Wake Forest™
School of Medicine

Fishing Further Upstream: The Palliative Care Imperative

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Objectives:

1. Identify barriers to early implementation of palliative care for patients with serious illness
2. Discuss recent impactful articles in Palliative Care
3. Explore initiatives to improve serious illness care at WFBMC

Modern History of EOL Care

- 1960’s-1970’s: Modern hospice movement started by pioneers such as Drs. Cicely Saunders and Elisabeth Kubler-Ross in UK and North America
- 1983: Medicare Hospice Benefit Program
- 1990’s-2000’s: Palliative Care emerges
- 2006: American Board of Medical Specialties certifies Hospice and Palliative Medicine
- 2011: The Joint Commission begins certificate process for Palliative Care

Conditions for Hospice Eligibility Under Medicare

- Terminal illness
- Prognosis of ≤ 6 months confirmed by two physicians
- Eligible for Medicare Part A
- *Willing to forego life-prolonging therapies related to terminal illness*
- Patient or family must give informed consent
- Care must be provided by a Medicare-certified hospice

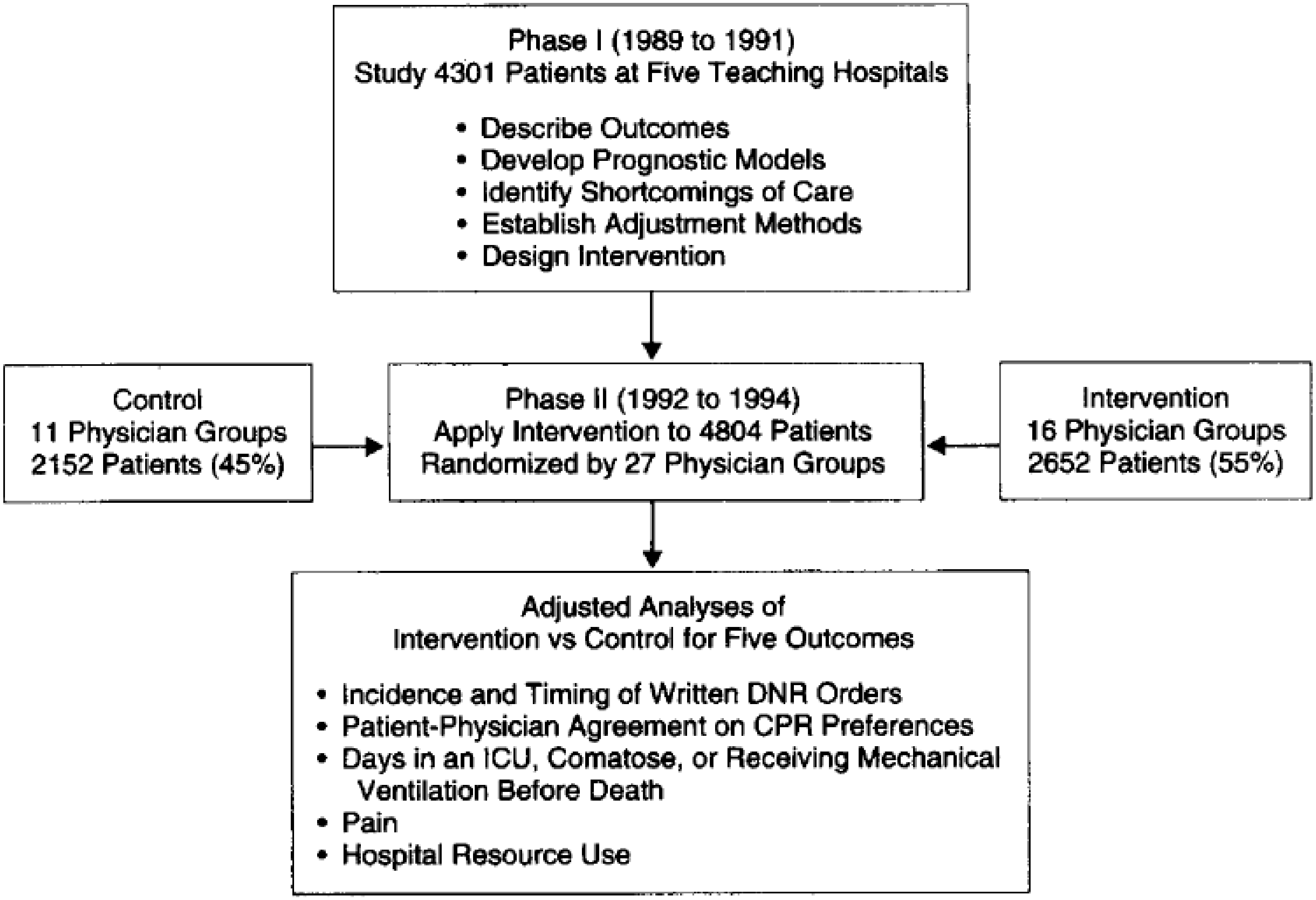
*Patient may choose to stop Hospice Care and revert to Cure-Oriented Care at any time

SUPPORT Project 1995

The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. JAMA 1995;274:1591-8.

- $29 million, Robert Wood Johnson Foundation
- over 100 SUPPORT publications
- 1376 citations of original publication

Objectives and Organization of SUPPORT



Phase I (1989 to 1991)
Study 4301 Patients at Five Teaching Hospitals

- Describe Outcomes
- Develop Prognostic Models
- Identify Shortcomings of Care
- Establish Adjustment Methods
- Design Intervention

Control
11 Physician Groups
2152 Patients (45%)

Phase II (1992 to 1994)
Apply Intervention to 4804 Patients
Randomized by 27 Physician Groups

Intervention
16 Physician Groups
2652 Patients (55%)

Adjusted Analyses of
Intervention vs Control for Five Outcomes

- Incidence and Timing of Written DNR Orders
- Patient-Physician Agreement on CPR Preferences
- Days in an ICU, Comatose, or Receiving Mechanical Ventilation Before Death
- Pain
- Hospital Resource Use

SUPPORT Project- inclusion criteria

- 9 life-threatening diagnoses
    - Acute respiratory failure
    - MOSF with sepsis
    - MOSF with malignancy
    - Coma
    - COPD
    - CHF
    - Cirrhosis
    - Metastatic colon cancer
    - Non-small cell lung cancer

SUPPORT Project- intervention

- Provide timely and reliable prognostic info.
- Elicit and document patient and family preferences and understanding of disease prognosis and treatment
- Provision of skilled nurse to:
  - Carry out discussions
  - Convene meetings
  - Bring to bear relevant information

