Palliative Medicine
The Tip of the Spear for Health Reform
What is Palliative Care?
CMS Definition

Palliative Care means patient and family - centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information and choice.

T3 FR 32204, June 5, 2008
Medicare Hospice Conditions of Participations – Final Rule
High Treatment Variability at Life’s End

• Utilization of health care resources in the last 6 months of life varies 3 to 6 fold across regions, independent of severity of illness or outcome of treatment.
  • Hospital days varies 3 fold (9.4 – 27.1)
  • ICU days varies 6 fold (1.6 – 9.5)
  • % of decedents enrolled in hospice varies 4 fold (10.8 – 43.8)
    • www.dartmouthatlas.com
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• “Money and Medicine” PBS documentary
  • Significant differences exist across America in the care planning for comparable diseases
  • This creates striking/alarming cost differences without any demonstrable impact on outcome
  • A number of procedures/illnesses were presented with startling costs in LA but not so much in Utah
  • A common problem for both was end of life cases and Palliative Care
Palliative Care Basics

- Improving patient outcomes through pain and symptom control
- Expediting communication and decision making for patients, family
- Increasing coordination among health care providers
- Easing patient care transitions between care settings
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• “Takehomes”
  1. Palliative Medicine has a Global application from pre-hospital to hospital to out-patient care
  2. A Cultural change in end-of-life expectations must (and will) happen
  3. Costs will drive decision making
  4. Physicians need to lead and guide these changes in healthcare
  5. Palliative Medicine is about Quality of Life and Comfort
CAPC
Center for Advancement of Palliative Care

• Started in the late 70’s
• Based in Mount Sinai Hospital, NYC
• Dedicated to promoting Palliative Medicine in the Healthcare System
• Enormous impact in the Growth of PC and the Education of Healthcare providers
• Annual Meetings and a Robust Website
• Encouraging Hospitals to join as paying memberships
Dying in America
Institute of Medicine

• 2 Fundamental changes in organized medicine
• Universal Education and training for all healthcare professionals and clinicians in the core principles and practices of Palliative Care
• Coverage of both social and medical needs of the most serious and complex patients.
• 40% of medical spending is precipitated by unmet social support needs – including low literacy, language barriers, poor nutrition, unsafe housing, family violence, mental illness, and absence of support for exhausted and overwhelmed care givers.
American Healthcare

- State of Turmoil currently
- 18.3% of GDP 2017 – largest ever – and more than anywhere else
- The ACA and the Political and Economic Fallout
  - Turned American Healthcare Direction - for the Better
  - Bad Legislation – poorly understood, doomed fiscally
  - Achieved better Coverage for more Americans
  - Brought Awareness of Healthcare to new Heights
  - Included Palliative Care and the Discussion of End-of-Life
- Waste in Our System is Staggering
- The Pot of Money in Healthcare is Sufficient
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• The advent of HCAPHs
• Hospital Consumer Assessment of Physician and Hospital Services
  • An important new methodology that hospitals and other health systems must “endure”
  • How consumers/patients will impact performance evaluation of the health systems in America
  • Actually a very forward thinking application
  • An Improvement Plan for American HealthCare
  • Palliative Care as an integral component—one of four basic measures of system performance
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• A new Paradigm – Value Based Purchasing - Two distinct thrusts in Healthcare

  1. Preventive Care Direction
     • Curbing obesity, smoking and other behaviors that contribute to health costs – Public Health
     • A Palliative Care opportunity?

  2. Value Based Health Industry Contracting
     • Purchasing from systems that measure outcome and cost that provides the Best return on that dollar figure

• A single payment plan that pushes the “Provider” to become efficient cost center
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• Emmanuel Ezekiel, MD – Longevity Comes Up Short – DMN Oct 12, 2014

• "How I want to Live and the kind and amount of healthcare I will consent to after 75."

