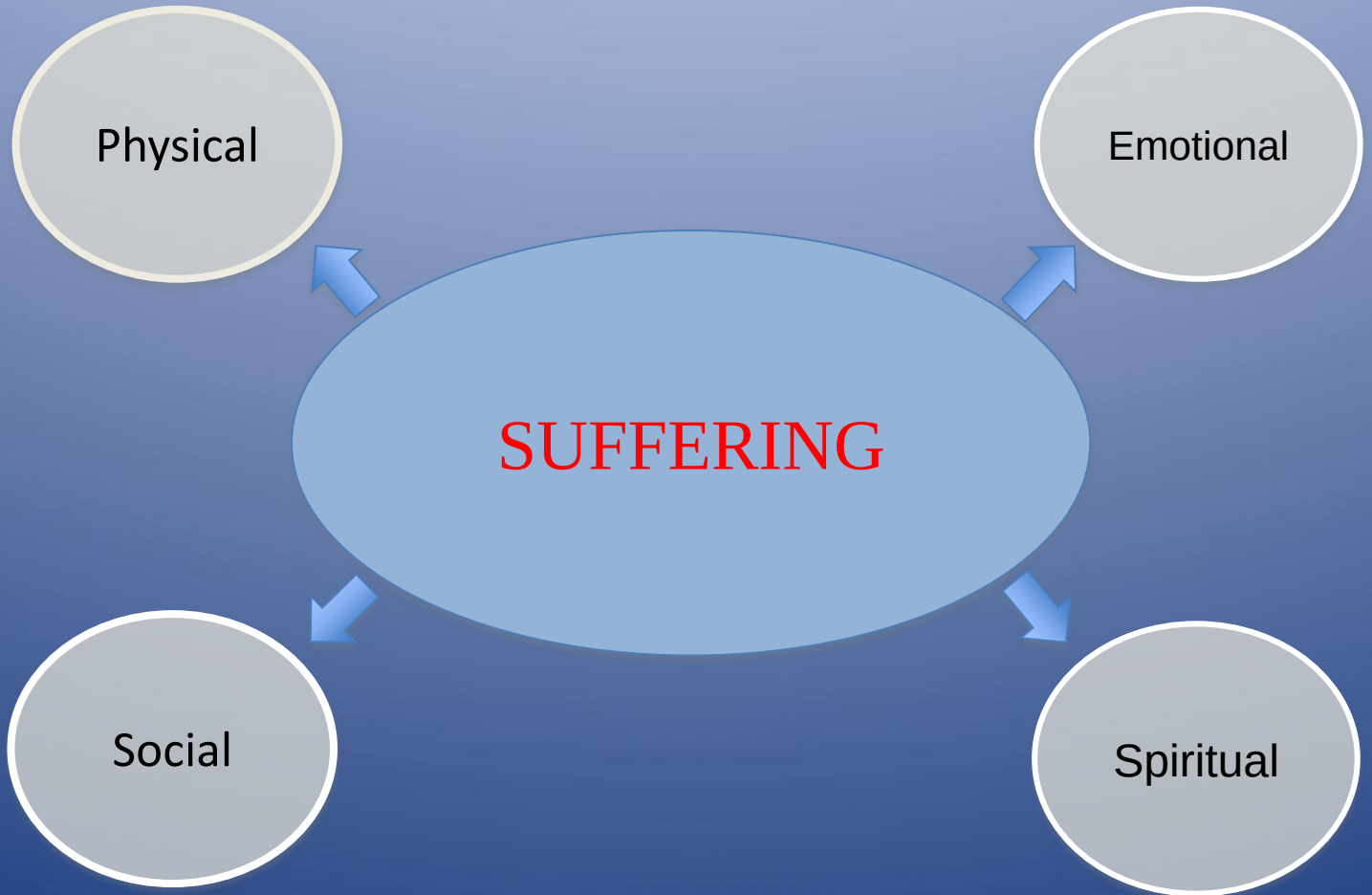
Definition from public opinion survey conducted by ACS CAN and CAPC http://www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf

"Don't ask what's the matter with me. Ask what matters to me."

Palliative Care Teams Address 3 Domains

1. Physical, emotional, and spiritual distress
2. Patient-family-professional communication about achievable goals for care and the decision-making that follows
3. Coordinated, communicated, continuity of care and support for social and practical needs of both patients and families across settings

Some of the Domains of Suffering



The Tools of Palliative Care are Defined by the Goals of that Care

1. The first goal is healing not curing - patient and family

2. Relief of suffering from any source is the daily work

3. The most powerful intervention is presence with compassion

4. The palliative care team steps into the suffering

Does Palliative Care Work?