SUPPORT Project- results

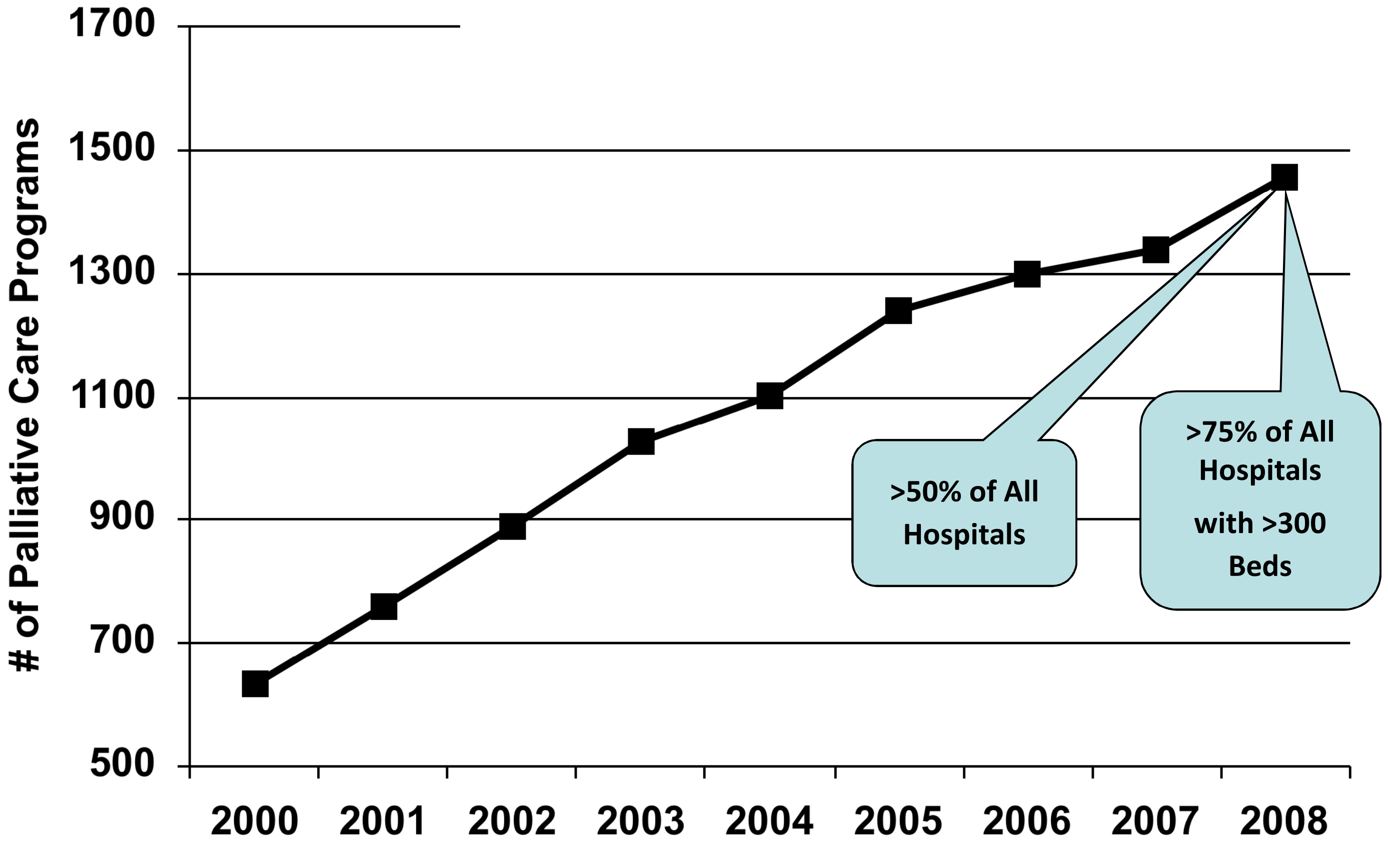
NO SIGNIFICANT IMPACT:

- Earlier writing of DNR orders
- Physicians knowledge of their patients' preferences for CPR (AR, 1.22;95% CI, 0.99 to 1.49)
- Number of days spent in an ICU before death
- Patient reports of moderate or severe pain
- Use of hospital resources

SUPPORT Project- 16years later…

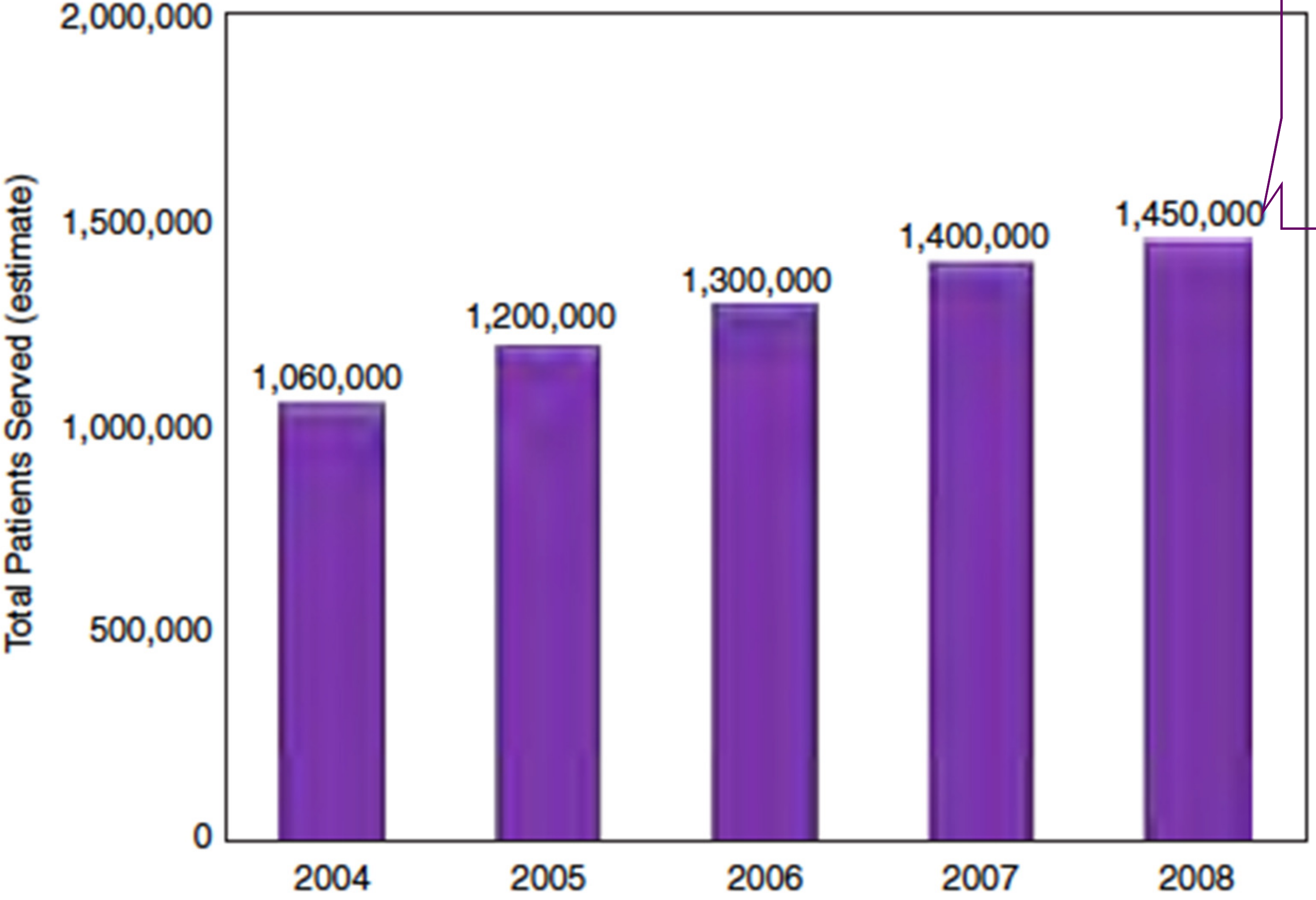
- A negative study, but a legacy/foundation of:
  - Rapid growth of palliative care programs and the field of hospice and palliative medicine
  - greatly increased understanding of care at the end of life, and care of the seriously ill
  - Increased utilization of hospice care

