The Impact of Palliative Care Integration on Healthcare's Value Equation

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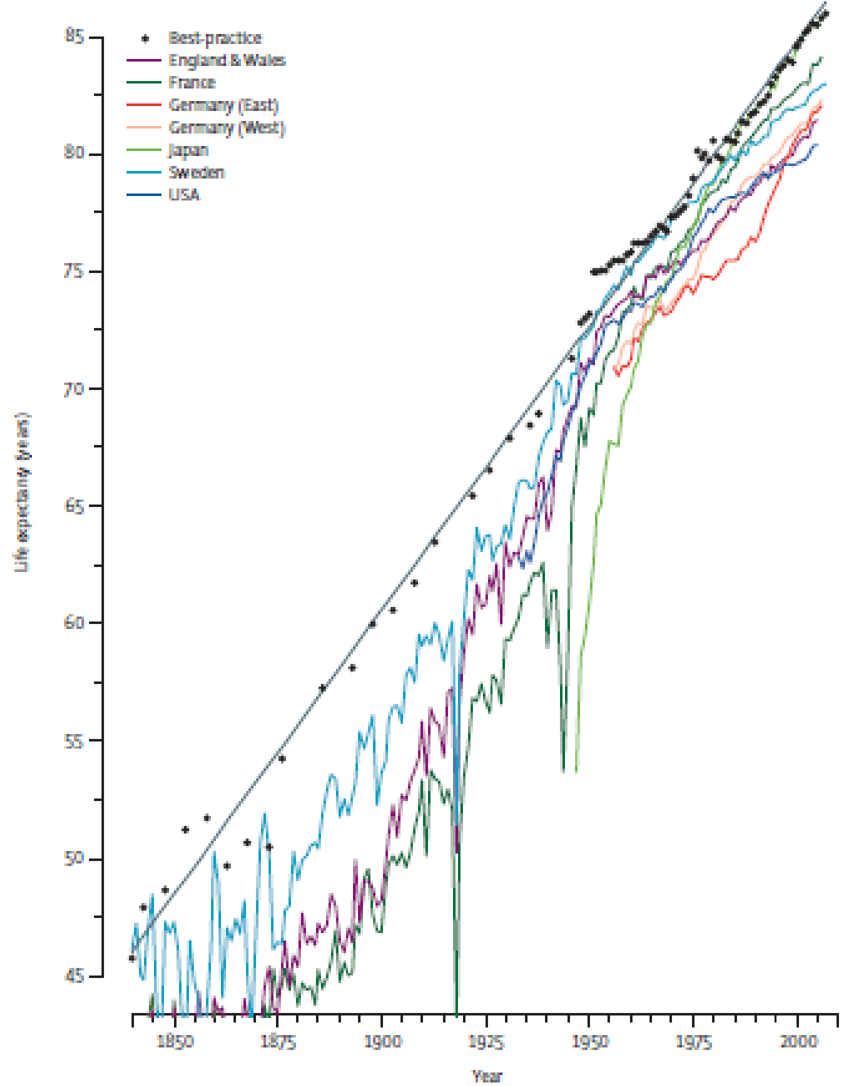
Objectives

- New realities in aging, multimorbidity and complexity in the U.S
- The value equation in the context of these new realities
- The role of palliative care in complexity care
- Case studies of palliative care in integrated healthcare models

Population Aging



- Best practice life expectancy (the highest value recorded in a national population) has increased 3 mo/yr since 1840

Christensen K et al Lancet 2009;374:1196

Population Aging

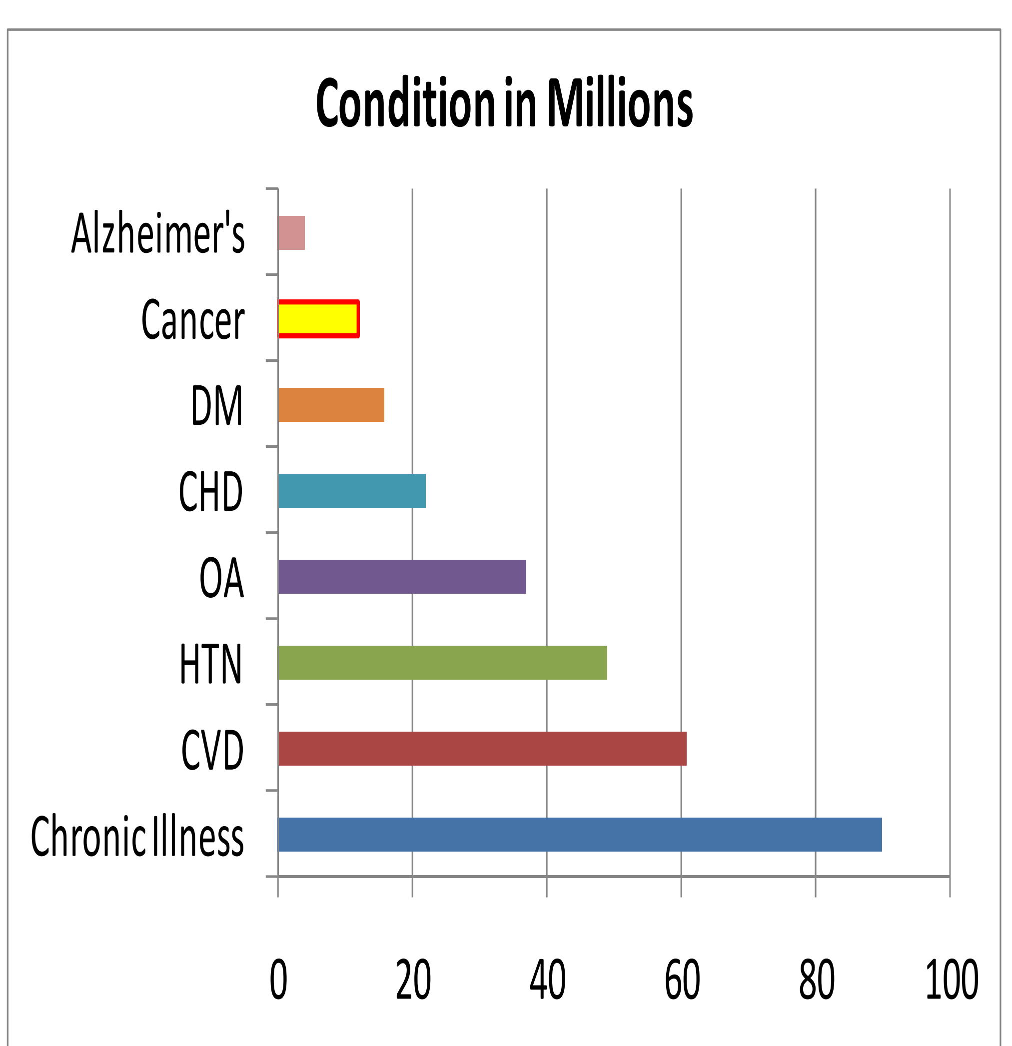
	1850-1900 (%)	1900-25 (%)	1925-50 (%)	1950-75 (%)	1975-90 (%)	1990-2007 (%)
0-14 yrs	**62.13**	**54.75**	30.99	29.72	11.20	5.93
15-49 yrs	**29.09**	**31.55**	37.64	17.70	6.47	4.67
50-64 yrs	5.34	9.32	18.67	16.27	24.29	10.67
65-79 yrs	3.17	4.44	12.72	28.24	**40.57**	**37.22**
>80 yrs	0.27	-0.06	-0.03	8.07	**17.47**	**41.51**

Age-specific contributions to increase in record life expectancy in women*

- Life expectancy initially related to decreases in infant mortality
- Since the 50’s, mortality rates for 80+ has continued to fall