Randomized Trial of Advance Care Planning Among 309 Elderly

- Hospitalized patients age >80 randomized to ACP by trained facilitator vs. usual care
- 81% received ACP; 56% completed AD
  - Facilitator used "Respecting Patient Choices"
  - ACP in collaboration with physician
  - Families present for 72%
  - Sessions took median 60 minutes

Detering, Br Med J, 2010; 340:c1345

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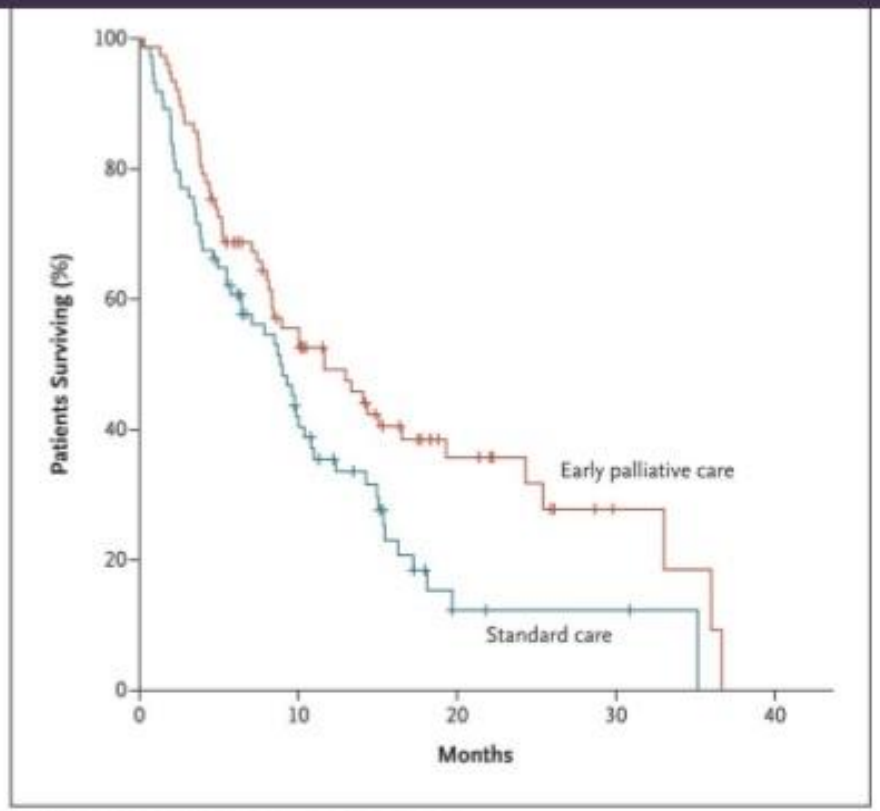
Randomized Trial of Advance Care Planning Among 309 Elderly

Outcome (%)	ACP	Control	p value
Death in ICU	0	14	0.03
PTSD in family	0	14	0.03
Depression in family	0	30	0.002
Anxiety in family	0	19	0.02
Satisfied with death	80	68	0.02
Satisfied with care	93	65	0.001

Detering, Br Med J, 2010; 340:c1345

…Improves Survival



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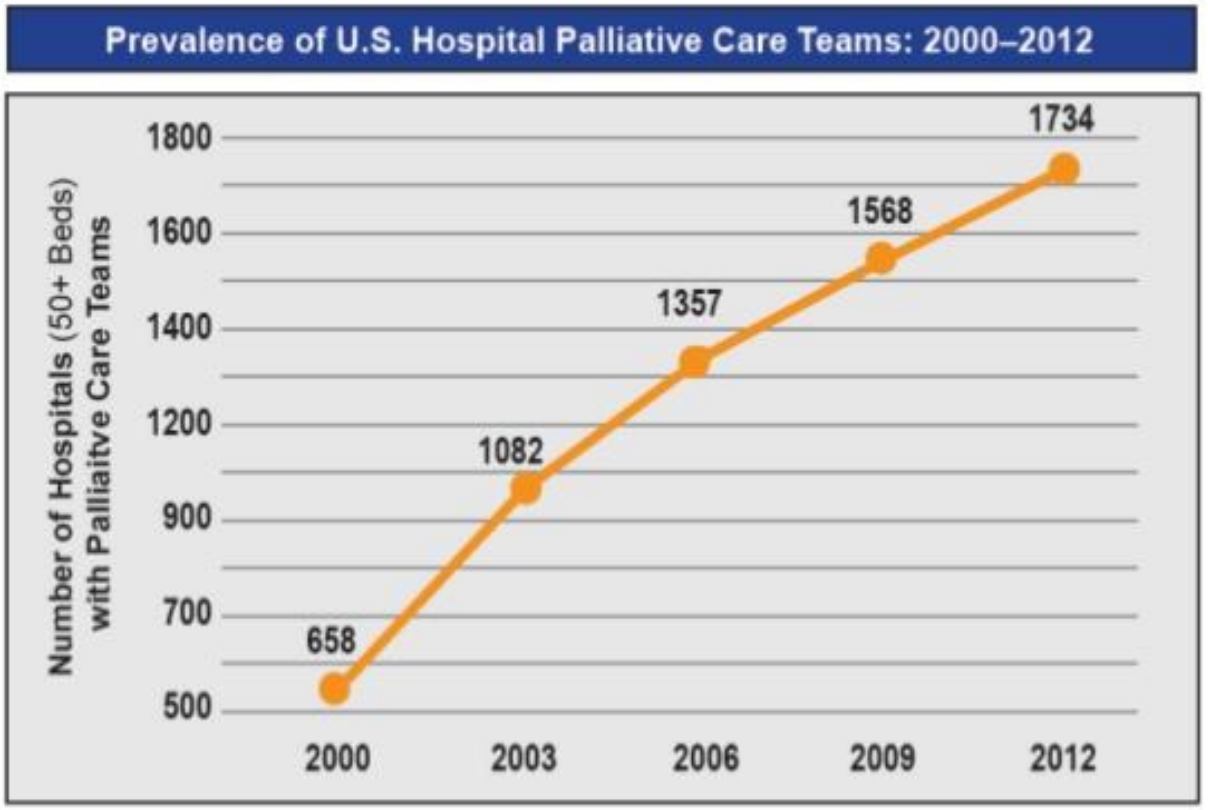
Temel, N Engl J Med, 2010; 363:763