Growth of Non-Hospice Palliative Care Programs



Goldsmith et al, J Palliat Med, 2008, AHA Annual Hospital Survey, 2009

Growth of Patients Enrolled In Hospice



>40% of Deaths

nhpco.org

Dying in the Hospital: The Impact of a Palliative Care Program on End of Life Care

- Laurel Kilpatrick, R. Morgan Bain, David Miller
- Best Research Poster- NC ACP Winter Scientific Meeting (2010)
- Looked at outcomes similar to SUPPORT
  - DNR orders, ICU stay, use of mech. vent.
  - Decedents in 2002 (538) and 2007 (521)

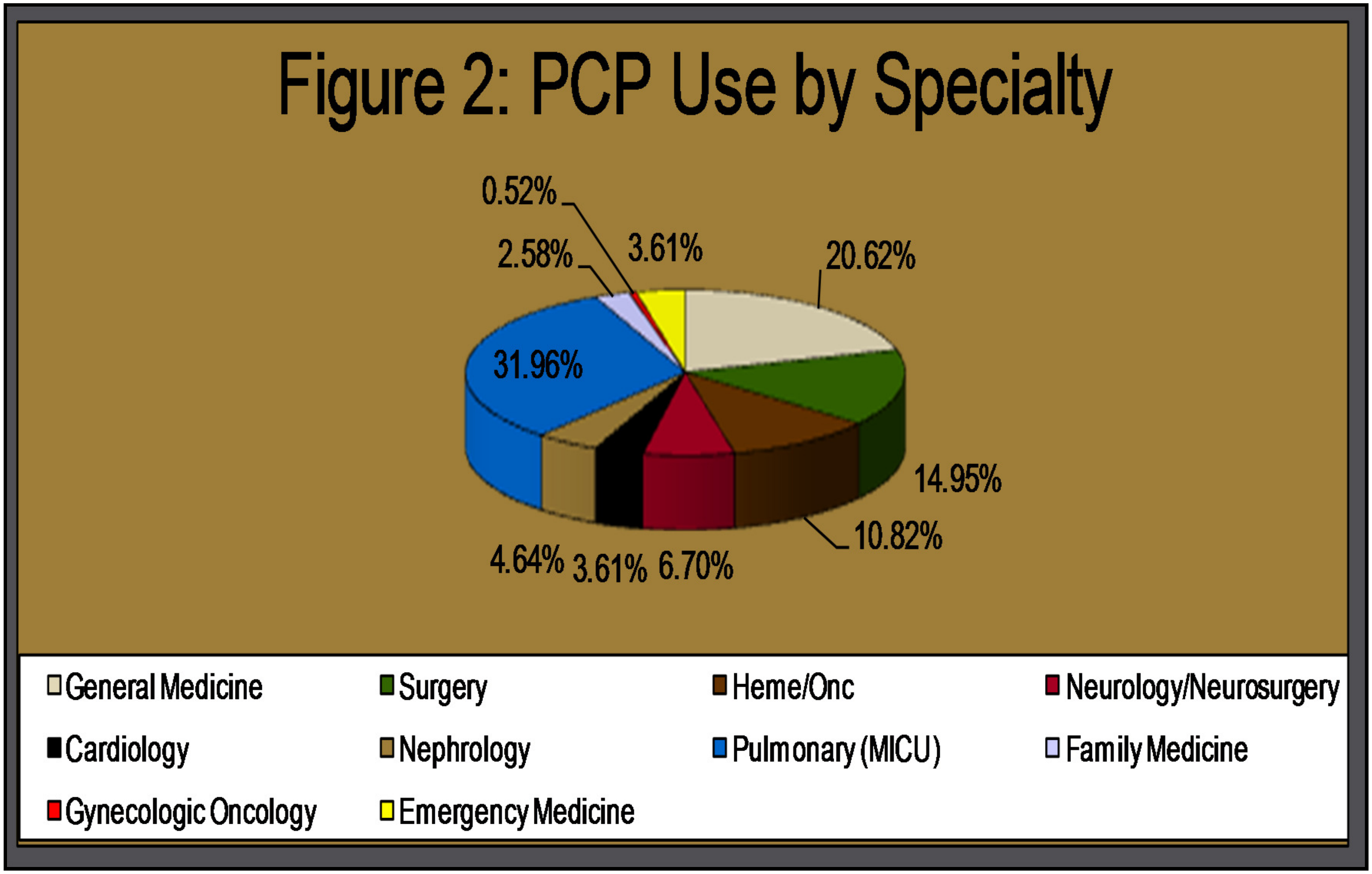


Figure 2: PCP Use by Specialty

Dying in the Hospital: The Impact of a Palliative Care Program on End of Life Care

