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Palliative Care

Improving Quality and Reducing Cost

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CENTER TO ADVANCE PALLIATIVE CARE

Definition

Palliative care means patient and family-centered care that optimizes quality of life.

Palliative care throughout the continuum of illness involves physical, emotional, social, and spiritual needs.

73 FR 32204, June 5, 2008

Medicare Hospice Conditions of Participation – Final Rule

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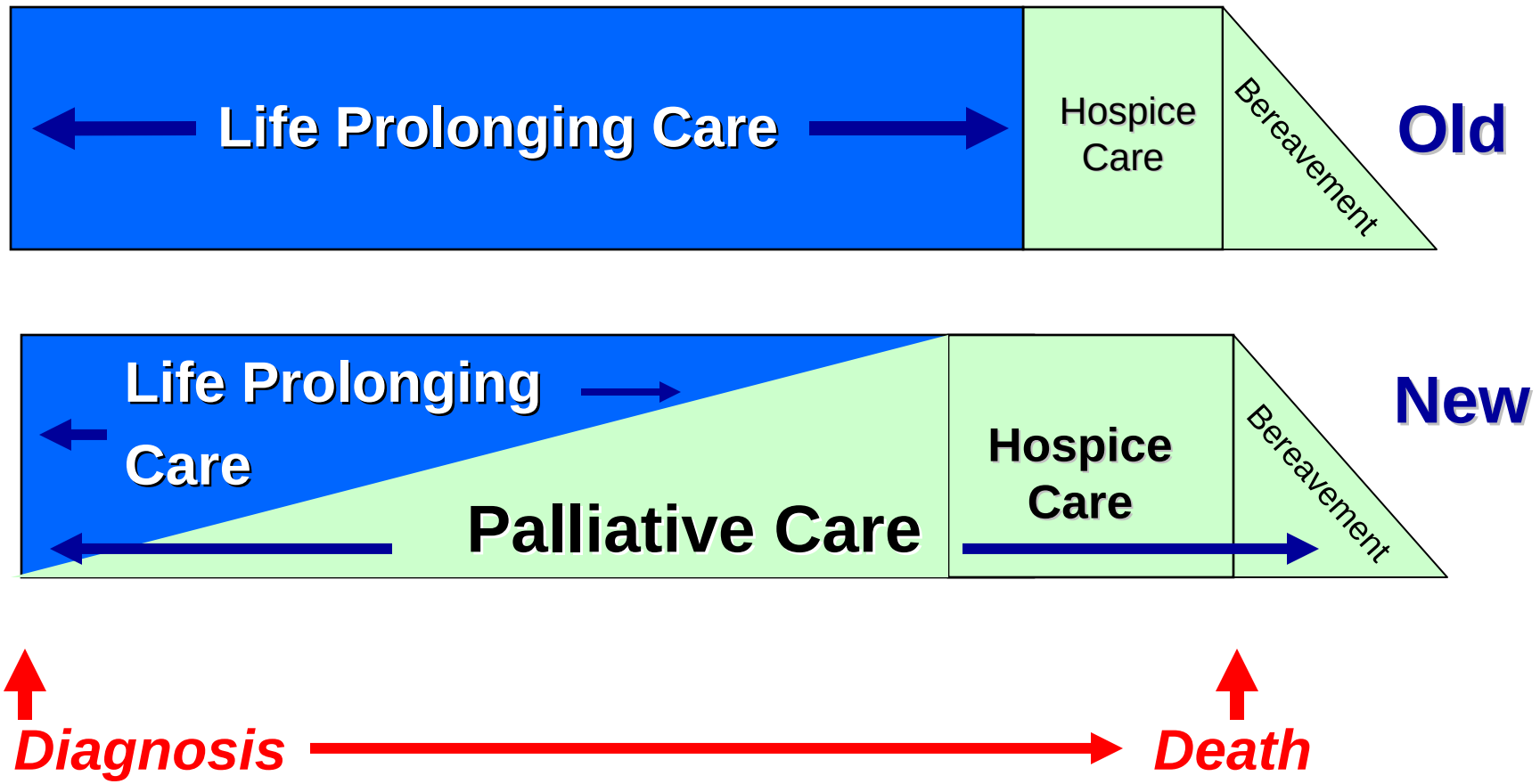
Conceptual Shift