Christensen K et al Lancet 2009;374: 1196

Growth of Chronic Illness

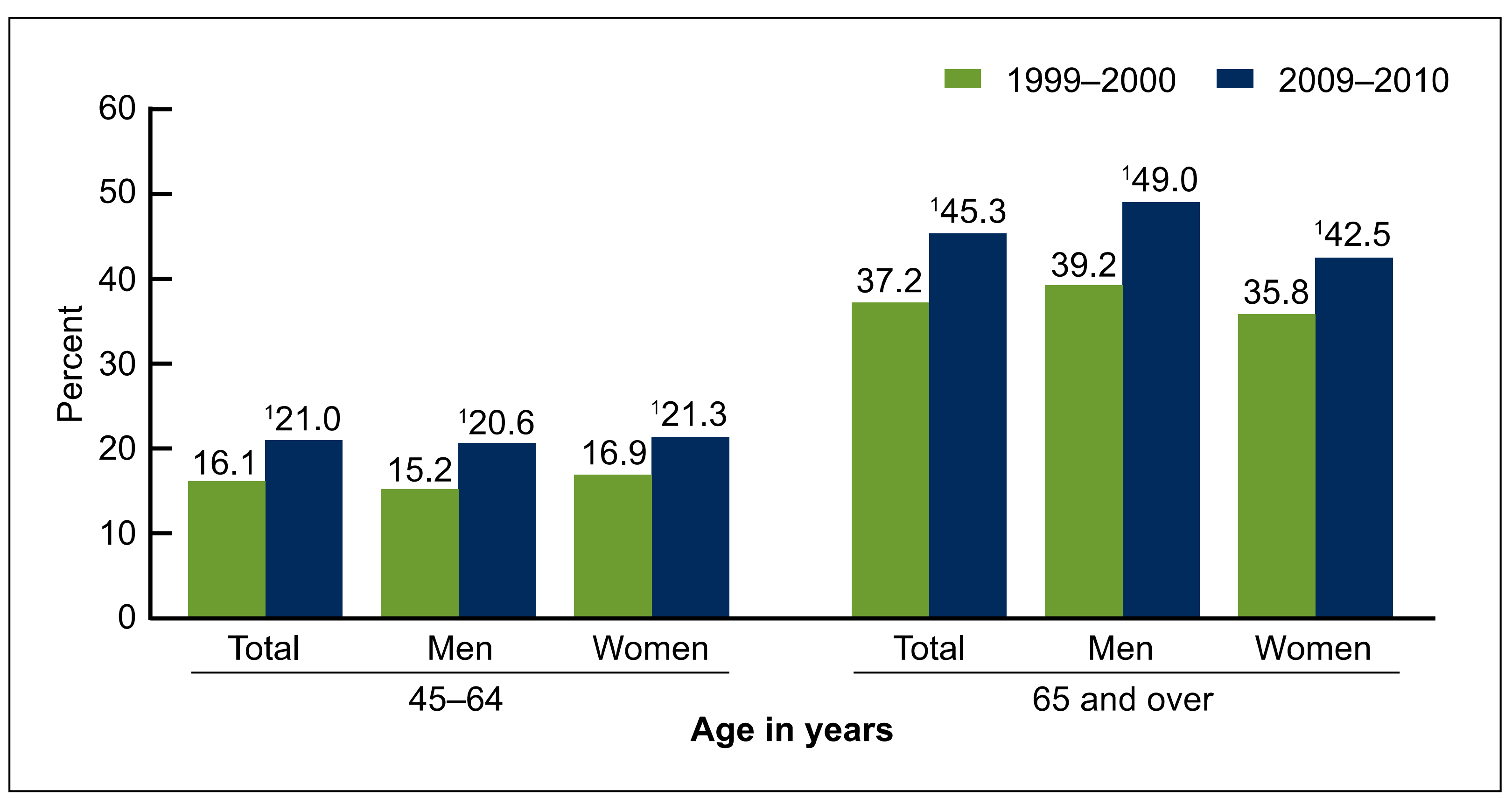


Disease	Prevalence Estimate
Chronic Illness	1 in 3
CVD	1 in 4
HTN	1 in 5
Arthritis	1 in 7
Osteoporosis	1 in 9
DM	1 in 12
CHD	1 in 17
COPD	1 in 20
Kidney Disease	1 in 26
Cancer	1 in 30
Alzheimer's	1 in 68

Source: Centers for Disease Control; NHLBI, NIAMS

Growth in Multimorbidity

Figure 1. Prevalence of two or more of nine selected chronic conditions among adults aged 45 and over, by age and sex: United States, 1999–2000 and 2009–2010



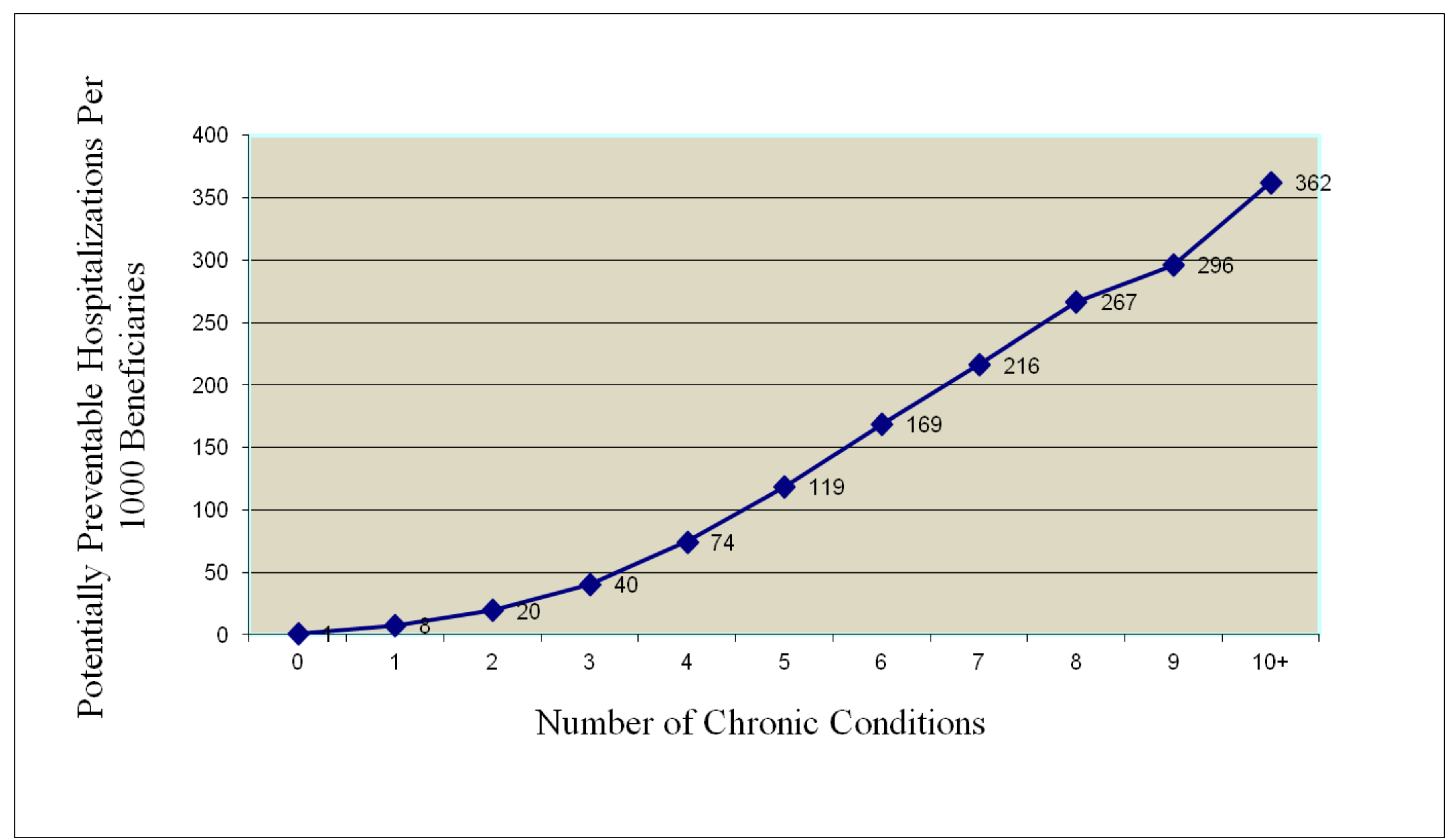
[1]Significantly different from 1999–2000, $p < 0.05$.

NOTE: Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db100_tables.pdf#1.

SOURCE: CDC/NCHS, National Health Interview Survey.

Fried VM et al. NCHS Data Brief; #10. July 2012

Impact of Multimorbidity on Hospitalization



Wolff, J. NIA Comorbidity Conference, 2005

Multimorbidity: Medicare Expenditures

Number of Chronic Conditions	Mean Medicare Expenditures Per Beneficiary
0	$211
1	$1,015
2	$1,870
3	$3,204
4	$5,246
5	$8,159
6	$11,948
7+	$23,825

Wolff JL, Starfield B, Anderson G. *Arch Intern Med.* 2002;162:2269-2276

Other Indicators of “Complexity”