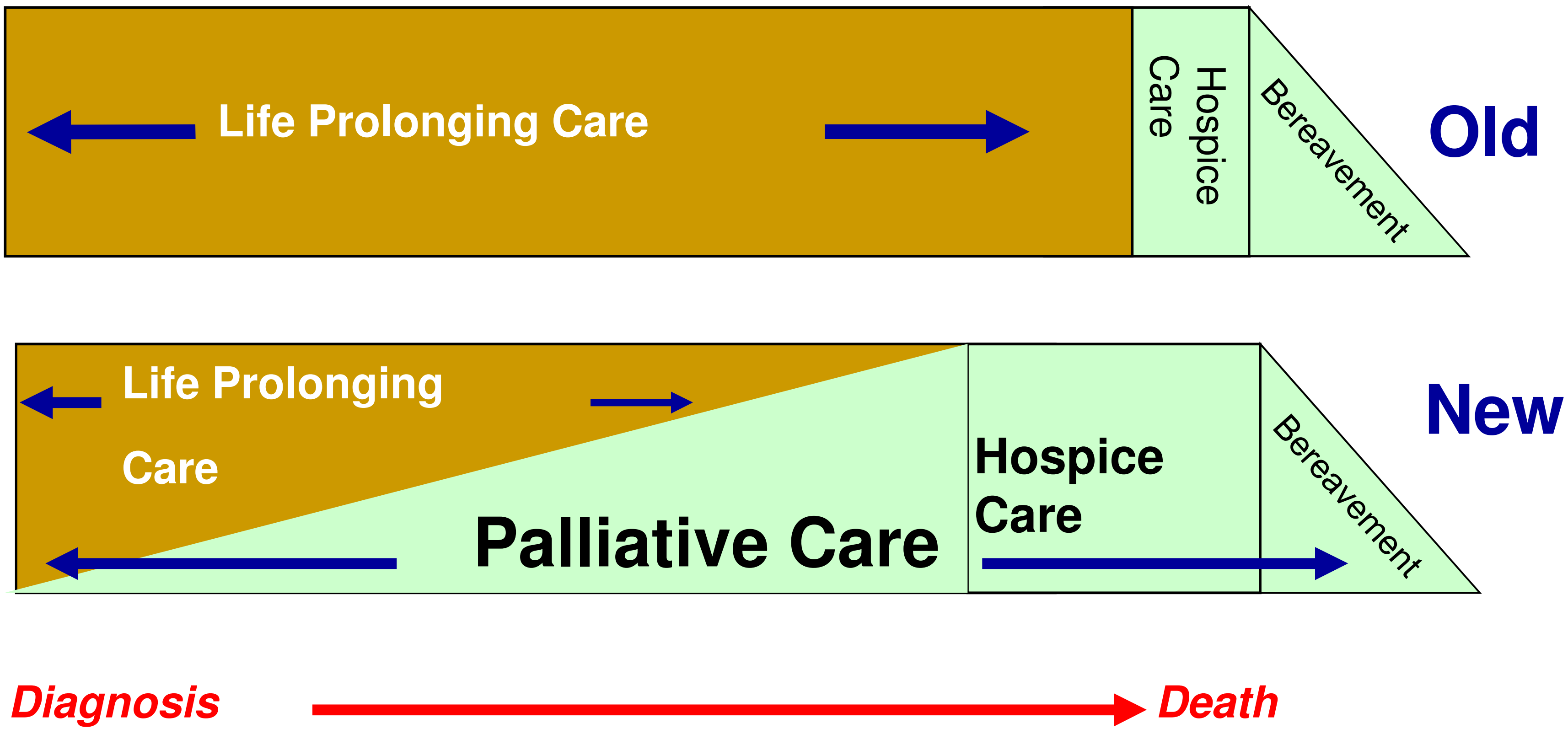
Results:

- The average number of days from DNR being signed until death in 2002 was 7.22 days and in 2007 was 21.63 (p value = <0.001)
- Of the 194 PCP consults (out of 521 decedents in 2007), 99% were called to address goals of care; only 1% were called for symptom management only.

WFBMC Mortality Committee Data

Month/YR	Discharges	**Deaths**	% Mortality	**EOL addressed on adm**	DNR at death	Comfort care at death	**Palliative Care Consulted**	**Died WFUBMC PCU**
Jun-10	2,660	**76**	3.66	**34% (26)**	96% (73)	83% (63)	**37% (28)**	**32% (24)**
Jul-10	2,785	**107**	3.88	**33% (35)**	92% (98)	77% (82)	**37% (40)**	**34% (36)**
Aug-10	2,724	**76**	2.79	**36% (27)**	88% (67)	72% (55)	**37% (28)**	**32% (24)**
Sep-10	2,694	**76**	2.78	**42% (32)**	84% (64)	72% (55)	**45% (34)**	**36% (27)**
Oct-10	2,699	**92**	3.52	**34% (31)**	91% (84)	78% (72)	**41% (32)**	**35% (32)**
Nov-10	2,628	**74**	2.82	**35% (26)**	92% (68)	77% (57)	**38% (28)**	**24% (18)**
Dec-10	2,641	**85**	3.22	**46% (39)**	82% (75)	73% (62)	**49% (42)**	**36% (31)**

Conceptual Shift



We’ve Come a Long Way, But… Caveats to Scaleability

- Variability in access to palliative care
- Evidence base
- Workforce pipeline
- Myths and legends about hospice and palliative care

2011 Public Opinion Research on Palliative Care

A Report Based on Research by Public Opinion Strategies

Research Commissioned by the Center to Advance Palliative Care

Support Provided by the American Cancer Society
and the American Cancer Society Cancer Action Network