Average number and type of hospital admissions pre- and post-enrollment to *Care Choices*

Hospitalization	Pre M(SD)	Post M(SD)	t	df	p
Emergency Room	1.79(1.46)	1.00(1.08)	4.46	80	0.000***
Inpatient	1.21(1.02)	0.38(0.70)	6.54	80	0.000***

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

Growth of PC Programs Nationally



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The Benefit

Benefits of Palliative Care

- Honors residents' wishes for dignity
- Provides evidence based measures for good symptom management
- Demonstrates partnering and collaboration with:
  - resident, family, staff, and palliative care team
- Provides a common platform to discuss
  - Goals of Care
  - Advanced Directives

Coverage

Many private insurance companies and health maintenance organizations (HMOs) offer palliative care and hospice benefits.

Medicare (mostly for people 65 and older) offers hospice benefits, and the extra Medicare plan (Part B) offers some palliative care benefits. Medicaid coverage of hospice and palliative care for people of limited incomes varies by state.

The trend in palliative care is for more coverage not less.

Medicare Hospice Benefit

- Established in 1982 for high-quality end-of-life care

- Eligibility
  - Medicare Part A
  - Terminal illness (6 months or less if illness runs its natural course)
  - Forgo intensive medical interventions of curative intent
- Benefit Period
  - Two 90 day periods, followed by unlimited 60 day periods
  - Initial certification by two physicians
  - Recertification by hospice physician

How Reimbursement Currently Works

- All-inclusive per diem rate
  - Routine home care**
  - General inpatient care
  - Continuous care
  - Respite care
- Not adjusted for case-mix or NH setting
- Medicare caps aggregate payments

Huskamp HA, et al. Health Affairs 2010; 29(1):130-135 Hospice Care in America. NHPCO Facts and Figures, 2013

