The Role of Palliative Care in a Successful ACO: Managing Quality and Health Care Spending Among the Seriously Ill

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July 27, 2013
AHA Leadership Summit
Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Objectives

• At the end of the session, participants will:

  • Understand how palliative care improves the healthcare value equation

  • Appreciate how team-based palliative care programs align providers across settings and redesign care processes to target the highest cost, highest risk populations

  • Be familiar with specific examples of payers and major health system ACOs that are investing in palliative care across settings
Health Care Cost

NYT
3/01/09
Business section
page 1

How High Could It Go?

Health care spending has swelled since the 1960s, with the bulk of the spending coming from private insurance companies and federal programs.

TOTAL NATIONAL HEALTH CARE SPENDING
Adjusted for inflation

Wall Street Journal
page 1
Sept. 18, 2003
International Comparison of Spending on Health, 1980–2009

Average spending on health per capita ($US PPP*)

United States
Canada
Germany
France
Australia
United Kingdom

Total expenditures on health as percent of GDP

United States
France
Germany
Canada
Australia
United Kingdom

* PPP=Purchasing Power Parity.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.
Health Care Costs Concentrated in Sick Few—
Sickest 10 Percent Account for 65 Percent of Expenses

Distribution of health expenditures for the U.S. population,
by magnitude of expenditure, 2009

Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.
What is this money buying us?

Among OECD member nations, the United States has the:

- U.S. has highest per capita spending in the world, yet ranks 20th in quality indices
- Lowest life expectancy at birth
- Highest mortality preventable by health care

Organization for Economic Development and Cooperation
Rising Healthcare costs

Options to “Bend the curve” of health care costs:

• continue, indiscriminate cuts like the sequester

• shifting of federal costs onto consumers, health plans or employers

• savings approach that addresses the waste and inefficiency in our health system
Association between cost and quality of death in the final week of life (adjusted $P = .006$)
The Value Equation

Value of health care = \text{Quality} \div \text{Cost}

Numerator problems

- 100,000 deaths/year from medical errors
- Millions more harmed by overuse, underuse, and misuse
- Fragmentation
- Medical practice based on evidence <50% of the time
- 49 million Americans (1/8th) without access
- U.S. ranks 20th in quality indexes by OECD
The Value Equation - 2

Value of health care = **Quality** Cost

Denominator problems

- Insurance premiums increased by >200% in the last 10 years.
- U.S. spending 17% GDP, >$8400/person/yr
- Nearing 35% of total State spending
- Despite high spending, 15% of our population has no insurance, and half are underinsured in any given year.
- Health care spending is *the #1* threat to the American economy and way of life.
Example: Mr. S

- 84 year old man admitted via the ED for pain management related to spinal stenosis
- Pain is 8/10 on admission, for which he is taking OTC acetaminophen
- Admitted 4 times in the last 6 months for pain.
- His wife who is 77 years old is overwhelmed.
- He does not want to go back to the hospital but the pain is so bad and his wife cannot help him so she would call the ambulance since that is the only thing she feels that she COULD do.
Challenges of Serious Illness

For patients/families
• Uncoordinated care
• Lack of psychosocial support
• Inadequate attention to goals/preferences
• Poor symptom management
• ED+hospital = only option

For health systems?
• High-cost care
• Frequent (re)hospitalizations
• Dissatisfaction with care (HCAHPS scores)
• Financial penalties/adverse effect on public reporting

With thanks to Dave Casarett
What is Palliative Care?
Palliative care is specialized medical care 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 provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
Conceptual Shift of Palliative Care

Disease Directed Therapies

Palliative Care

Hospice

Bereavement

Diagnosis ——> Death
How can Palliative Care help?

- Improve Quality
- Decrease Cost

Value of health care = Quality
Cost
Evidence: Palliative Care Improves Value

**Quality improves**
- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- Care matched to patient-determined goals

**Costs reduced**
- Hospital costs decrease
- Need for hospitalization/ICU decreases
Palliative Care
Address 3 Domains

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

Data on impact on 4 of the 6 domains of quality:
- Patient centered
- Beneficial
- Safe
- Efficient
- (Equitable)
- (Timely)
Palliative Care’s Impact on Quality and Cost
What Family Caregivers Get...