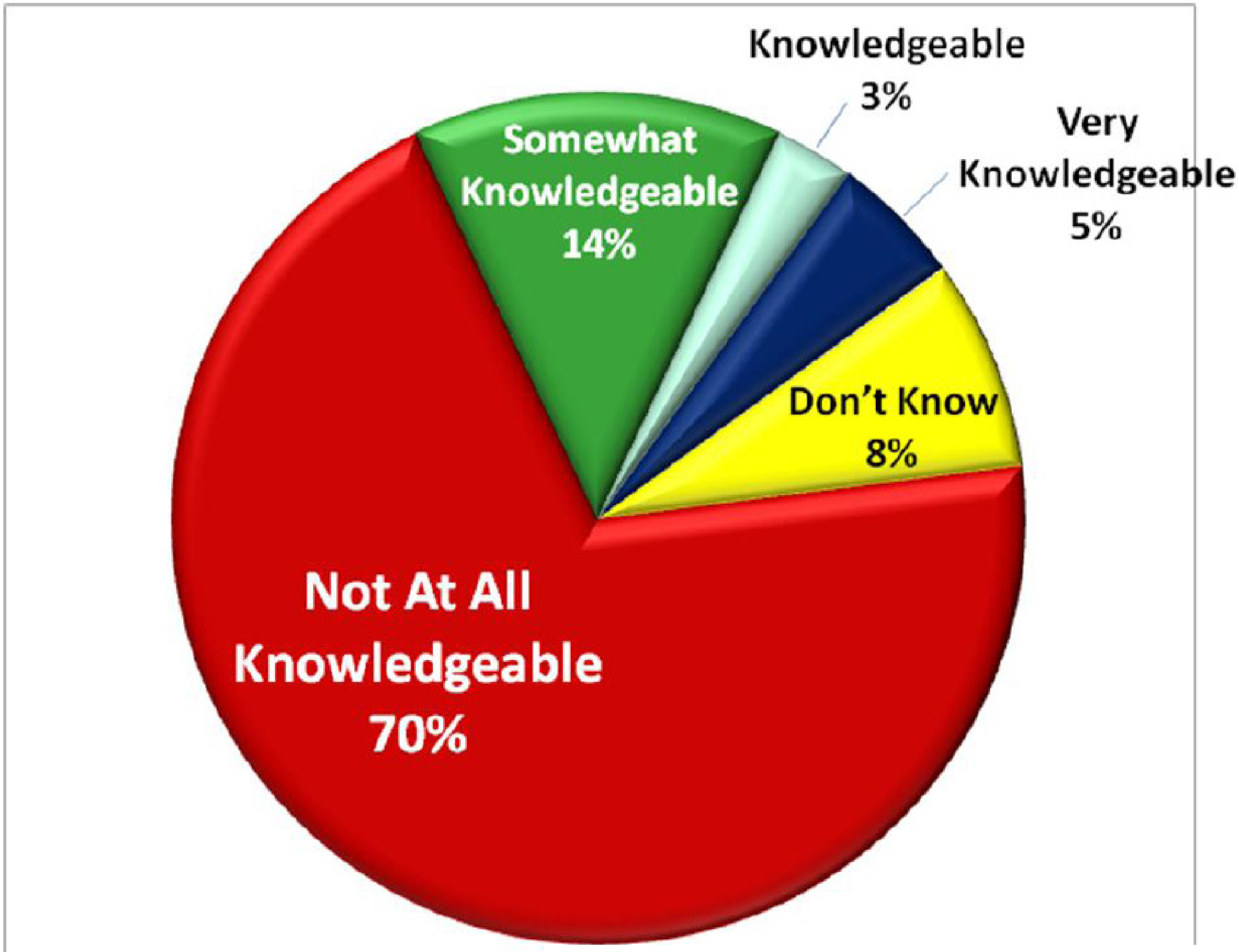
Conducted by Bill McInturff and Elizabeth Harrington of the national polling firm Public Opinion Strategies

Objectives:

- Explore key audiences' awareness and understanding of palliative care; and,
- Test language, terminology, definitions and messaging to be used in discussing palliative care with consumer audiences.

Consumer Awareness About Palliative Care

How knowledgeable, if at all, are you about palliative care?



***Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.**

Key Finding:

Physicians are a much more difficult audience than consumers.

- Physicians tend to either equate palliative care with “hospice” or “end of life” care, and they are very resistant to believing otherwise.
- We spoke with a total of eight physicians across the IDIs and focus groups. Although these physicians say they have referred patients to palliative care services, they admit they only do so when it is end of life care.

The End-of-Life care quandary

> “If you’re selling death, no one is going to buy.”
>
> - Diane Meier, MD

Palliative Care Message

- Palliative care is specialized medical care for people with serious illnesses.
- 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.*

Additional Barriers to Receiving PC

- Lack of integration into healthcare systems
- Lack of knowledge of palliative care principles and methods
- Stringent requirements for hospice admission
- Differences in religious and cultural beliefs
- Paucity of physician referrals

Rhymes J. Barriers to Palliative Care. Cancer Control. 1996 May;3(3):230-235.

Palliative Care in the Literature

1. Early palliative care for patients with non-small-cell lung cancer.
2. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care
3. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries
4. Estimate of current hospice and palliative medicine physician workforce shortage

Early Palliative Care for Cancer Pts.

- Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with non-small-cell lung cancer. N Engl J Med. 2010 Aug 19;363(8):733-42.
- Objective: Does early PC for ambulatory NSCLC pts. improve QoL and other factors?
- Methods: RCT simultaneous standard cancer care with palliative care co-management from diagnosis vs. control of standard cancer care only

Early Palliative Care for Cancer Pts.

- Results:
  - **Improved QOL** (FACT-L 98 vs. 91.5, $p<0.03$)
  - **Reduced depression** (HAD 16% vs. 38%, $p<0.01$; PHQ-9   4% vs. 17%, $p< 0.04$)
  - **Reduced 'aggressiveness'** (chemo < 14d before death, no hospice care, or hospice < 3 d before death) of care (33% vs. 54%, $p<0.05$)
  - ***Improved survival*** (11.6 mos. vs 8.9 mos., $p<0.02$)

Is Palliative Care Beneficial?

Palliative Care and Hospice PROLONG Life

New England Journal of Medicine, August 18, 2010

419,193,994 impressions

Helping cancer patients live better, longer

NBC Nightly News (9/10/10)

Cancer strategy: Easing the burden

Boston Globe (8/19/10)

Palliative care can help cancer patients live longer

USA Today (8/18/10)

Palliative Care Extends Life, Study Finds

The New York Times (8/18/10)

Study shows value of quality-of-life cancer care

The Washington Post (8/18/10)

New Studies in Palliative Care

National Public Radio, *The Diane Rehm Show* (8/24/20)

Study: Advanced Cancer Patients Receiving Early Palliative Care Lived Longer

The Wall Street Journal (8/18/10)

Translation to WFBMC

- Palliative Care Program is initiating work with Thoracic Oncology Program (TOP) Clinic
- Plan is to have outpatient clinics in:
  - OPD (started July 2011)
  - Outpatient Comprehensive Cancer Center (TBD)
  - Downtown Health Plaza (TBD)
- Increased ambulatory education about ADs and PC

Increased Identification of Patients Needing PC

- Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care. J Palliat Med. 2011 Jan;14(1):17-23. Epub 2010 Dec 6
- Consensus panel convened to select criteria by which patients at high risk for unmet palliative care needs can be identified in advance for a palliative care screening assessment.

Increased Identification of Patients Needing PC

Definitions

- Primary Palliative Care
  - Skills and competencies required of all practitioners
- Secondary Palliative Care
  - Specialist clinicians that provide consultations and specialty care
- Tertiary Palliative Care
  - Care provided at tertiary medical centers where specialist knowledge for the most complex cases is researched, taught, and practiced.