Palliative Care focuses on …

- Honoring patient wishes …
  - Patient and family suffering
  - Overwhelmed family caregivers
  - Poor timing and quality of communication
  - Extreme overuse and misuse of medical resources
  - Health professional moral distress

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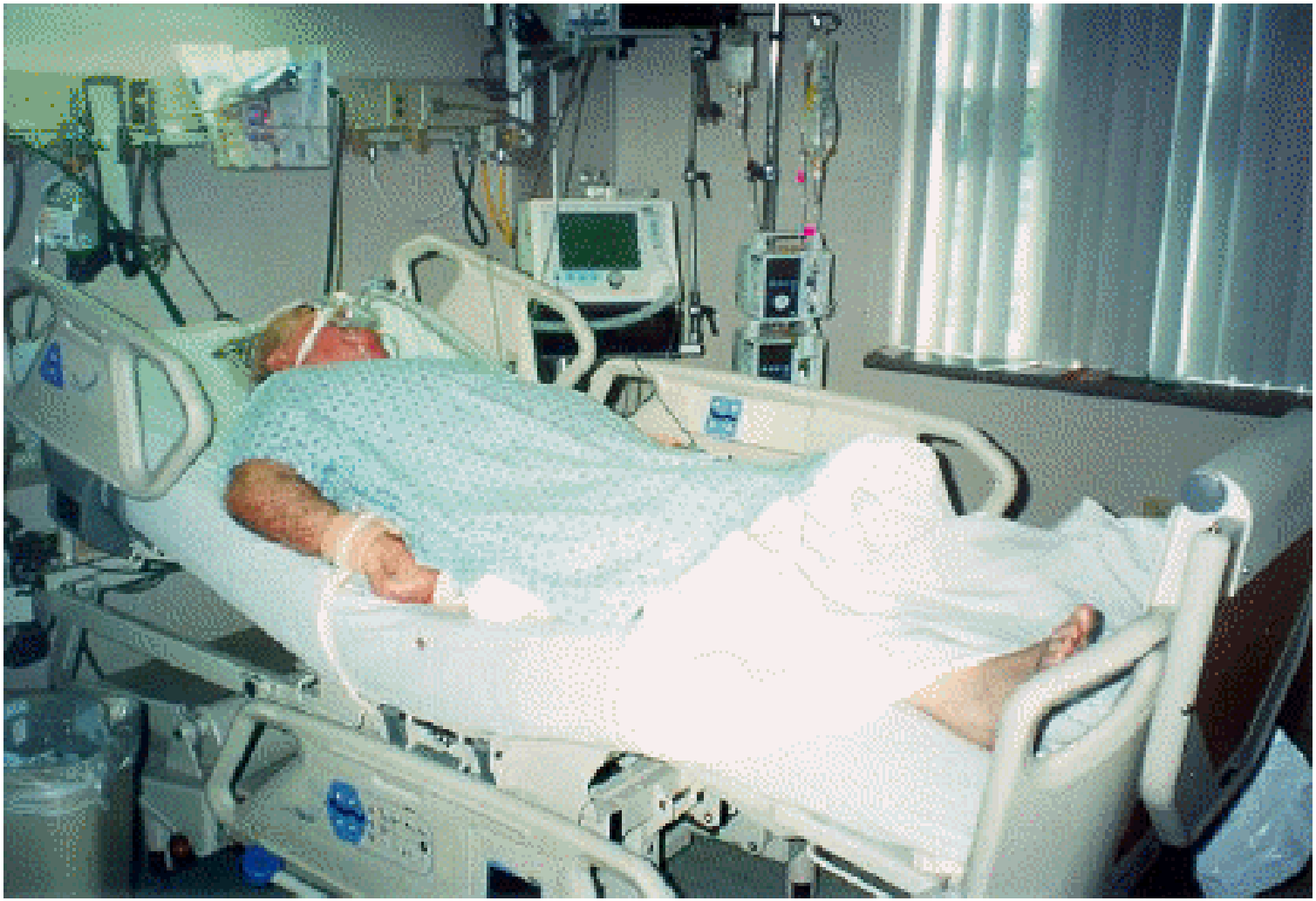