Family Satisfaction with Hospitals as the Last Place of Care
2000 Mortality follow-back survey, n=1578 decedents

Not enough contact with MD: 78%
Not enough emotional support (pt): 51%
Not enough information about what to expect with the dying process: 50%
Not enough emotional support (family): 38%
Not enough help with pain/SOB: 19%

Evidence of the Impact

Palliative Care Improves Quality
Palliative Care vs. Usual Care

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Bivariate Comparisons of Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care</td>
</tr>
<tr>
<td>Emotional spiritual needs of family</td>
<td></td>
</tr>
<tr>
<td>Religious/spiritual beliefs addressed</td>
<td>23 (24)</td>
</tr>
<tr>
<td>Enough support in dealing with own feelings</td>
<td>52 (55)</td>
</tr>
<tr>
<td>Feelings after death addressed</td>
<td>14 (15)</td>
</tr>
<tr>
<td>Referral to psychosocial support for family</td>
<td>13 (14)</td>
</tr>
<tr>
<td>No emotional/spiritual needs met</td>
<td>61 (65)</td>
</tr>
<tr>
<td>Self-efficacy of family</td>
<td></td>
</tr>
<tr>
<td>Fairly-very confident knew what to expect when patient dying</td>
<td>55 (68)</td>
</tr>
<tr>
<td>Fairly-very confident knew what to do when patient died</td>
<td>64 (71)</td>
</tr>
<tr>
<td>Fairly-very confident knew about medications to treat symptoms</td>
<td>74 (82)</td>
</tr>
<tr>
<td>Not confident in one or more domains</td>
<td>52 (56)</td>
</tr>
</tbody>
</table>

*Items may not total 100% because individuals refused to answer item.

Gelfman et al, JPSM 2008;36:22-28
Evidence of the Impact (con’t)

Palliative Care Improves Satisfaction
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
- Well-being/Dignity
- Care + Setting Concordant With Patient Preference
- Pain
- PTSD Symptoms

Following Their Loved Ones Death, Percent of Palliative Care Families Satisfied or Very Satisfied With:

- Control of pain - 95%
- Control of non-pain symptoms - 92%
- Support of patient’s quality of life - 89%
- Support for family stress/anxiety - 84%
- Manner in which you were told of patient’s terminal illness - 88%
- Overall care provided by palliative care program - 95%

Source: Post-Discharge/Death Family Satisfaction Interviews, Mount Sinai Hospital, New York City
RCT of Nurse-Led Telephonic Palliative Care Intervention

• N= 322 advanced cancer patients in rural NH+VT
• Improved quality of life and less depression (p=0.02)
• Trend towards reduced symptom intensity (p=0.06)
• No difference in utilization, (but v. low in both groups)
• Median survival (p = 0.14):
  – intervention group 14 months,
  – control group 8.5 months

Bakitas M et al. JAMA 2009;302(7):741-9
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)

People Who Use Palliative Care Live Longer

People Who Use Hospice Live Longer


Matched cohort study: hospice use or not. 4493 Medicare patients, 2095 (47%) received hospice care for at least one day, 1999

<table>
<thead>
<tr>
<th>Disease</th>
<th>Added survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>+ 81 days, P = 0.0540</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>+ 39 days, P &lt; 0.0001</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>+ 21 days, P = 0.0102</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>+ 33 days, P = 0.0792</td>
</tr>
<tr>
<td>Breast</td>
<td>+ 12 days, P = 0.6136</td>
</tr>
<tr>
<td>Prostate</td>
<td>+ 4 days, P = 0.8266</td>
</tr>
</tbody>
</table>
What are the potential cost drivers?

- The business model of modern medicine:
  - hospitalize
  - refer to colleagues
  - do more tests/procedures/treatments
- Financial disincentives inhibiting coordinated communication about goals (Takes time)
- Fragmented multi-specialty care
- Lack of training on needs of seriously ill, including symptoms, communication, coordinated transitions
- Lack of primary coordinated care
“It is thornlike in appearance, but I need to order a battery of tests.”
COST #1: Conversations about Goals can improve quality, reduce costs

In a prospective multi-center 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
- Less hospital/ICU care and thus lower cost

Wright et al. JAMA 2008;300:1665-73.
# Medical Care Received in the Last Week of Life by End-of-Life Discussion

| Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion |
|-----------------------------------------------|----------------|----------------|----------------|----------------|
|                                               | No. (%)         | Adjusted OR (95% Confidence Interval) |  |
|                                               | Total (N=332)   | Ended-of-Life Discussion |  |
|                                               | Yes | No            | OR  | Confidence Interval | P Value |
| Medical care received in the last week        | 332 | 123 (37.0) | 209 (63.0) | 0.35 (0.14-0.90) | .02 |
| ICU admission                                 | 31 (9.3)       | 5 (4.1) | 26 (12.4) | 0.35 (0.14-0.90) | .02 |
| Ventilator use                                | 25 (7.5)       | 1 (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.