Increased Identification of Patients Needing PC

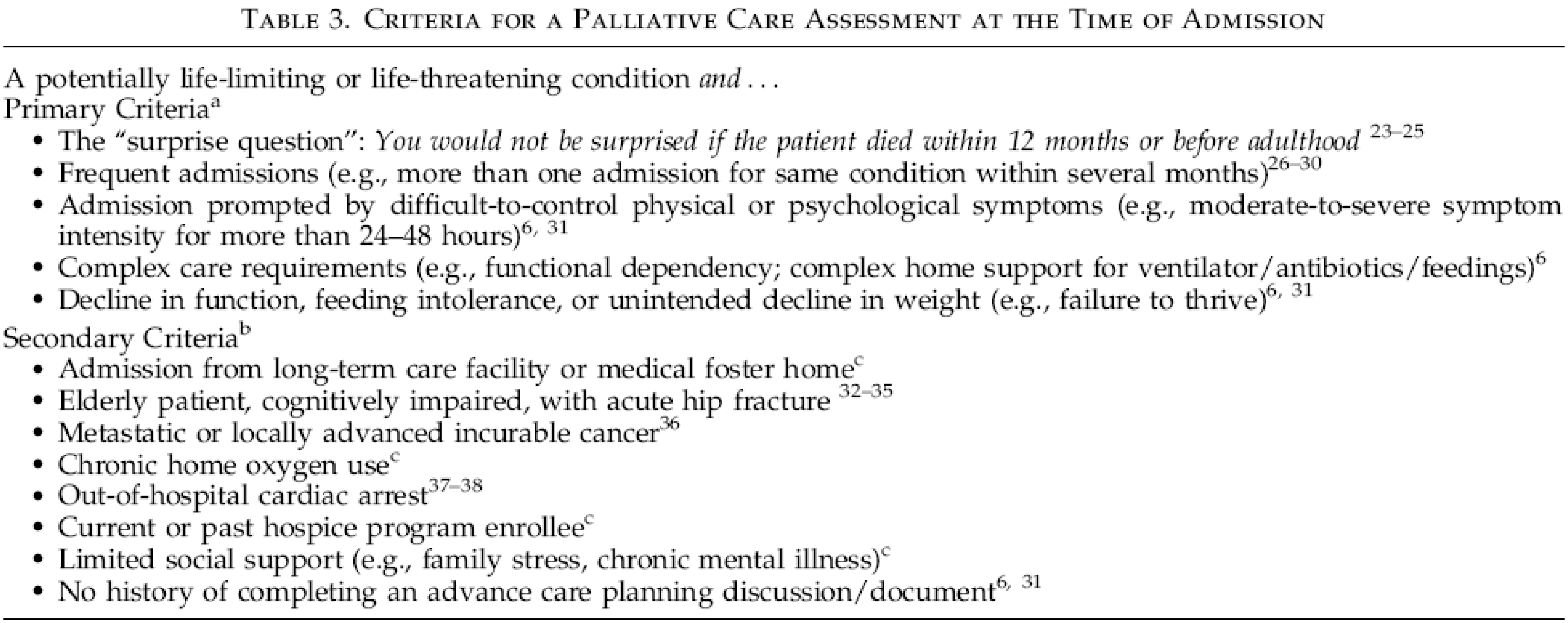


TABLE 3. CRITERIA FOR A PALLIATIVE CARE ASSESSMENT AT THE TIME OF ADMISSION

A potentially life-limiting or life-threatening condition *and* . . .

Primary Criteria[a]

- The "surprise question": *You would not be surprised if the patient died within 12 months or before adulthood* [23–25]
- Frequent admissions (e.g., more than one admission for same condition within several months)[26–30]
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)[6, 31]
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)[6]
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)[6, 31]

Secondary Criteria[b]

- Admission from long-term care facility or medical foster home[c]
- Elderly patient, cognitively impaired, with acute hip fracture [32–35]
- Metastatic or locally advanced incurable cancer[36]
- Chronic home oxygen use[c]
- Out-of-hospital cardiac arrest[37–38]
- Current or past hospice program enrollee[c]
- Limited social support (e.g., family stress, chronic mental illness)[c]
- No history of completing an advance care planning discussion/document[6, 31]