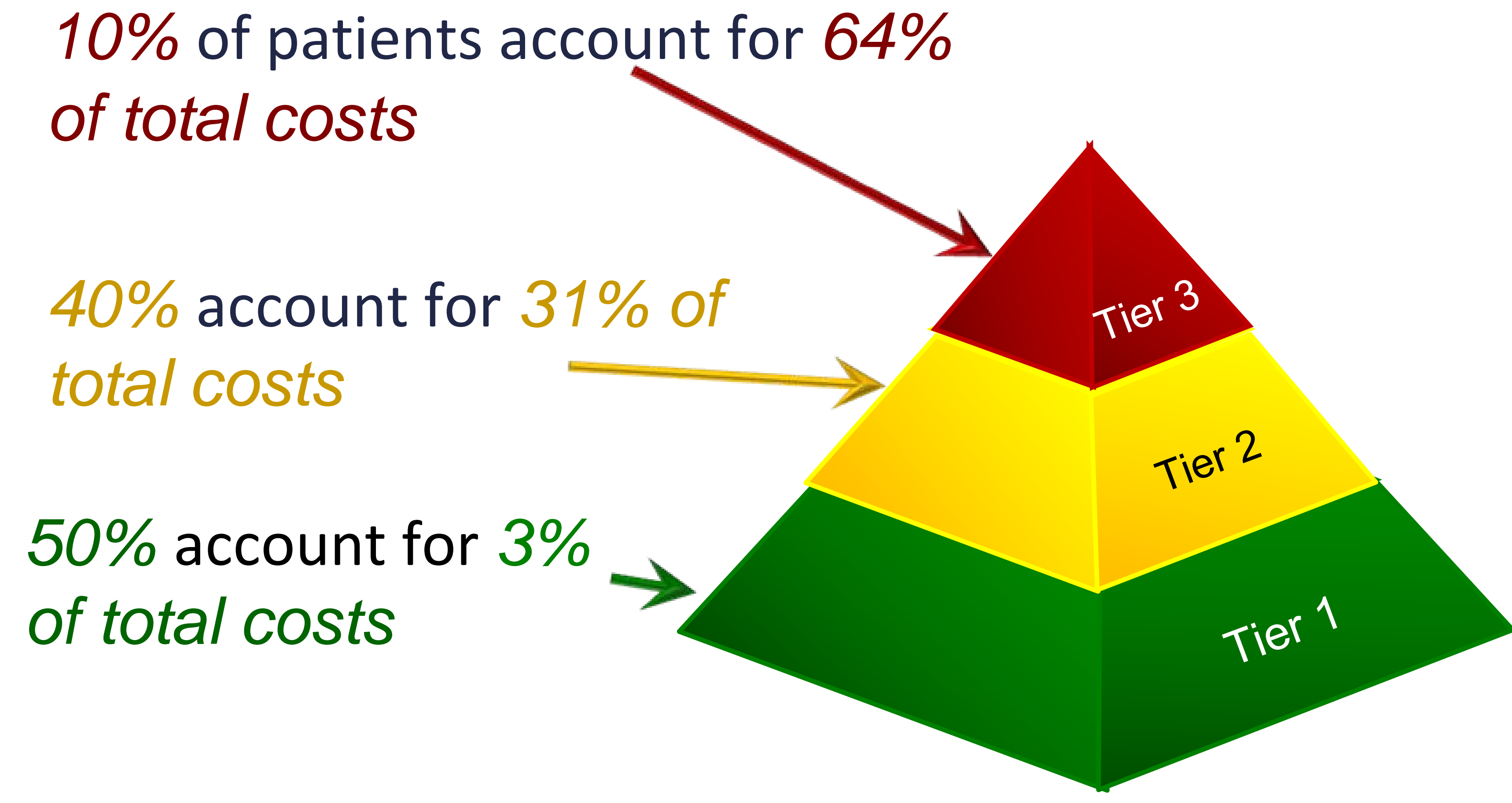
CHD + Diseases		CHD + Clinical Factors		CHD + Health Status Factors	
Art	1.36	> 4 Rx meds	**3.15**	Mobility difficulty	**2.05**
Art + DM	**2.33**	> 4 Rx meds + dizzy or falls or falls + incontinence	**4.65**	Mobility difficulty + hearing impair	2.11
Art + CLRT	1.48	> 4 Rx meds + incont	**3.51**	Hearing impair	1.03
Art + CHF	**2.20**	Incontinence	1.11	Mobility difficulty + visual impair	**3.24**
DM	**1.72**	> 4 Rx meds + low GFR + incont	**4.44**	Visual impair	1.58

Courtesy of Weiss, Boyd, Wolff, Leff

Chronic Serious Illness

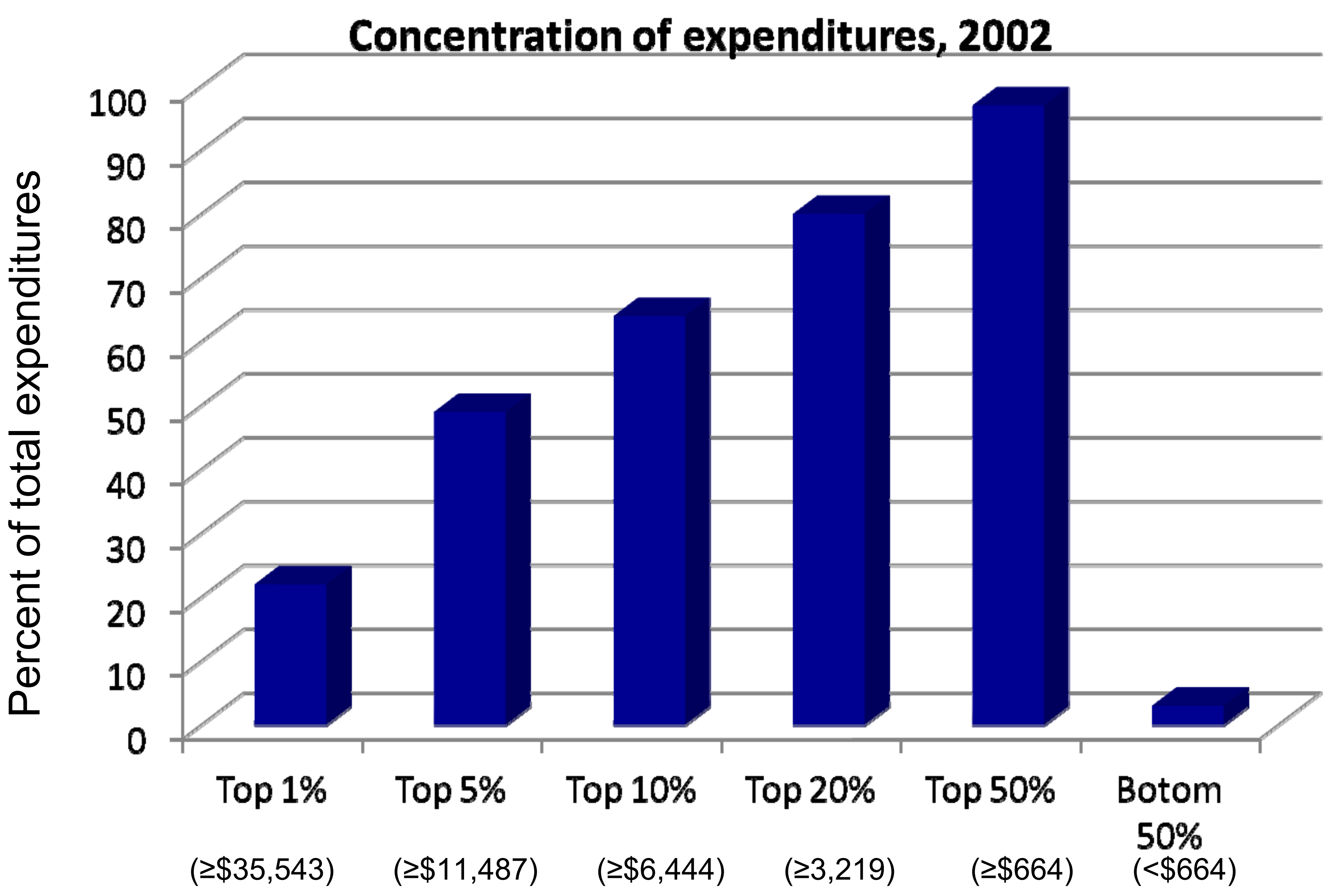
- Longer survival with advanced disease
- High illness and symptom burden
- Management complexity increased
  - Patient/caregiver fatigue
  - Ongoing financial stressors from serious illness
  - Multiple providers
  - Dynamic goals and treatment preferences
  - Conflicting/interacting treatment regimens

Illness, complexity and cost



Conwell LJ, Cohen JW. *Statistical Brief* #73. March 2005.
Agency for Healthcare Research and Quality