Consequences of Late Referral to Palliative Care

Serious Adverse Outcomes for Bereaved Caregivers:
Compared to care at home with hospice,
• Care in ICU associated with 5X family risk of Post Traumatic Stress Disorder; and
• Care in hospital associated with 8.8X family risk of prolonged grief disorder

Wright A et al. Place of death: Correlation with quality of life of patients with cancer and predictors of bereaved caregivers mental health. JCO 2010; Sept 13 epub ahead of print
## Hospital Palliative Care Reduces Costs

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

<table>
<thead>
<tr>
<th></th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Day</td>
<td>$867</td>
<td>$684</td>
</tr>
<tr>
<td>Per Admission</td>
<td>$11,498</td>
<td>$9,992</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$1,160</td>
<td>$833</td>
</tr>
<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$1,726</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$2,223</td>
<td>$2,037</td>
</tr>
<tr>
<td>Imaging</td>
<td>$851</td>
<td>$1,060</td>
</tr>
<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

Kaiser Permanente System *Randomized* Clinical Trials of IDPCTs

- Equal survival
- Better communication and quality of care
- Net savings of $5-7000/person, now standard in all KP markets

![Bar graph showing cost comparisons between Usual Care and IDPCTs](attachment:bar_graph.png)

- Brumley, Out Pt, JAGS 2007: $-7,552
- Gade, In Pt, JPM 2008: $-4,855

Slide courtesy of Dr. Tom Smith
Palliative Care Reduces Costs (con’t)

How?

COST #2: Allows provision of higher quality care in appropriate, often less costly, settings.
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

Bar chart showing service use among chronic conditions in usual Medicare home care versus palliative care intervention.
People Who Use PC or Hospice...

- **PC involvement reduced readmissions from 1.15 to 0.7 in six months.**
  

- **Hospice saves Medicare $2-6000 per decedent, and the longer the hospice length of stay, the bigger the savings.**
  
  Kelley AS, Morrison RS. *Health Aff (Millwood).* 2013 Mar;32(3):552-61

- **Setting up services before discharge dramatically reduces readmissions.**
  

### Table 2. Readmission Rate by Post-discharge Medical Service Use

<table>
<thead>
<tr>
<th>Post-discharge medical services</th>
<th>Ratio of readmissions</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>11/240</td>
<td>4.6</td>
</tr>
<tr>
<td>Home-based palliative care</td>
<td>5/60</td>
<td>8.3</td>
</tr>
<tr>
<td>Home health</td>
<td>2/15</td>
<td>13.3</td>
</tr>
<tr>
<td>Nursing facility</td>
<td>14/58</td>
<td>24.1</td>
</tr>
<tr>
<td>Home no care</td>
<td>9/35</td>
<td>25.7</td>
</tr>
</tbody>
</table>

Slide courtesy of Dr. Tom Smith
The Case of Mrs. G
Case 1

Ms. G is a 96 year old women with osteoporosis & osteoarthritis who was dx’d with colon CA; after declining surgery, put on bi-monthly transfusions.

• From a palliative care perspective, we explored how the recent medical conditions affected her life. Her quality of life was not acceptable to her.
• After the surgery & no longer transfusion dependent, she even tolerated some chemotherapy.
• One year later, she presented once again with melena and dx’d with a recurrence.
• We spoke the meaningful parts of her life– the parties, the ability to entertain, be independent, & in control of her body and she appointed her daughter as HCP.
Case 1 cont...

• She underwent another surgery, tried chemo but stopped early.

• 4 months after surgery, she took a trip back to Israel where she enjoyed a big 96th B-day party. She came back early because she was not feeling well.

• She was admitted to the hospital directly upon landing at 7pm, evaluated and treated.

• On Hospital Day #3, she was weak in bed with multiple tubes not responding to treatment. Suspicion—metastasis
Case 1 cont...

• Together with her family and the HCP, we reviewed her goals.