• His Plan for Himself-no life prolonging therapy
  • “American Immortal”-lifestyle for “valiant effort to cheat death and prolong life”
  • “Compression of morbidity - more time before disabilities...and fewer disabilities” – James Fries 1980
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• Emmanuel, DMN Oct 12, 2014
  • Study showing loss of functional mobility in the elderly increased 1998-2006
  • Contemporary dying process elongated
  • “American Immortals” operate on the assumption that they will be outliers
  • By definition few of us can be exceptions
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‘The Conversation’

• The “opportunity” to discuss End-of-Life possibilities with a patient
• There is no better authority on the therapy and non-therapy options than the doctor
• The “kicker” is that this conversation has to get done
• There are not other doctors who can come to do this
• Any illness has the potential for a bad outcome
• Patients need empowerment to Address Directions about Care
• Quality of Life and Comfort
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‘The Conversation’

• Question for The Provider -

• Would (you) be surprised if your patient died this year?
  • “NO” answer begs the question – What have you discussed with your patient about end of life [and associated questions regarding Advanced Directive and designated MPOA]?
  • Isn’t that the opportunity for the Provider? – YES
  • Isn’t it the BEST TIME to have that discussion? - YES
Advanced Directive

• Current Advance Directive “forms” need overhaul
  • The “WANT EVERYTHING DONE” phrase is UNTENABLE
  • “Everything” is limited in Time, Space, and DOLLARS
  • Medical Costs Dictate Restraint – and unless the patient pays for everything, restraints will come to force decreased costs of care
  • A reasonable Advanced Directive defines limits to care based on “reasonable outcome and quality of life” as determined by the medical team
• NEW POLITICAL ACTIVITY – Texas Legislature – to prohibit Advanced Directives - Right to Life promoted
Advanced Directive
Living Will

• Requires sitting with family and discussing
  • Not a favorite thing but critically important
• Age, state of health, insurance- all NON-issues
• The sooner the better to guide plan of care
• A written document that will likely be altered as we age
• When illness hits it can be TOO Late to create
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CPR

• Cardiopulmonary Resuscitation, Kowenhoven et al, JAMA 1960
  • “immediate resuscitative measures can now be initiated to give...adequate cardiac massage without thoracotomy.”
  • “Anyone, anywhere, can [do CPR]..All that is needed are two hands.”
  • Never originally recommended for all patients!!
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CPR

• Outcome of CPR-witnessed arrest – 17% survival to discharge – average all comers
  • One of Three survivors alive at one year
  • Age is a factor - >65 yrs – lower survival
  • Asystole/PEA – Lower survival
  • History of Sepsis – co-morbidity- lower survival
• Rib Fractures – “expected with effective CPR”
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• “How Doctors Die”, Ken Murray, MD
  • “It’s not like the rest of us but it should be”
  • “they know enough about death to know what all people fear most: dying in pain, and dying alone”
  • “they know enough about modern medicine to know its limits”
Physician Choices
At End of Life

- 1997 Study – Physicians choose less aggressive treatment than they offer patients
  - 59% had “least aggressive treatment” preference
  - 31% had “moderate treatment” preference
  - Less than 10% wanted CPR or Ventilator

- 2011 survey of 500 Board Certified Physicians
  - 96% - “more important to enhance Quality of Life for seriously ill even if it means a shorter life”
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- Do Not Resuscitate – DNR - outmoded terminology that has negative connotations of denial of care
  - Part of the existing American Health Culture that needs to change
- Allow a Natural Death – AND – the new terminology that more appropriately defines the intentions of the caregiver for end of life in a terminally ill patient
- NO difference in patient care plan – patients continue to receive quality care
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• Atul Gawande, MD – Being Mortal: Medicine and What Matters in the End

• Aging – The Challenge to Healthcare
  • Aging – the random breakdown of cells and systems that is unrelenting and eventually overwhelming
  • Aging – a relatively new challenge for medicine and society – from poorhouses to hospitals to nursing homes
  • American response to aged – not family centered for multiple reasons – institutionalized care
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• Gawande, Being Mortal..
  • Geriatrics – a woefully underserved medicine specialty, timely role for Palliative Care help
  • “The Gappers” – 75 and older, frail and/or chronic disease - not likely to die in 2 years - with a sole healthcare helper- a spouse, maybe as infirm, or a child who works
    • Fearlessly independent
    • BUT realistically facing increased limitations
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• Questions for the patient
  1. What do you understand about your illness?
  2. What are your goals now?
  3. What are your fears now?
  4. How will you prioritize these goals and deal with these fears? How can I help you?