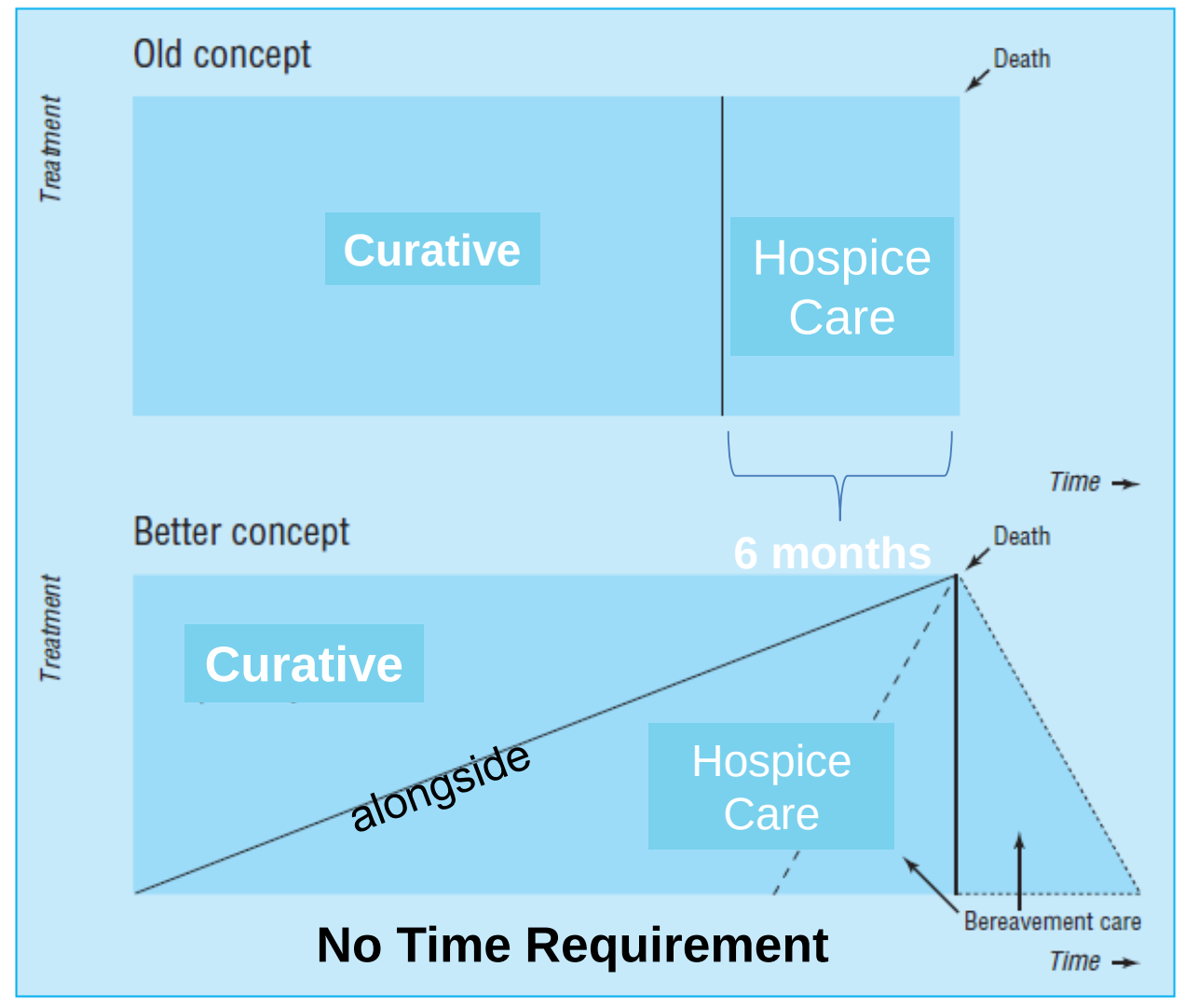
Proposed Changes to Reimbursement

- Move away from flat per diem rate

- Consideration for different payment structure for hospice care in the nursing home (being studied)

Medpac Report to the Congress. Reforming Medicare's Hospice Benefits 2009; Chap 6:347-376