• We spend the next day getting her ready for discharged with home hospice so she can spend time with her family.

• When I visited her on the day she died, she had exactly what she wanted— one last party where everyone of her friend and family were there, at her bedside, chatting and talking. Although she could no longer participate in conversation, this is what she had declared her life was all about.
How did palliative care help?

• Clarified goals
• Eliminated ambiguity & decreased the decision-making burden on the family
• Active treatment of symptoms
• Allowed her to die at home in a manner according to her wishes
• In the process of doing what she wanted, we also eliminated unnecessary tests and cut costs.

• The alternative scenario could have been...
  – More tests, more procedures, more tubes, more meds, longer ICU stay until she died.
GOOD LUCK WITH THE AMERICAN HEALTH CARE SYSTEM
The Future of Palliative Care and Health Reform

• Not enough to have access to palliative care in hospitals

• Most illness occurs at home and in communities

• Home palliative care needed without regard to prognosis or goals of care

• Goal = insure access to palliative care across all settings and stages of illness
Access to Palliative Care Across the Continuum: The Future

Hospital Consult Service

Provider Home Visits

NH Services

Inpatient Unit

Outpatient Specialty Clinics

Outpatient PCP Clinics

Cancer Center
Integrate Palliative Care into New Delivery and Payment Models

Adding palliative care targeted to the highest risk populations to the specifications for these delivery models is key to their success at improving quality and reducing cost.
At Last: A Business Case for Palliative Care in the Community

The business case:

• PAYORS, especially commercial payers with Medicare Advantage and Managed Medicaid contracts

• LARGE EMPLOYERS seeking value for their healthcare dollar

• INTEGRATED or ACCOUNTABLE Care Organizations
Payers Get It

Private sector approaches to community-based palliative care
Payer Models

Highmark Introduces
Advanced Illness Services Program

Beginning Jan. 1, 2011, Highmark will offer the Advanced Illness Services (AIS) program as part of its Medicare Advantage plans. The program will provide 100 percent coverage for as many as 10 outpatient care visits by AIS network hospice and/or palliative care providers to promote quality of care for members with progressive, life-limiting illness.

Stratis Health
Leading collaboration and innovation in health care quality and safety

Aetna
End of Life Care
Aetna Compassionate Care SM Program

Excellus
Public Service Announcements on End-of-Life Care Earn Bronze Telly

RURAL PALLIATIVE CARE EMERGING AS A HEALTH CARE PRIORITY
Hospice of Michigan and the @Home Support Program: The “Missing Piece” Solution

**Partnership:** @HOMe: Hospice of Michigan and **Payer:** BCBS Michigan

**Providers:** ACOs, Employers in SE Michigan

**Saves 30% Net Total Health Care Costs**

- **Chronic Disease Management:** 2-20 yrs
- **Advanced Illness Management:** 12-18 mos
- **Hospice Care:** 6 mos

Thank you Dottie Deremo!
How? System Redesign

Tier 3

Telesupport
24/7/365

Outcomes
Analytics

Predictive
Modeling

ER & Hospital
Transition
Coaches

Analytics

AIM
Home Services
24/7/365
Major Health Systems/ACOs Get It

Making multimillion dollar investments in palliative care integration across settings:

- Partners Health System/ Harvard Medical School
- U. of Pittsburgh Health System
- Duke U. Health System
- North Shore-LIJ Health System
- OSF Health System
- Iowa Health System
- Ohio Health System
- Sharp Health System
- Banner Health System...
Partners Health System

- Brigham and Women’s Hospital; Massachusetts General Hospital; Affiliated community hospitals

Provide coordinated care across the continuum meeting the patient’s need in all settings

And

Uniform standards for palliative care across the system

- triggers for consultation
- pay for performance initiatives
- feedback on palliative care quality indicators
How do we increase the value of Health care?

Value of health care = **Quality**

Cost
The eye of the beholder—

Who benefits from palliative care?

- Patients and their families
- Referring physicians
- Hospital administrators/ACO and health systems
Summary

• High cost of care ≠ High quality of care
• Palliative care impacts on the value of health care by improving quality
• Better quality reduces need for acute, high cost care
• Palliative Care integration in health systems is essential in the care of the seriously ill
Do the right thing. It will gratify some people and astonish the rest.

Mark Twain (1835 - 1910)
Questions?

Thank you
and special thanks to Diane Meier
and CAPC