Model of care

- Hospital Consultation Service
  - Physician-Nurse-Social Worker-Chaplain teams
  - Consultation services
  - Inpatient units
  - Outpatient clinics
  - ED and ICU integration

Hospital Palliative Care Reduces Costs

Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals

	Live Discharges			Hospital Deaths		
Costs	**Usual Care**	**Palliative Care**	Savings	**Usual Care**	**Palliative Care**	Savings
Per Day	$867	$684	$183	$1,515	$1,069	$446
Per Admission	**$11,498**	**$9,992**	**$1,506**	**$23,521**	**$16,831**	**$6,690**
Laboratory	$1,160	$833	$327	$2,805	$1,772	$1,033
ICU	$6,974	$1,726	$5,248	$15,531	$7,755	$7,776
Pharmacy	$2,223	$2,037	$186	$6,063	$3,622	$2,441
Imaging	$851	$1,060	-$208	$1,656	$1,475	$181
Died in ICU	X	X	X	**18%**	**4%**	**14%**

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Morrison, RS et al. Archives Intern Med 2008;

Impact on cost: VA

- Palliative Care vs. Usual Care
  - 5 hospitals (2004-2006)
- $464 lower cost in PC patients
  - 43% reduction in ICU admissions

Penrod et al. J Pall Med 2010; 13:973-979.

How does Palliative Care Reduce Cost

- Reduce time to symptom relief
- Help patients/families select medical treatments and care settings that match their goals
  - Coordinate discharge planning to meet clinical realities and patient goals