Illness, complexity and cost



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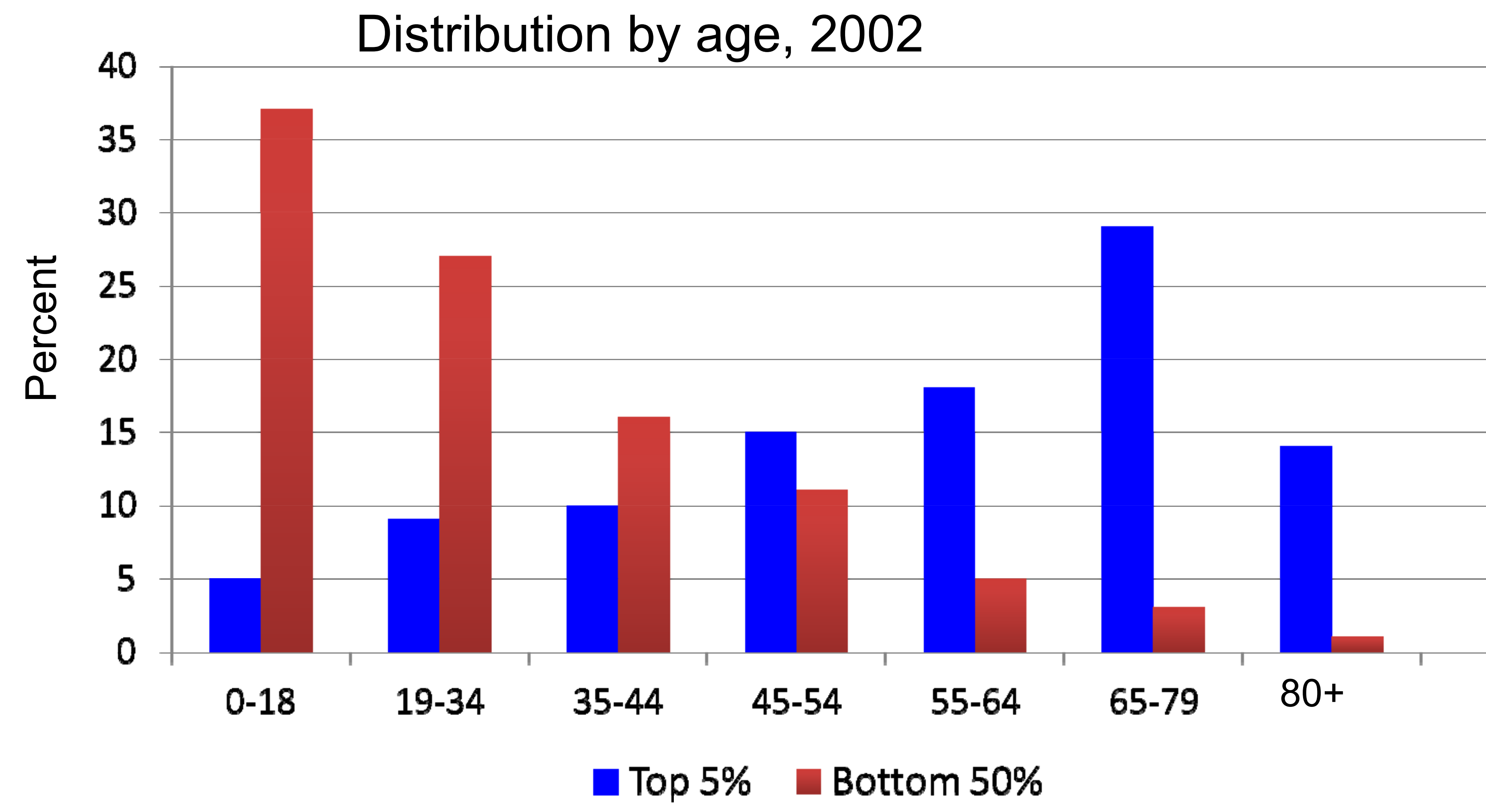
Illness, complexity and cost



Conwell LJ, Cohen JW. *Statistical Brief* #73. March 2005.
Agency for Healthcare Research and Quality

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

The value equation…

What does this mean for the seriously ill with complex care needs?

Quality: What Do Patients with chronic Serious Illness Want?

- To have trust and confidence in the doctors looking after you
- Not to be kept alive on life support when little hope for a meaningful recovery
- Information about one's disease communicated to you by your doctor in a honest manner

Heyland DK et al. CMAJ 2006;174:5

Quality: What Do Patients with chronic Serious Illness Want?

- To complete things and prepare for life's end
- To not be a physical/emotional burden to family
- Upon discharge, have an adequate plan of care
- To have relief of symptoms

Heyland DK et al. CMAJ 2006;174:5

And What They Get …

Mortality follow-back survey of family members or other knowledgeable informants representing 1578 decedents

Not enough …

contact with physician:	78%
emotional support (pt):	51%
information about the dying process:	50%
emotional support (family):	38%
help with pain/dyspnea:	19%

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

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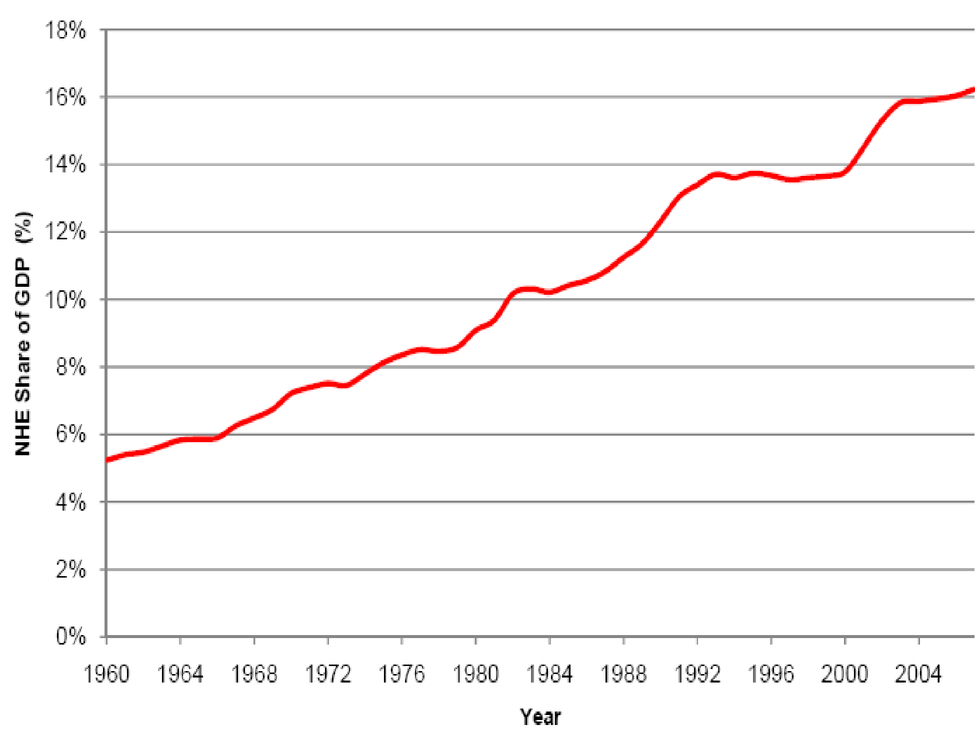
BALDWIN
WAITING ROOM
THANK YOU FOR SUFFERING IN SILENCE

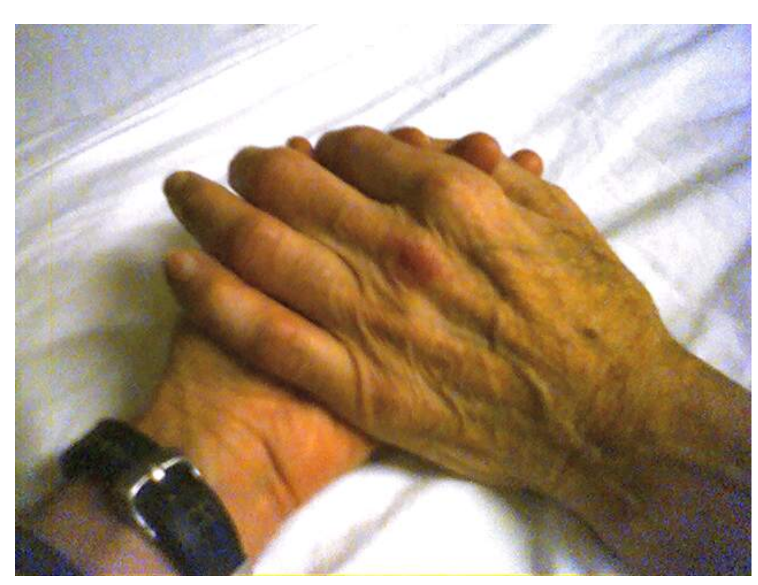
Cost

- Health premiums for workers have risen 114 percent in the last decade.
- U.S. spending 17% GDP, >$7,000 per capita/yr
- Despite high spending, 15% of our population has no insurance
- Lack of health coverage contributes to at least 45,000 preventable deaths/year.



Welper et al. AmJPH 2009, www.cfr.org

How does palliative care contribute to the value equation in chronic serious illness?



Palliative Care

- Specialized medical care by a team of doctors, nurses and specialists for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.

- The goal is to improve quality of life for both the patient and the family.

- Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Palliative care is about *matching treatment to patient goals*.

http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc

Palliative Care Hits the High Notes

Better health. Better care. Lower cost.

Key Messages:

Palliative care sees the person beyond the cancer treatment.

Palliative care is all about treating the patient as well as the disease.