Concurrent Care Demonstration



Persisting Issues with the Hospice Benefit
(after 2015 changes)

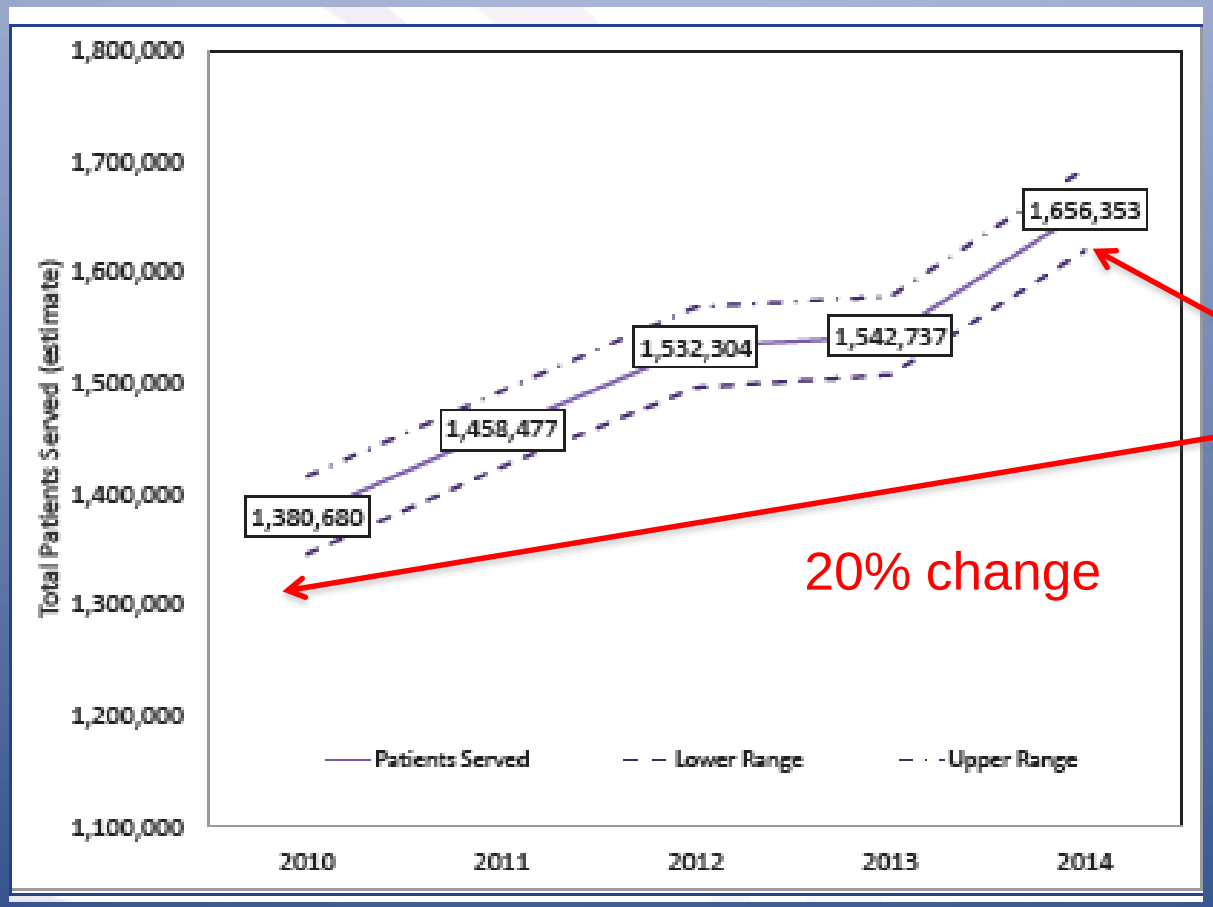
The barriers to care posed by current hospice eligibility Standards (continued chemotherapy)