Weissman DE, Meier DE. JPM 2011

Increased Identification of Patients Needing PC

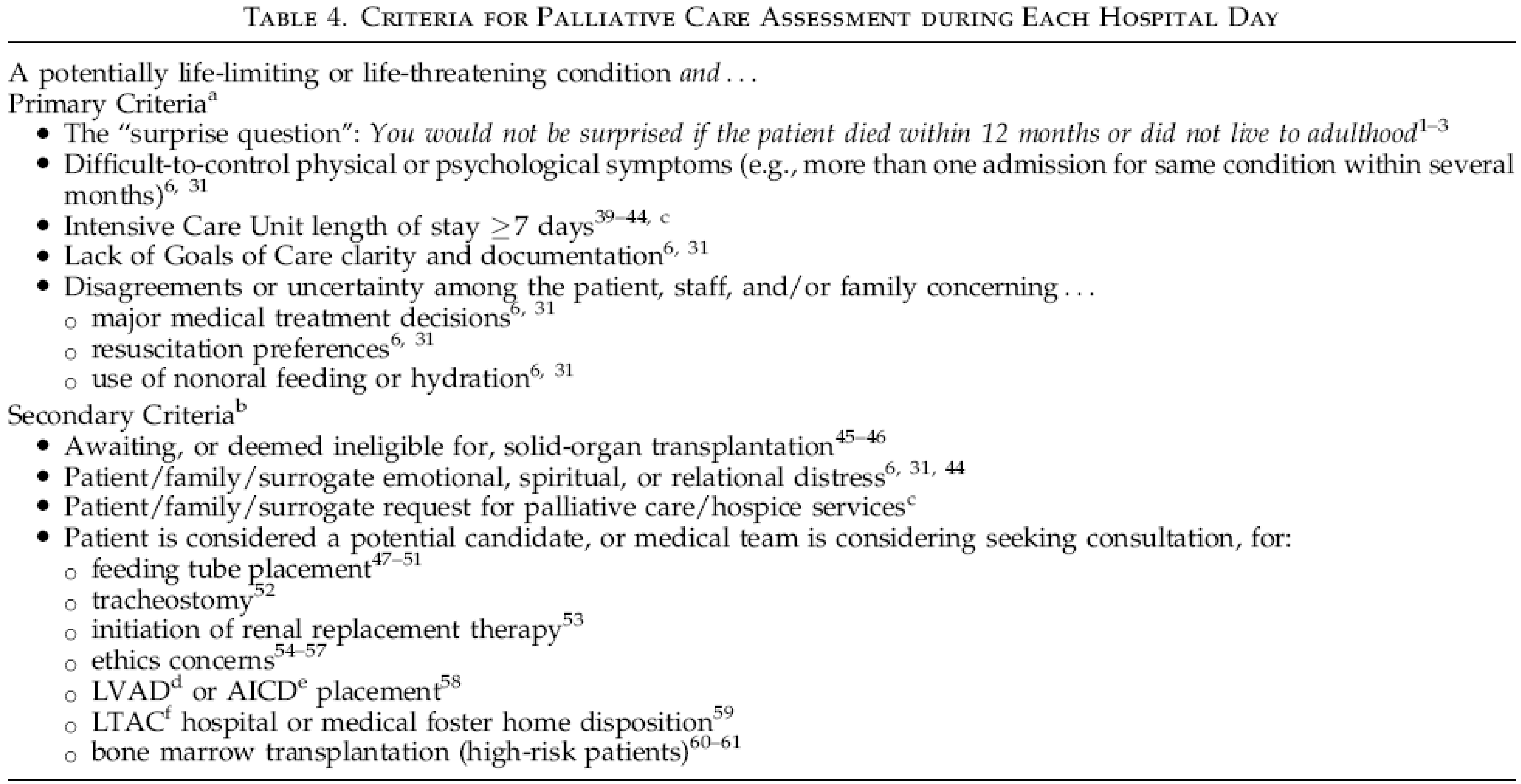


TABLE 4. CRITERIA FOR PALLIATIVE CARE ASSESSMENT DURING EACH HOSPITAL DAY

A potentially life-limiting or life-threatening condition *and* . . .

Primary Criteria[a]

- The "surprise question": *You would not be surprised if the patient died within 12 months or did not live to adulthood*[1–3]
- Difficult-to-control physical or psychological symptoms (e.g., more than one admission for same condition within several months)[6, 31]
- Intensive Care Unit length of stay ≥7 days[39–44, c]
- Lack of Goals of Care clarity and documentation[6, 31]
- Disagreements or uncertainty among the patient, staff, and/or family concerning . . .
  - ○ major medical treatment decisions[6, 31]
  - ○ resuscitation preferences[6, 31]
  - ○ use of nonoral feeding or hydration[6, 31]

Secondary Criteria[b]

- Awaiting, or deemed ineligible for, solid-organ transplantation[45–46]
- Patient/family/surrogate emotional, spiritual, or relational distress[6, 31, 44]
- Patient/family/surrogate request for palliative care/hospice services[c]
- Patient is considered a potential candidate, or medical team is considering seeking consultation, for:
  - ○ feeding tube placement[47–51]
  - ○ tracheostomy[52]
  - ○ initiation of renal replacement therapy[53]
  - ○ ethics concerns[54–57]
  - ○ LVAD[d] or AICD[e] placement[58]
  - ○ LTAC[f] hospital or medical foster home disposition[59]
  - ○ bone marrow transplantation (high-risk patients)[60–61]

Weissman DE, Meier DE. JPM 2011

Translation to WFBMC

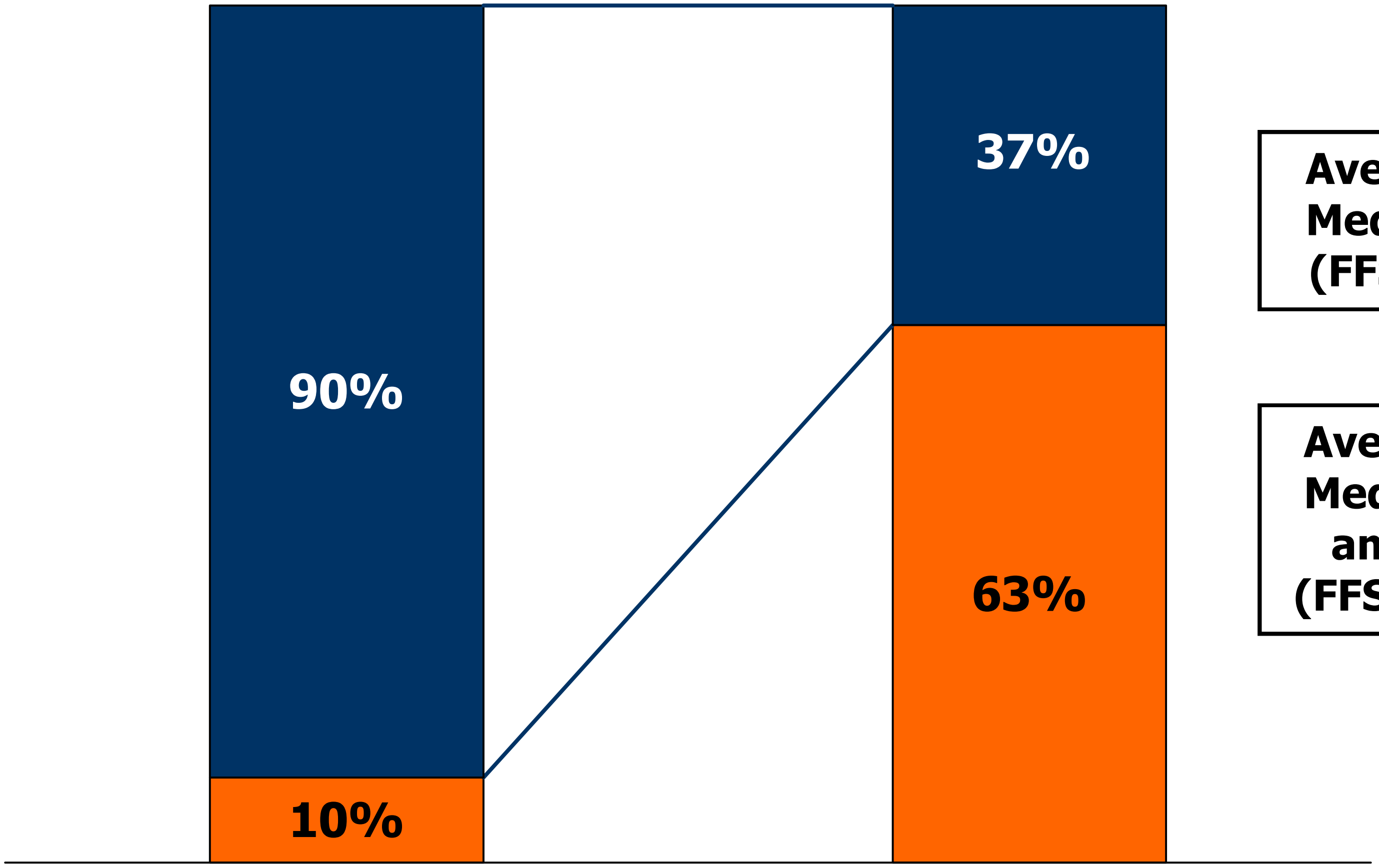
- Utilization of clinical indicators to improve quality of care, systematically, for all patients, reduce variability
- Major aim as part of the Ethics End of Life Task Force plan (discussed later)

PC Reduces Medicaid Costs

- Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Affairs 30. (3): 454-463.2011
- Problem: Patients facing serious or life-threatening illnesses account for a dis-proportionately large share of Medicaid spending.
- Objectives: Evaluate effect of palliative care consultations on Medicaid spending

Target Population for Palliative Care

Distribution of Total Medicare Beneficiaries and Spending, 2005



Average per capita Medicare spending (FFS only): $7,064

Average per capita Medicare spending among top 10% (FFS only): $44,220

Total Number of FFS Beneficiaries: 37.5 million

Total Medicare Spending: $265 billion

NOTE: FFS is fee-for-service. Includes noninstitutionalized and institutionalized Medicare fee-for-service beneficiaries, excluding Medicare managed care enrollees.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost & Use file, 2005.