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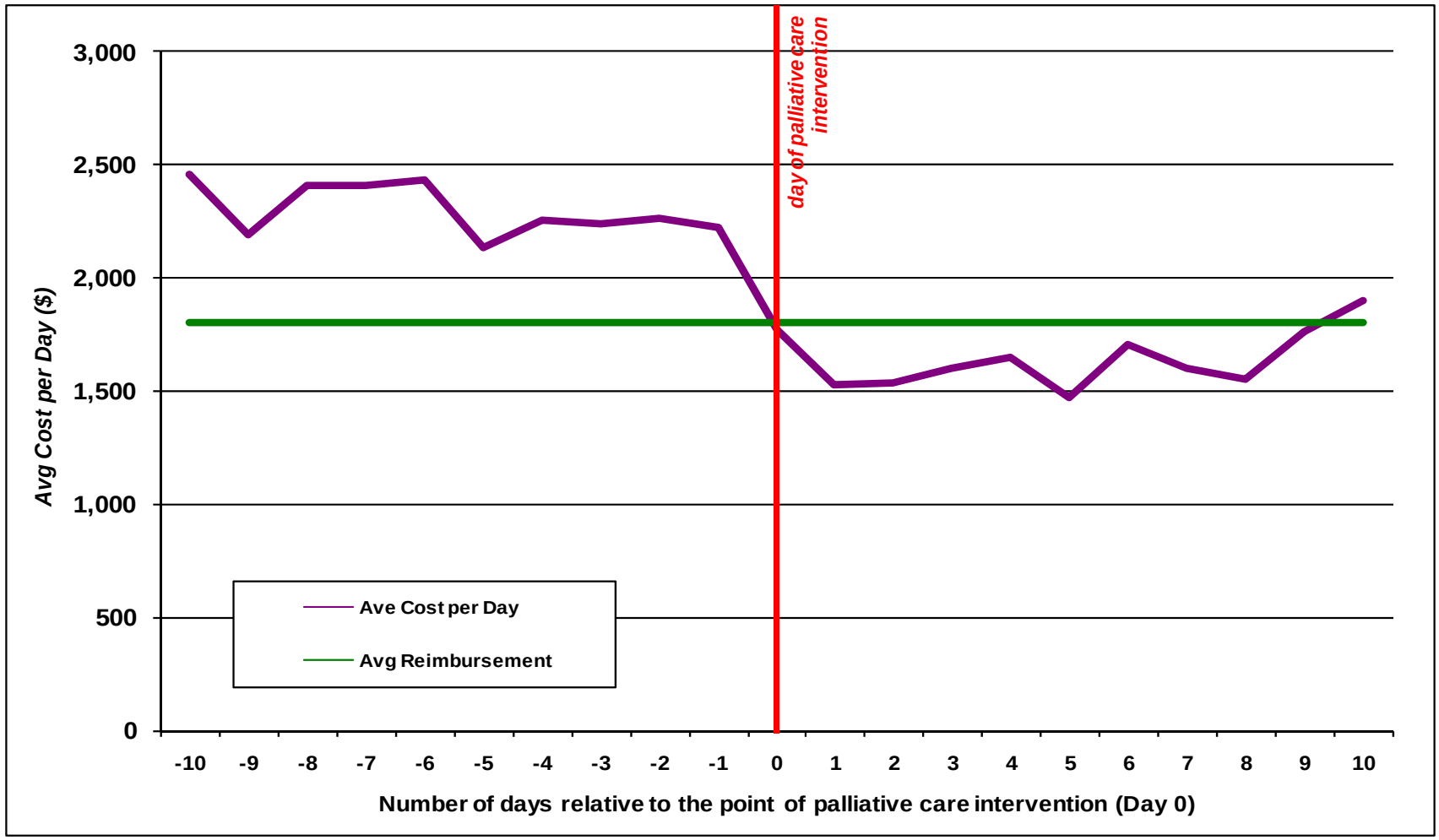