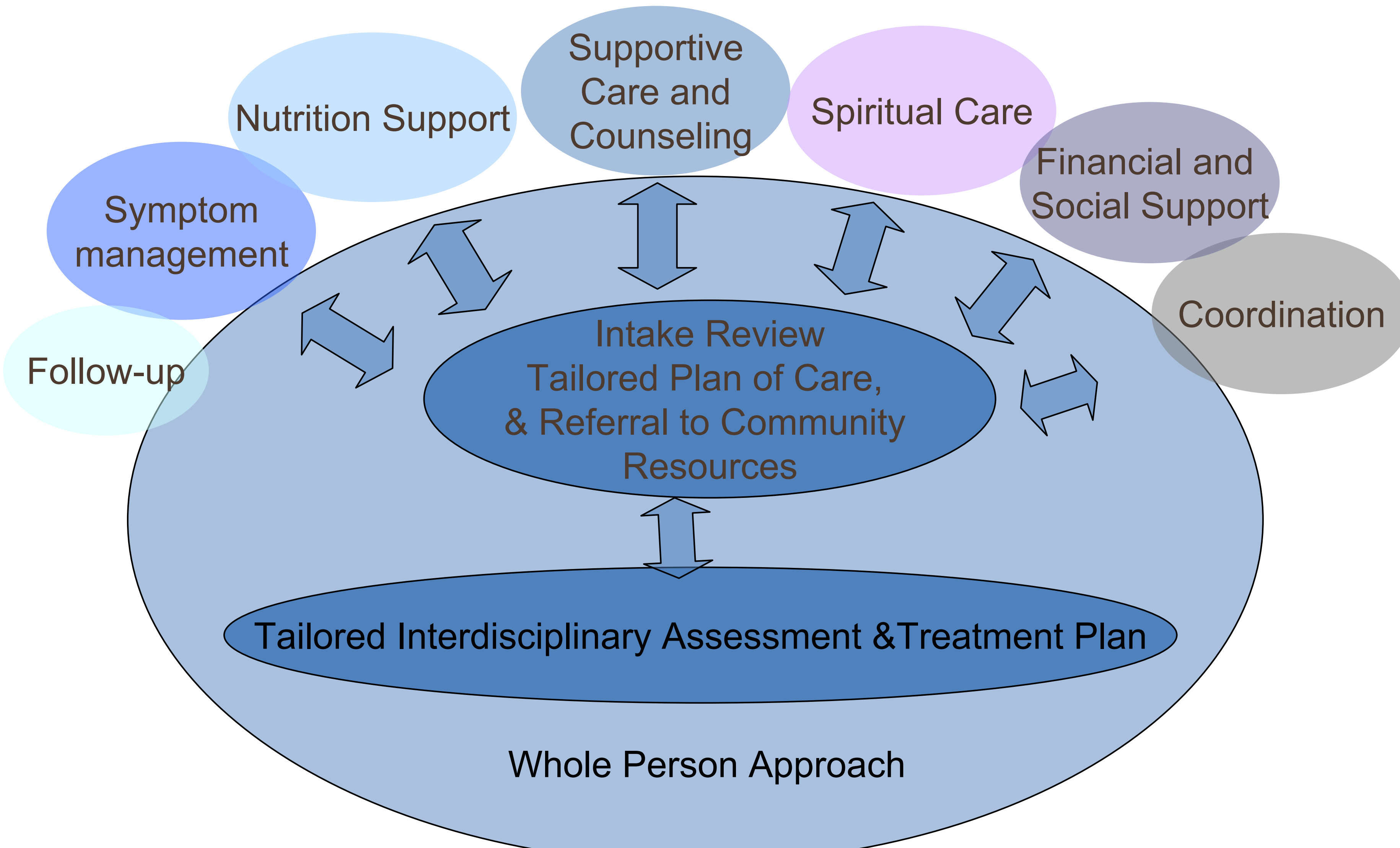
It's a big shift in focus for health care delivery—and it works.

What can I do? TAKE ACTION!

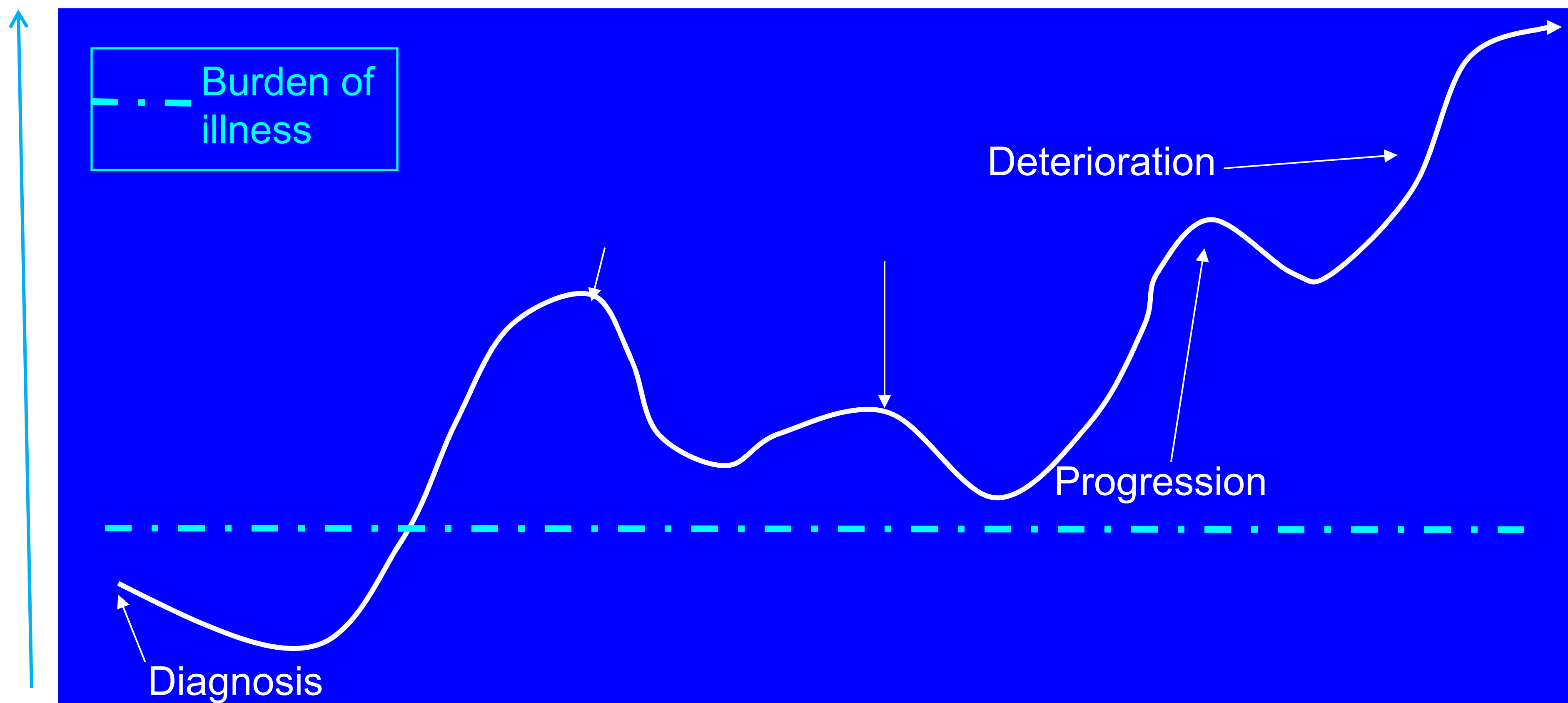
www.acscan.org/palliativecare

ACSCAN Capitol Hill ad campaign 2012

Palliative Care = Supportive Care = Team Care



Palliative Care- Dynamic, Not Linear…



…For when illness burden impacts the person or their loved one

Palliative Care and Patient/Caregiver Satisfaction

Mortality follow back survey palliative care vs. usual care (N=524 family survivors)

Overall satisfaction markedly superior in palliative care group, p<.001;

Palliative care superior for:

- emotional/spiritual support
- information/communication
- care at time of death
- access to services in community
- pain
- well-being/dignity
- care + setting concordant with patient preference
- PTSD symptoms

Casarett et al. J Am Geriatr Soc 2008; *Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.*