The exclusion of hospice from Medicare Advantage and other integrated payment models

The poor fit of the current hospice benefit for nursing home residents.

Hospice Trends in the US

Total US Patients Served by Year



NHPCO data 2015

Conditions Associated with Admission to Hospice 2014

Table 6. Percentage of Hospice Admissions by Primary Diagnosis[1]

Primary Diagnosis	2014	2013
Cancer	36.6%	36.5%
Non-Cancer Diagnoses	63.4%	63.5%
Dementia	14.8%	15.2%
Heart Disease	14.7%	13.4%
Lung Disease	9.3%	9.9%
Other	8.3%	6.9%
Stroke or Coma	6.4%	5.2%
Kidney Disease (ESRD)	3.0%	3.0%
Liver Disease	2.3%	2.1%
Non-ALS Motor Neuron	2.1%	1.8%
Debility Unspecified	1.9%	5.4%
Amyotrophic Lateral Sclerosis (ALS)	0.4%	0.4%
HIV / AIDS	0.2%	0.2%

Patients' Average Time on Hospice Service

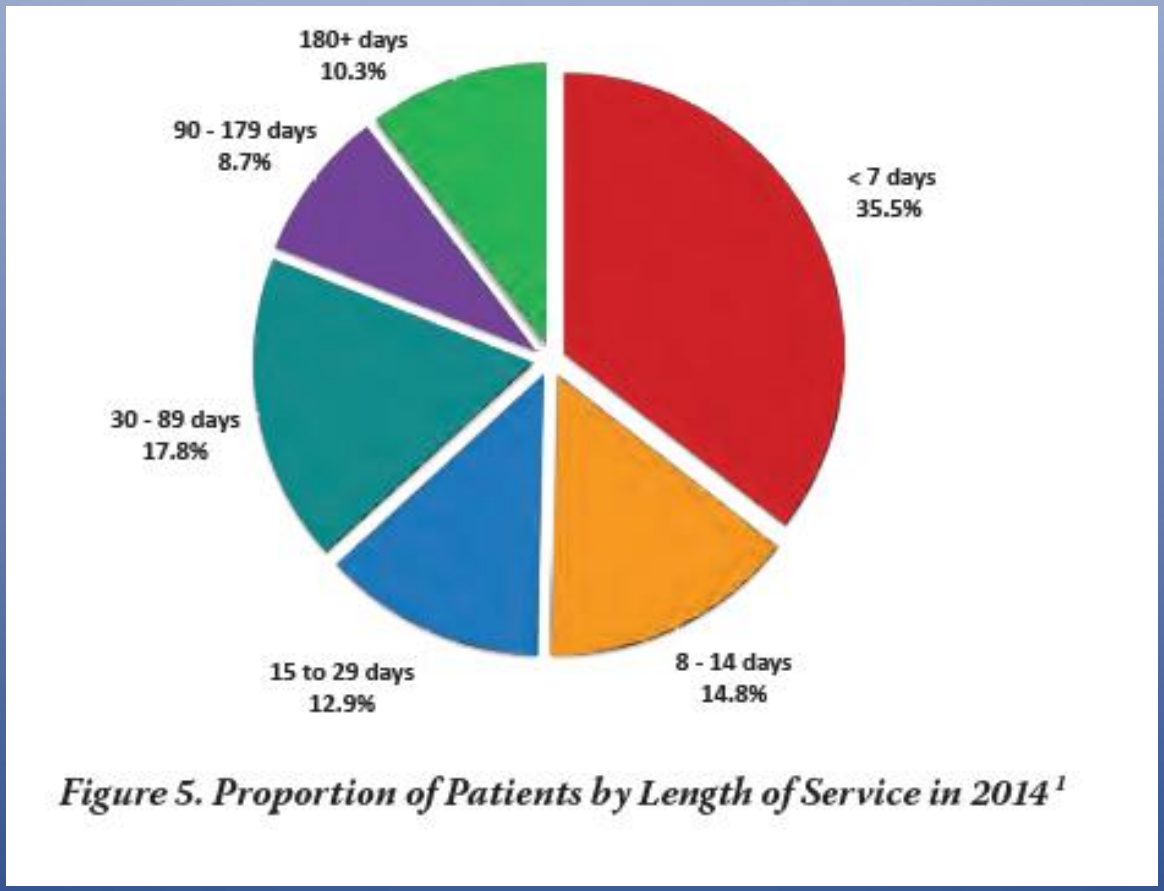
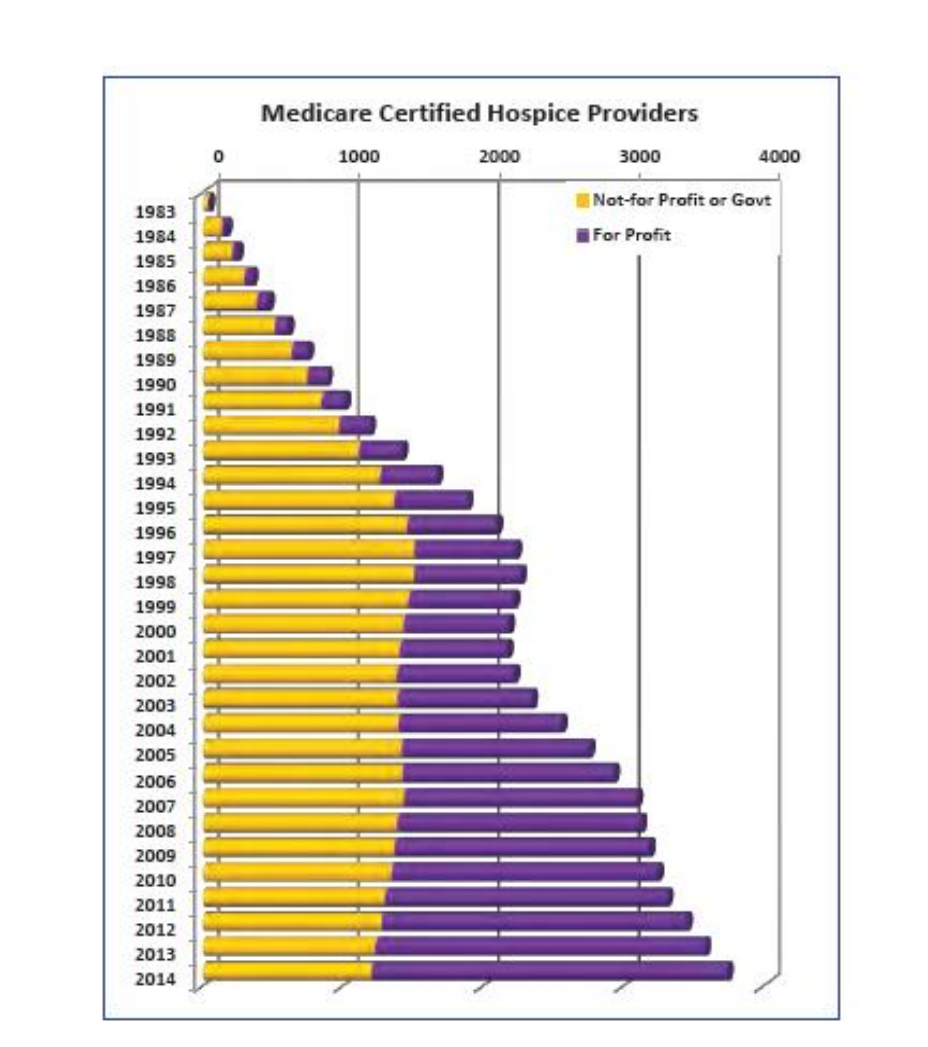


Figure 5. Proportion of Patients by Length of Service in 2014 [1]

The Shifting Trend Towards for Profit Hospice Centers



Who Pays for Hospice Care?