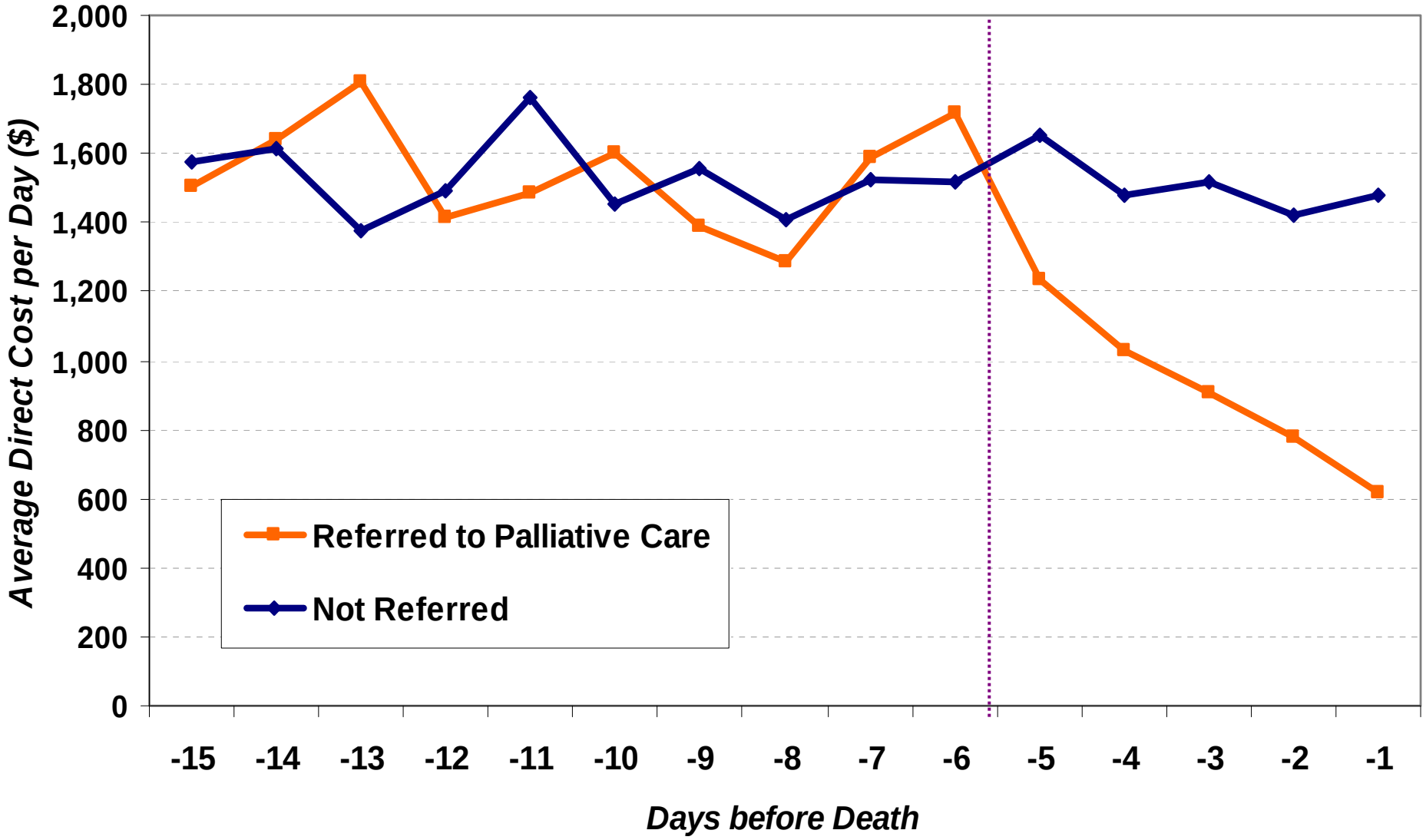
Average cost per day, 10 days before and after palliative care intervention