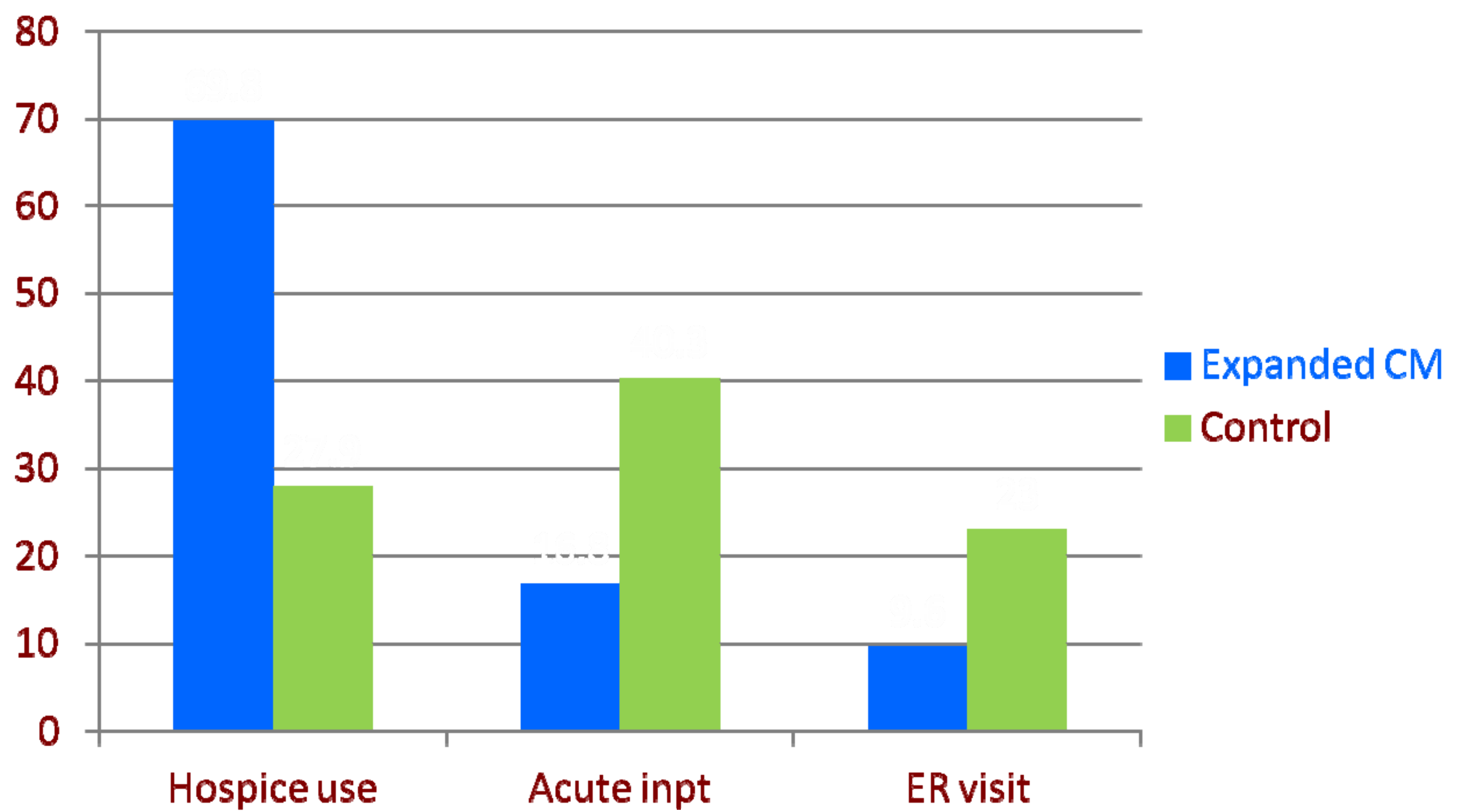
Palliative Care and Quality

- In a prospective multicenter study of 332 seriously ill cancer patients, recall of occurrence of a prognostic/goals conversation was associated with:
  - Better quality of dying and death
  - Lower risk of complicated grief + bereavement
  - Lower costs of care
  - Less 'aggressive'care

Zhang et al. Arch Int Med 2009;169:480-8.
Wright et al. JAMA 2008;300:1665-73.

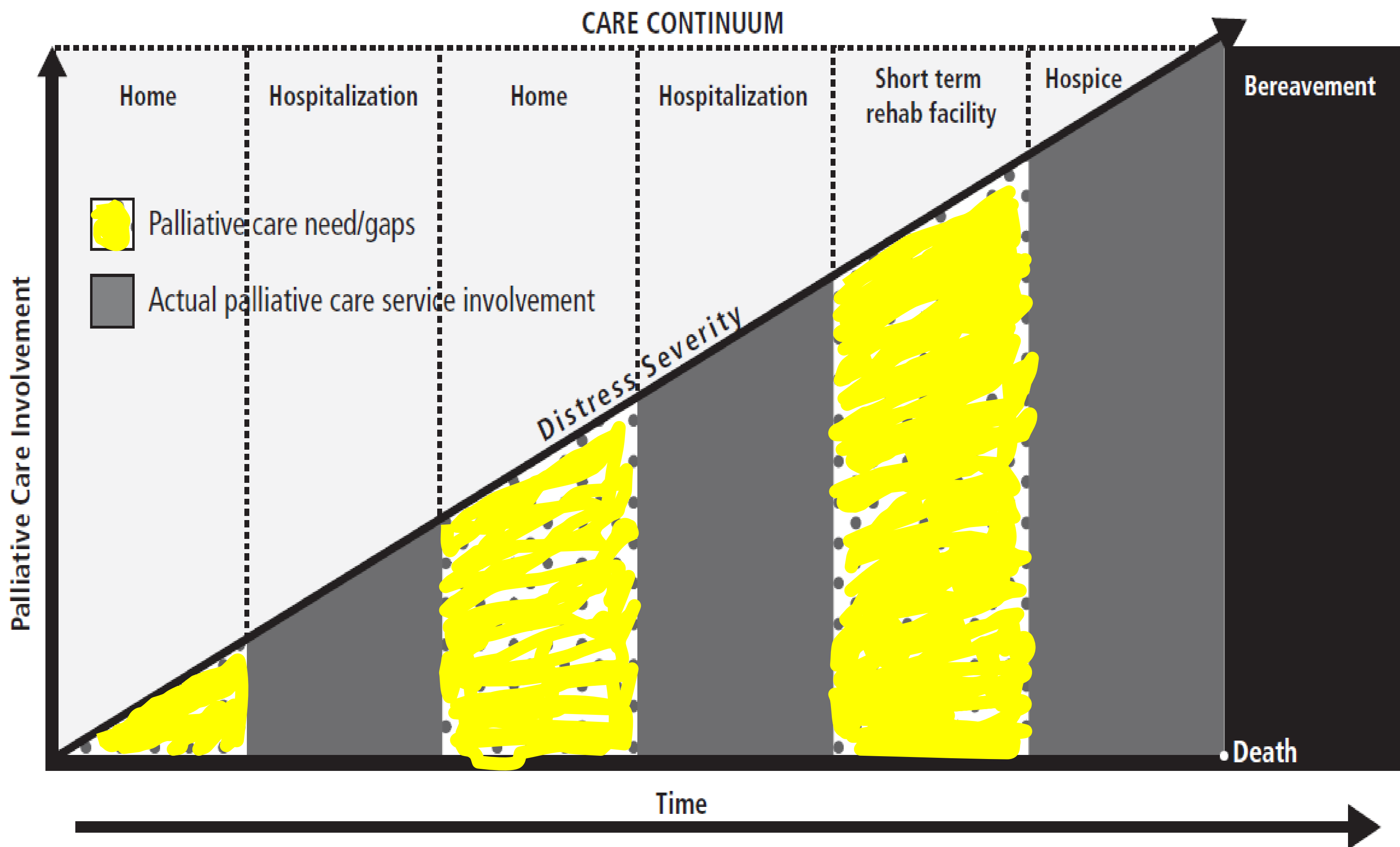
Palliative Care and Healthcare Utilization

“Expanded” hospice/CM services to 387 Aetna beneficiaries with advanced illness



Spettell CM et al. JPM 2009; 12: 827-832

Common Gaps in Palliative Care



Kamal et al. Journal of Pain and Symptom Management. 2012, In Press

ACCOUNTABLE CARE ORGANIZATIONS

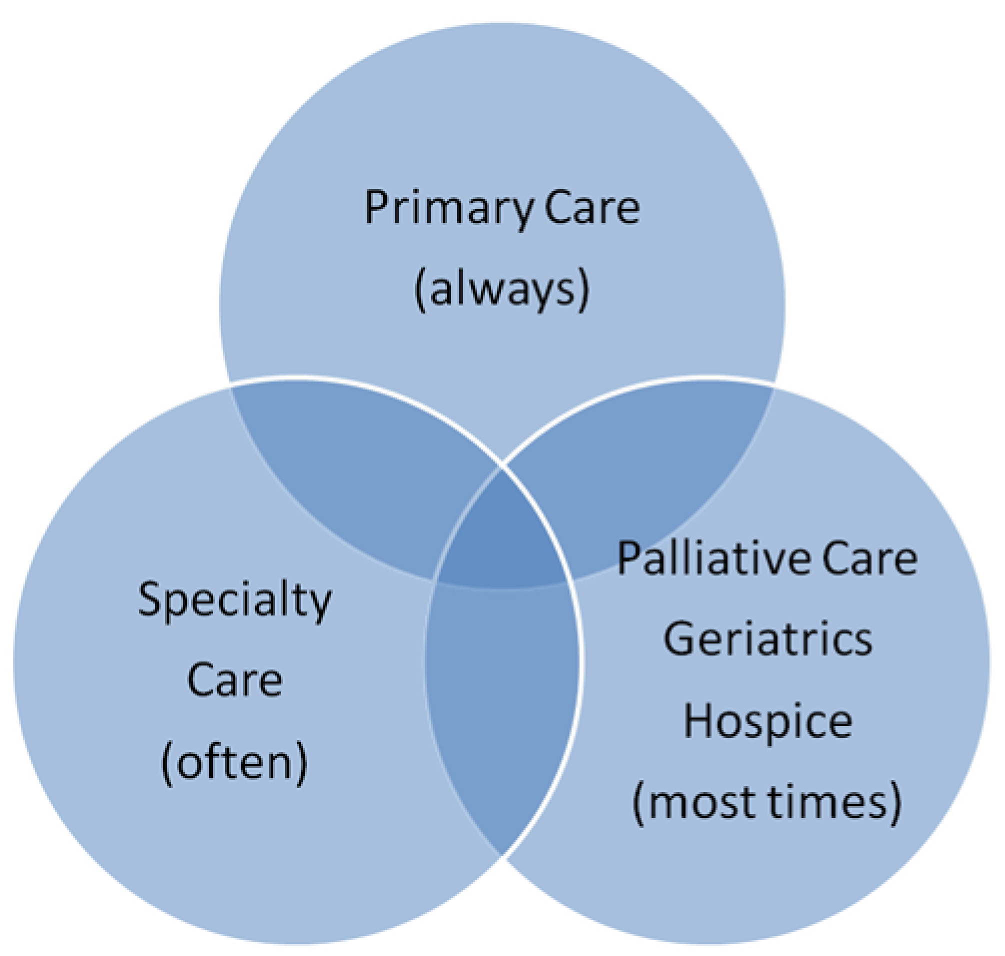
…An opportunity to fill in the gaps for value and care delivery for those with serious illness