Table 9. Percentage of Patients Served by Payer[1]

Payer	2014	2013
Medicare Hospice Benefit	85.5%	87.2%
Managed Care or Private Insurance	6.9%	6.2%
Medicaid Hospice Benefit	5.0%	3.8%
Uncompensated or Charity Care	0.7%	0.9%
Self Pay	0.8%	0.8%
Other Payment Source	1.2%	1.2%

Certified Hospice Programs by State 2014

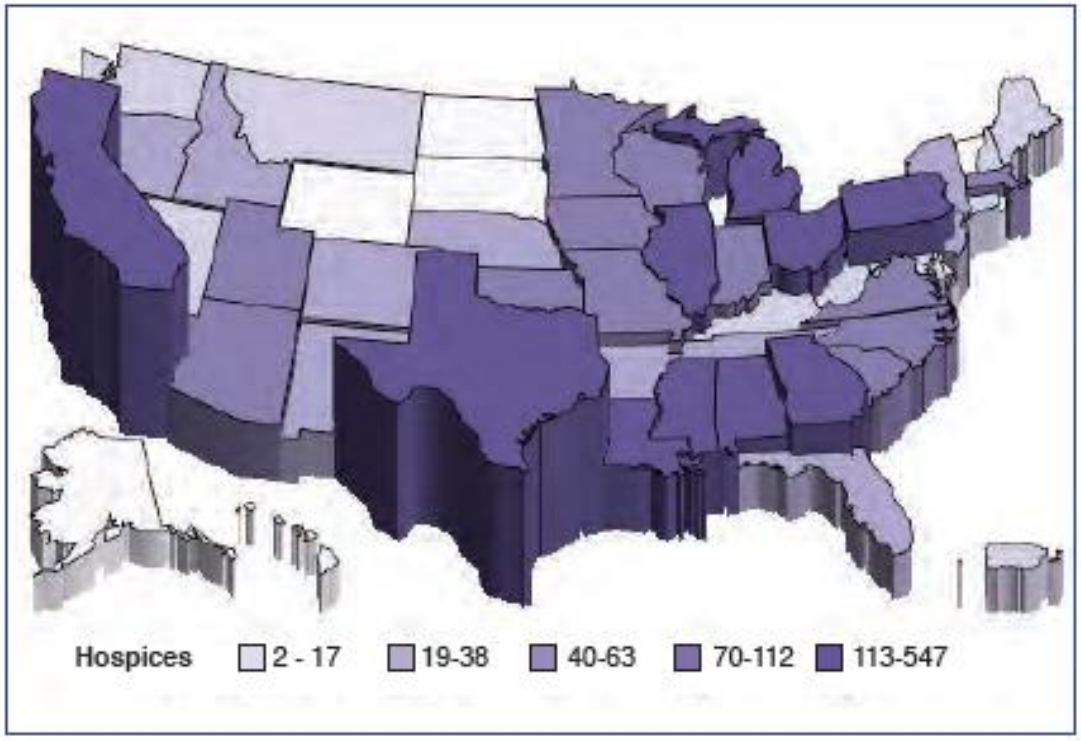
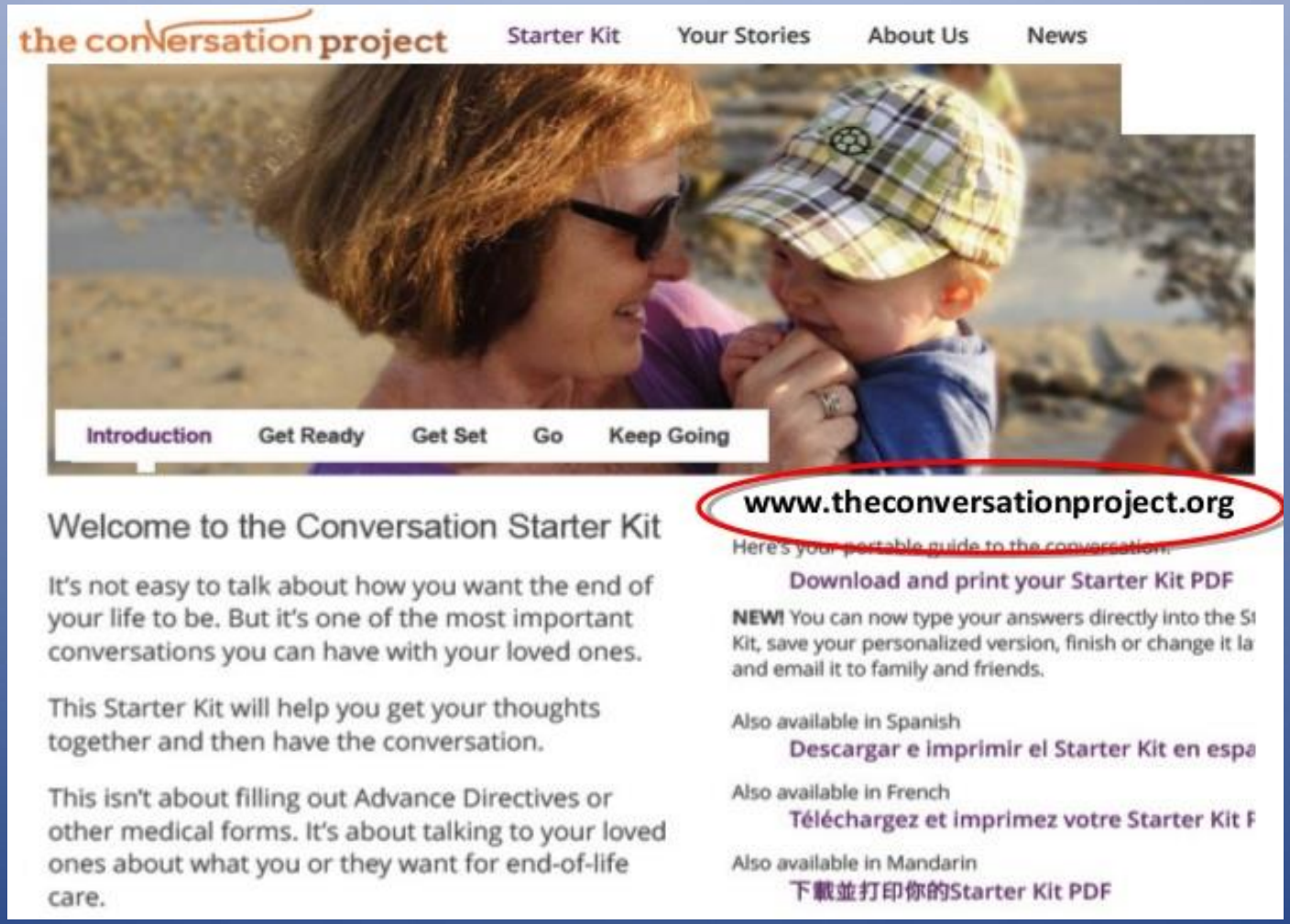