(for admissions of 3 days' stay or more)



Daily cost data 5 days prior to death



•Note: Purple Vertical Line represents day of Palliative Care Consultation

Better communication = Less resource utilization

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
	Total (N=332)	End-of-Life Discussion			
		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.

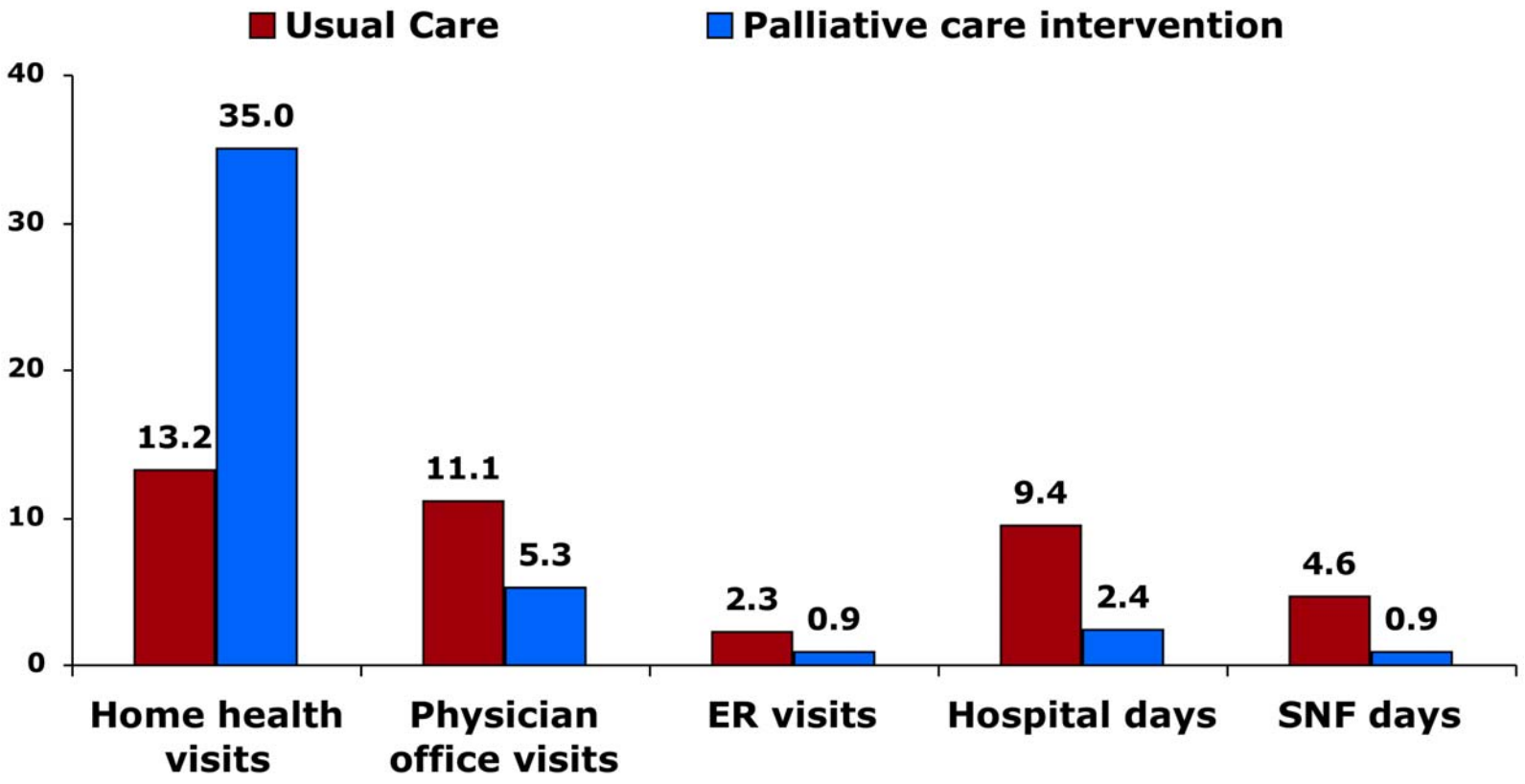
[a] The propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients' treatment preferences, desire for prognostic information, and acceptance of terminal illness.