Opportunities of new delivery models

- ✓ Delivery system re-design targeted to the highest-risk populations-- those with advanced disease and/ functional impairment-- key to success at improving quality and the patient/family experience.
- ✓ Training and skills- early integration of palliative care and geriatrics

(Policy) Goal: Add palliative care/geriatrics to the eligibility specifications/metrics for medical homes, accountable care organizations, and bundling strategies.

How should we envision a fully integrated (accountable) health care system for the most seriously Ill?



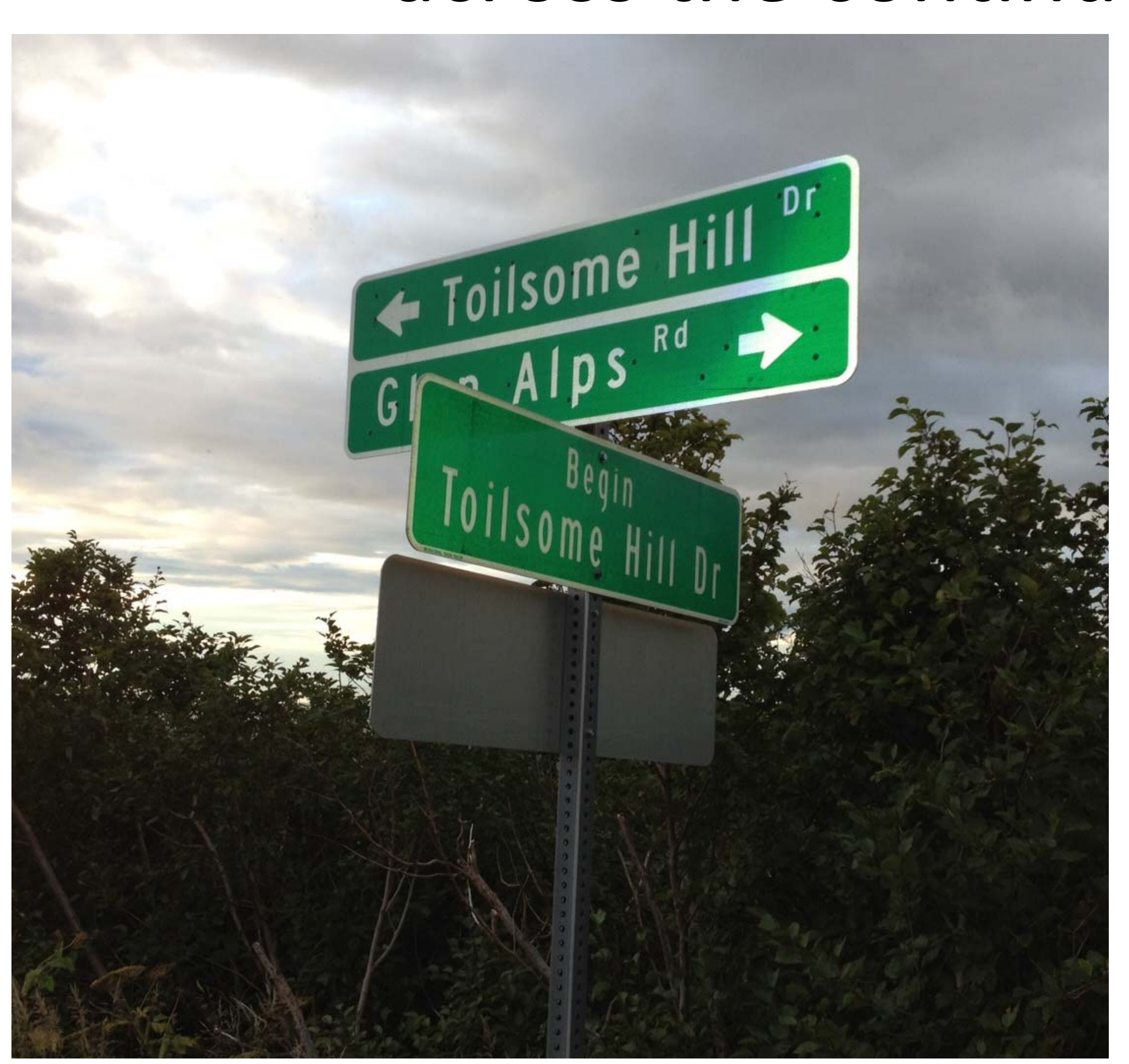
Courtesy of Allan Ramsay/CAPC

Managed care of the 80’s ≠ ACO’s

- **More Knowledge**
- **More Data**
- **More Guidelines and Quality Metrics**
- **More Collaboration**
- **More Physician Control**

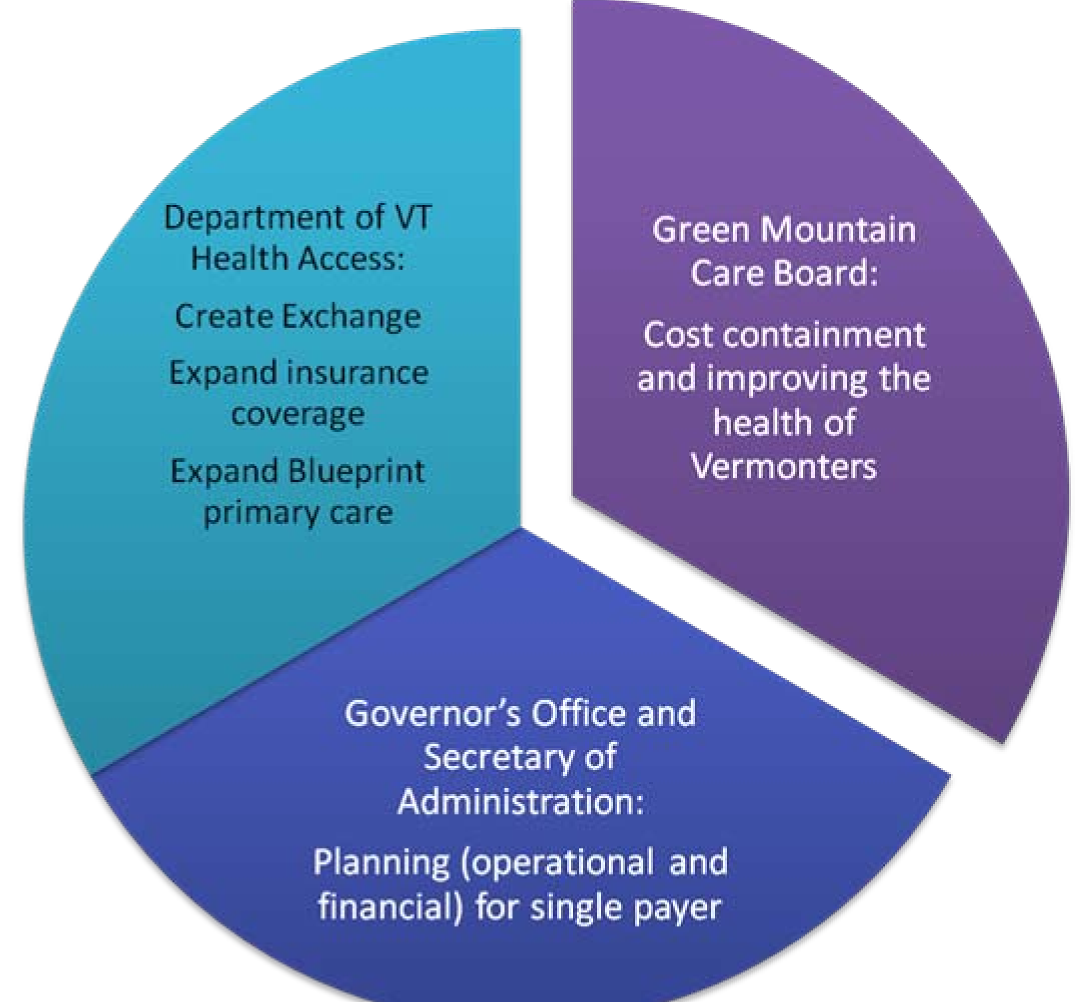
Emanuel EJ. JAMA. 2012 Jun 6;307(21):2263-4

Case studies of palliative care integration across the continuum



- Vermont
- Michigan
- California

Vermont and health reform (Act 48)?