Figure 9. Medicare-Certified Hospices by State [2]

Individual’s Responsibility

What can people do to ensure they receive the care they want?

- Advance Directives
  - Living will
  - Durable Power of Attorney for Health Care
  - Physician Order for Life-sustaining Treatments (POLST)
- Advance Care Planning
  - Communication with family and doctors about goals, values, and preferences


the conversation project
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Introduction
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Get Set
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Keep Going
www.theconversationproject.org
Welcome to the Conversation Starter Kit
It's not easy to talk about how you want the end of your life to be. But it's one of the most important conversations you can have with your loved ones.
This Starter Kit will help you get your thoughts together and then have the conversation.
This isn't about filling out Advance Directives or other medical forms. It's about talking to your loved ones about what you or they want for end-of-life care.
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NEW! You can now type your answers directly into the S
Kit, save your personalized version, finish or change it la
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What are advance directives good for?

- As a tool for raising the discussion
- Good for some specific situations:
  - If there is a specific treatment you know you don't want
  - If you don't want your legal next of kin to be making decisions for you
- Advance directives can ease the burden on your family

Preparing for a Discussion About End-of-life Care with Your Doctor

- Advance preparations
  - Who should be there?
  - What do you want to know?
  - Bring in your documents
- Think about the things you might want
  - Specific treatments you don't want
  - Aspects of health important to you: independence, ability to communicate
  - Consider adaptation

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Understanding the Discomfort

- Discomfort discussing dying is universal
  - Patient and family fears
  - Clinician fears and concerns of inadequacy
- Recognizing the discomfort can help us work through it
  - Consider talking about the discomfort with the doctor

Communication With Patients: Competencies

- Listens to patients
- Encourages questions from the patient
- Talks with patients in an honest and straightforward way
- Gives bad news in a sensitive way
- Willing to talk about dying
- Sensitive to when patients are ready to talk about death

Curtis, J Gen Intern Med, 2000;16:41

Thanks to:

J Randall Curtis, MD, MPH
Cambia Medical Center University of Washington

Diane Meier, MD Professor of Geriatrics
Director of CAPC

Phil DiSorbo MSW Care Choices

George Giokas, MD Community Hospice

Center to Advance Palliative Care (CAPC)

Begin doing what you want to do *now*.

We are not living in eternity.

We have only *this* moment, sparkling like a star in our hand--and melting like a snowflake.

Francis Bacon