Wright, A. A. et al. JAMA 2008;300:1665-1673.

JAMA

Shifts care out of hospital

CHF, COPD, or Cancer Palliative Home Care versus Usual Care, 1999–2000



Brumley, R.D. et al. 2007. J Am Geriatr Soc.

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Palliative care improves quality

Simultaneous standard cancer care with palliative care co-management from diagnosis vs. control of standard cancer care only:

- **Improved QOL**
- **Reduced depression**
- **Reduced 'aggressiveness**
- ***Improved survival***

Temel et al. Early palliative care for patients with non-small-cell lung cancer NEJM2010;363:733-42.

Center to Advance Palliative Care

Mission ...

- To improve care for all patients with serious illness and their families through increasing access to quality palliative care in the nation's hospitals and other health care settings.

NYSHF – CAPC Grant

- Provide CAPC technical assistance to New York hospitals through prepaid registration fees for CAPC technical assistance products.
- Goal #1 Increase number of programs:
  - 70 to 95 NY Palliative Care programs in past 5 years.
- Goal #2 Increase number of patients served:
  - 1.6 Million to 2.2 Million patients

CAPC Technical Assistance

- Palliative Care Registry
- National Seminar
- Leadership Center training/mentoring
- E-learning courses
- Audioconferences

1st year of grant …

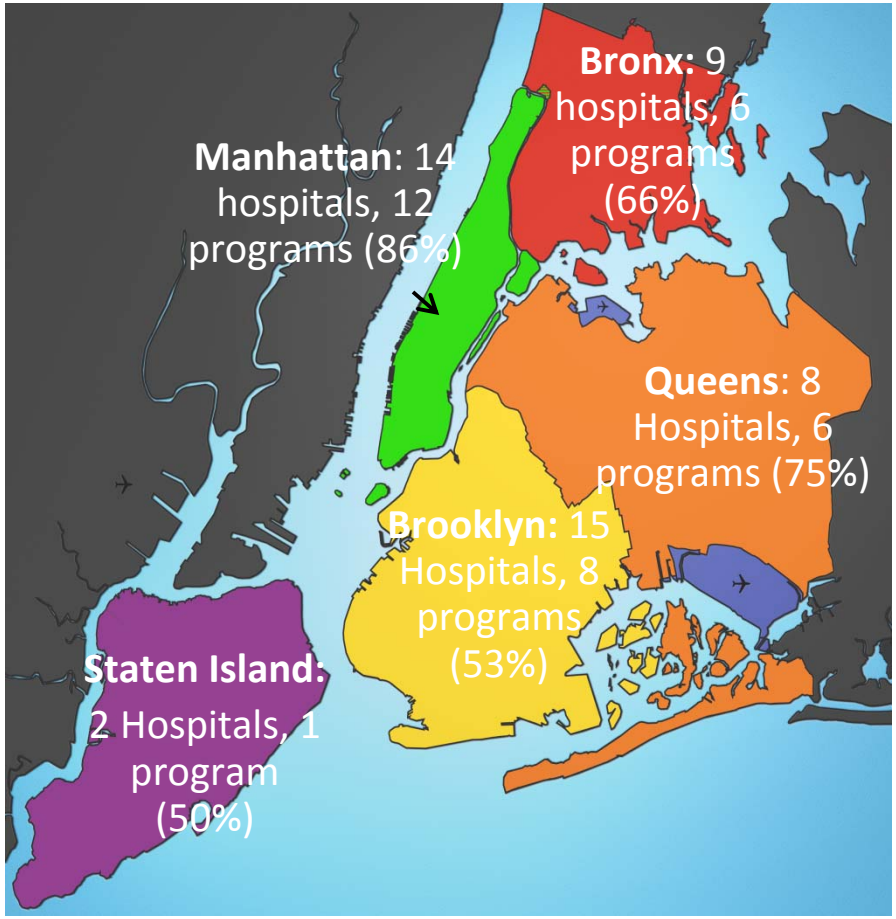
- 35% of NYS hospitals (n=80) have used CAPC TA materials + 15 hospices
  - Representing **63%** of total NY hospital beds
- 22% of hospitals (n=51) have entered program data in CAPC Registry
  - Representing **47%** of total NY hospital beds

Who used CAPC products?

- 45% (N=43) established palliative care program
- 35% (N=33) planning process or were new start-up programs
- 20% (N=19) unknown program status

NYC Palliative Care Landscape: Hospital-Based Palliative Care

- **Total NYC Population**:8,391,881 (http://www.nyc.gov/html/dcp/html/census/popcur.shtml)
- **National PC Program Rate:** 53%
- **New York State Program Rate:** 58%
  - (Goldsmith, et al)
- **Manhattan**: 14 hospitals, 12 programs (86%)
- **Queens**: 8 hospitals, 6 programs (75%)
- **Bronx**: 9 hospitals, 6 programs (66%)
- **Brooklyn**: 15 hospitals, 8 programs (53%)
- **Staten Island**: 2 hospitals, 1 program (50%)



Public vs. Private

Program Statistic	HHC Hospitals (N=8)	Non-HHC Hospitals (N=10)
Percent with 24/7 coverage	**37.5%**	100%
Number of consults	3450	5675
Consult rate	**2.3%**	1.5%
Number of MDs/1000 pt	**4.4**	6.5
Percent board-certified MDs	**20%**	54%
Number of APNs/1000 pt	**2.0**	2.5
Percent board-certified APNs	**43%**	71%
MD + APN FTE	**13.8**	41.9
MD + APN FTE/1000 pt	**4.0**	7.34

Veterans Affairs

- Major national Hospice and Palliative Care Initiative (2009-2011)
  - Contract with CAPC to lead/mentor program design/growth in all VA hospitals
- New York (VISN 3) is leading this project
  - Carol Luhrs, Brooklyn VA

Lewin Report

- Palliative Care Action Plan components
  - Assessment; Program design; Implementation; Measurement; Resources
- Levers for diffusion of innovation through:
  - technical assistance
  - social marketing to key audiences
  - recognition/prizes
  - regulatory levers
  - payment incentives (e.g. preferred provider status, conditions of participation)

Lessons Learned

- New York has an active and growing palliative care footprint.
- Significant differences exist in public vs. other hospital settings.
- Data collection over the next year will help establish additional trend data to document program growth.

Next Steps

- Continue technical assistance support
- Analyze CAPC Registry trend data
- Develop and field test regulatory and payment incentives for palliative care program development and integration for appropriate patient populations