Courtesy of Allan Ramsay

What works?

Seven critical success factors:

1. Primary care physicians are in control
2. Clinicians are paid for quality not quantity via risk sharing
3. All-payer rate standardization
4. Regionalization of costly services
5. Limits on supply/capacity for costly services
6. Primary physicians follow their patients in the hospital
7. **There are well integrated palliative care and hospice services**

Bodenheimer T, West D. NEJM 2010; 363:1391-93

Developed a palliative care "delivery system" to make it accessible and fully integrated

Primary palliative care (outpatient PCMH or inpatient)

- Giving bad news and discussing prognosis
- Advanced care planning
- COLST

Tertiary Palliative Care (usually inpatient, specialty clinic, or HHA)

- Complicated symptom management
- Multidisciplinary intervention during acute illness
- Goals of care discussions about burdensome life supporting therapies

Specialty (cardiology, nephrology, oncology) Palliative Care

- Checklists
- Incentives

Courtesy of Allan Ramsay

Vermont Oncology Pilot Project

1. Patient-centered medical home, Cancer Center, community hospital palliative care and home health agency come to the table
2. Problems identified:
   - PCP's lose track of their cancer patients until late in their course,
   - Oncologists often pressured to provide disease modifying therapies late in the disease course,
   - Palliative care consulted too infrequently
   - Payers have seen significant cancer cost acceleration in imaging, drug costs, and the last thirty days of life
3. Consultation with expertise in operational advising, system design, and coordination expertise
4. GMCB provides cost analysis for cancer patients in the hospital service area with potential four year savings

Courtesy of Allan Ramsay

Estimated Cost Savings

State wide four year cancer expenditure	**$$$**	**5% savings**	**7% savings**	**10% savings**
Commercial	588,873,731	29,443,687	41,221,161	58,887,373
Medicaid	100,685,832	5,034,292	7,048,008	10,068,583
Total	689,559,563	34,477,979	48,269,169	68,955,956
The Pilot Community Hospital				
Commercial	13,849,653	692,483	969,476	1,384,965
Medicaid	6,029,475	301,474	422,063	602,948
Total	19,879,128	993,956	1,391,539	1,987,913

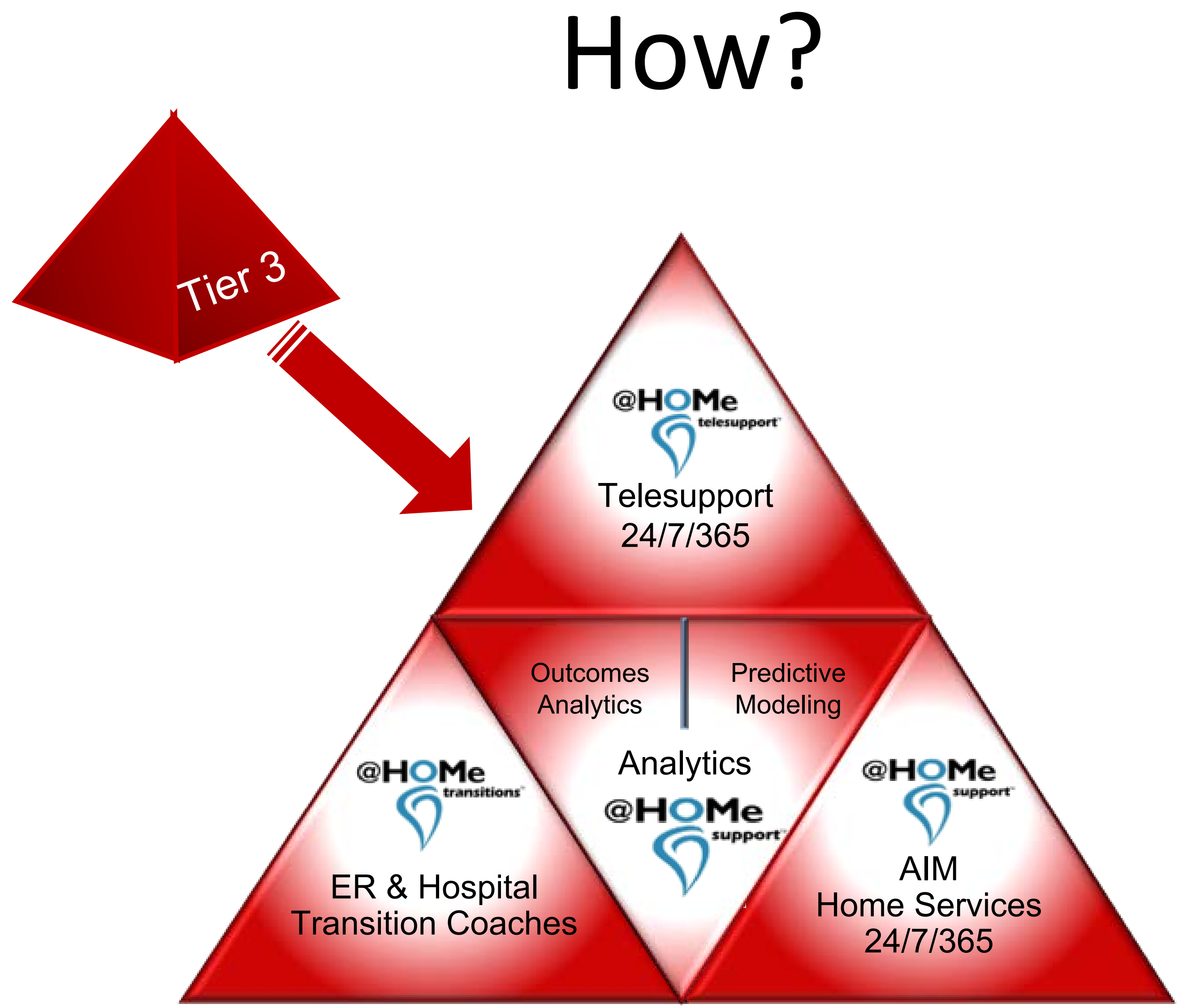
Courtesy of Allan Ramsay

Michigan: Hospice takes action

- Hospice of Michigan
  - Contract with DMC Michigan Pioneer ACO
  - Contract talks in progress with two additional ACOs
  - Expanding contracts with all major insurers
  - Potential Pilot with the State of Michigan retirees to reduce health care legacy costs

Courtesy Hospice of Michigan (HOM)

How?



Courtesy Hospice of Michigan (HOM)

Michigan: Hospice of Michigan

XYZ HMO Costs 6 Months Pre and Post @HOMe Support™ Program

XYZ HMO Cost Trends - Actual Costs

Entry Month of @HOMe Support™ Program

Mean Cost ($)

$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-

Pre-month 6
Pre-month 5
Pre-month 4
Pre-month 3
Pre-month 2
Pre-month 1
Entry Month
Post-month 1
Post-month 2
Post-month 3
Post-month 4
Post-month 5
Post-month 6

Courtesy Hospice of Michigan (HOM)

California: Blue Shield and a Global Budget Pilot Project

- Pilot ACO in Sacramento area for 41,000 California Public Employees' Retirement System (CalPERS) employees/dependents enrolled in a Blue Shield HMO
- Focused review of the 5,000 patients accounting for 75 percent of total health care costs

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

Blue Shield Pilot Strategies

- Coordinate pre- and postdischarge planning processes to avoid delays and readmissions
- Personalize care and disease management
- **Develop a comprehensive palliative care program across hospital, physicians, and care managers to engage patients and their families in end-of-life decisions**
- **Implement home-based medical care for high-risk, frail, elderly patients to improve their quality of life**

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

Blue Shield Pilot Project Outcomes

- Health care costs for CalPERS members ↓1.6 % from the 2009 baseline amount (nonmembers: 9.9 % ↑ from 2009).
- Inpatient days for CalPERS members ↓12.1 % (nonmembers: ↑ of 2.5%)
- Hospital readmissions within 30 days of discharge ↓ 15 %, from an already low 5.4 percent
- Extended hospital stays—those of twenty days or longer—↓ by 50 %

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

Take Home Messages

- All clinicians/partners need to be at the table
- Pay attention to the details: operational planning and implementation- patient attribution, defining appropriate quality indicators, cost analysis
- Don't fret over what it is called: "*supportive care,*" *"advanced illness management,*" "*palliative care*." Hospice will always be hospice.
- Have systems in place for communication, communication, communication, and for tracking the data.

Summary

- Palliative care is about quality: person/caregiver focused, informed choices, comfort and quality of life—an essential element in the value equation for the seriously ill.
- **Byproduct: more appropriate** utilization and communication- lower costs
- Planning is key to address supportive/palliative care needs across the continuum

We Can Do Better