• The role of the Palliative Care component of medicine to strive for quality time that remains for the patient
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Patient Centered

• What Elderly want today prioritized
  1. Independence
  2. Pain control/comfort
  3. Last- and not that important - longevity

• What Health System gives
  • Life sustaining support
  • Symptom control
  • Lastly- Placement wherever
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• Seniors want to be independent as long as possible
• Families strive to keep their seniors safe and happy
• Families often do not have the resources to meet the plan
  • Not enough family to provide coverage
  • Not enough money to meet the plan goal
  • Complex family interactions can cause planning failure
• “No Family” – A game changer – huge challenge
• The senior faces an “institution” option which is usually safe but not what is desired
• The push to have out-patient home support – can the model work
Palliative Care At Home

• A Growing Opportunity for the elderly
• Keep the patient ‘Centered’ at Home
• Increase outpatient support
  • Technological support, EMR, Skype/Facetime, Monitoring
• Reduce Health Crises – trips to the ER
• Balancing Independence with Safety
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• The patient “centered at home” option
  • More about supporting the caregiver to care for the patient
    • Care giver fatigue is a huge challenge seen frequently
    • Not just about physical care but also ancillary duties
  • Monitor the patient at home without being intrusive- defining what the patient really needs – AND WHAT THE CAREGIVER NEEDS
  • Hospital “teaming” to “brand” with home health companies that provide high quality home care
    • A better transition to post hospital care
    • Potential for transition to hospice for the family and patient
    • Potentially less “Bounce backs”
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• Patient centered home care
  • Requires good networking with hospital supportive care and case managers
  • Should be metric oriented to access quality and provide measured data to physician leaders who participate in out-patient care
  • Gradual identification of quality home health resources that are consistently reliable in an open market
  • Sharing the EMR as a facilitator for patient monitoring
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• 60 Minutes – “The 100,000 Homes”
  • A program started to find homes for the “hard-core homeless”
  • Roughly less than one in four homeless are truly homeless for an extended period of time
  • Find this population and find them shelter that is “permanent” – with ongoing monitors
  • First question posed was “How long have (you) been homeless?”
  • SECOND QUESTION – “How many times have (you) been to the ER in the past 2 months?”
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• “100,000 Homes” cont.
  • Focus of plan was to look at costs to the City/system
  • ER visits are costly and if they can be decreased there is more revenue to use elsewhere for the city/system
  • Homeless placed in apartments and “attempted rehab” with monitoring
  • Initial success was 80% with a number of people who got jobs and were regarded “permanently rehabilitated”
  • On-going study/program expansion
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• Critical assessment of hospice programs
• A real need to get smarter about the hospice systems
  • The “Novus Incident” in North Texas
  • The need for critical review supported by metrics
  • Best patient care to coincide with quality demands
• There are a lot of quality hospice programs in Dallas – OR ARE THERE
  • Data retrieval and reporting – should be hospice obligation
  • The need for excellence – a partnering need
• CMS Initiative – limit home health options – quality metric
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CMS Initiatives

• PACE - Program of All-Inclusive Care of the Elderly
  • “Home Based” with transportation to clinical facility that assesses medical, social, and emotional aspects of care
  • Designed to facilitate monitoring of the “complete patient” on a regular basis to avoid the hospital

• MCCM – Medicare Care Choices Model
  • Ramped up home health service as a transition to hospice for patients desiring or needing further therapy – or needing “bridge” to hospice
  • In practice since 2014 – now recently started with Dallas VNA
  • Improved Quality of Care – with reduction in Medicare expenses by avoiding the hospital
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• The “Moral Dilemma” – how to “operate” in the system that needs reduction in care costs for the elderly
  • Confronting a family that doesn’t want THEIR LOVED ONE to die
  • Weighing the likelihood of life time outcome and attendant costs to the system (forget who “pays”) that a therapy will generate vs. the risk of the treatment and the expected quality of life if the patient doesn’t improve
• Shifting Health Care monies to the underserved citizens might be better health for a lot more people and ultimately a “payable” health system
If not us then who?

If not now then when?