PC Reduces Medicaid Costs

- Methods:
    - Use of hospital administrative data to compare hospital costs of patients receiving palliative care consultations matched by propensity scores to patients receiving usual care for the period 2004–07 at four New York State hospitals.

PC Reduces Medicaid Costs

- Results:
  - On average, patients who received palliative care incurred $6,900 less in hospital costs
  - These reductions included $4,098 in hospital costs per admission for patients discharged alive, and $7,563 for patients who died in the hospital.

PC Reduces Medicaid Costs

- Results cont.:
  - Consistent with pt/family goals, PC recipients:
    - Spent less time in an ICU
    - Less likely to die in and ICU
    - more likely to receive hospice referrals than the matched usual care patients
  - reductions in Medicaid hospital spending in New York State could eventually range from $84 million to $252 million annually

Translation to WFBMC

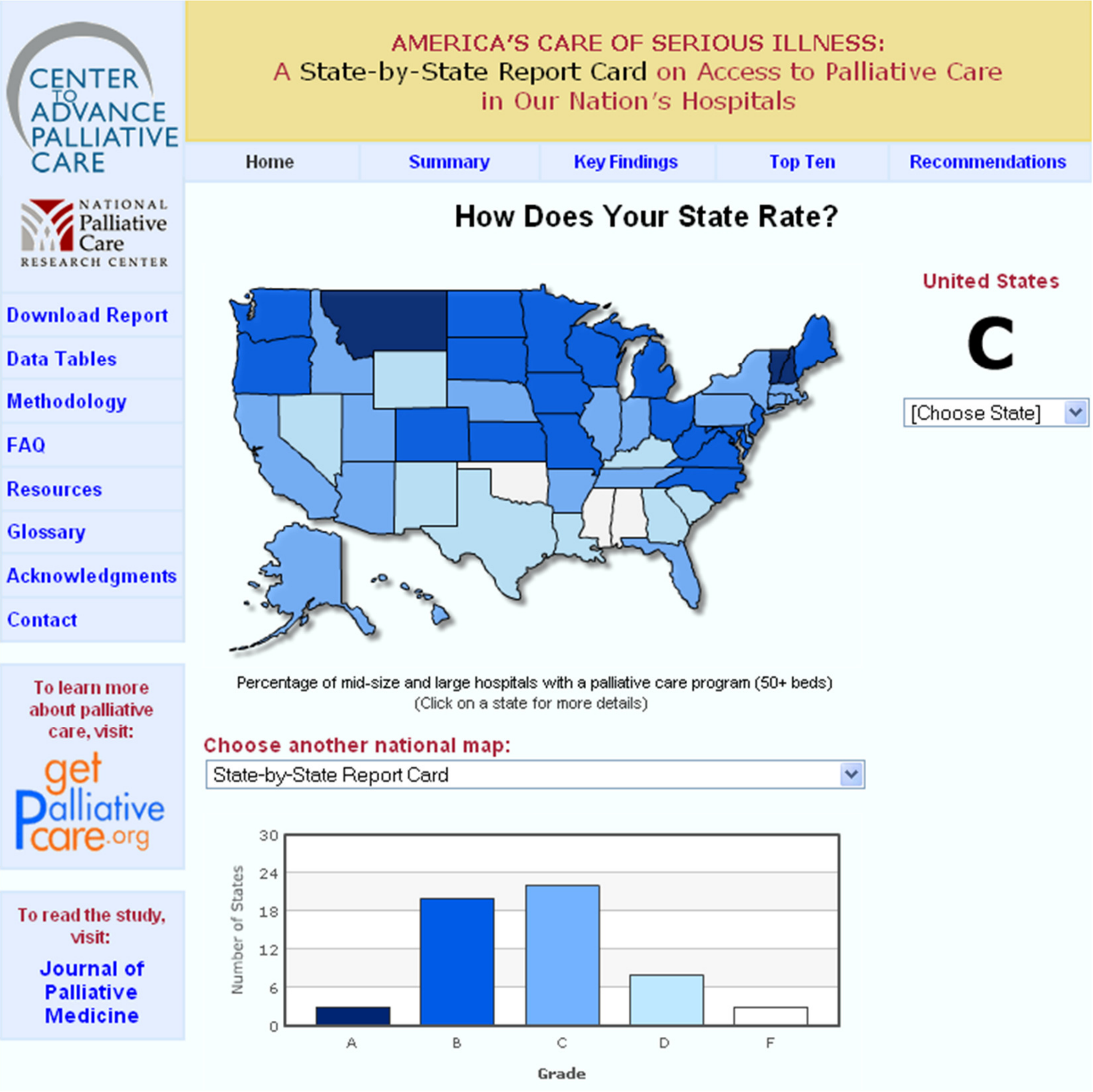
- Ongoing work with Northwest Community Care Network
  - Improved education of Housestaff
  - Outpatient palliative care clinic support
  - Hospital re-admission rate reduction collaboration (led by Pam Duncan)

Hospice and Pall. Medicine Workforce

- **Workforce: the #1 Major Barrier to Access**
- Current problem:
  - 1 palliative medicine MD for every 31,000 persons with serious and advanced illness
    - Compare to 1 oncologist per 145 newly diagnosed cancer patients or 1 cardiologist per 71 MI victims
  - 20 states have no GME fellowship training programs in palliative medicine

Hospice and Pall. Medicine Workforce

- Current problem
  - 50% of hospitals (27% of hospitals with over 300 beds) lack a palliative care program
  - Standards for palliative care programs are voluntary
  - Business model = cost savings + MD reimbursement (difficult to demonstrate and sustain)



AMERICA'S CARE OF SERIOUS ILLNESS:
A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals

How Does Your State Rate?

United States

C

Percentage of mid-size and large hospitals with a palliative care program (50+ beds)
(Click on a state for more details)

Choose another national map: State-by-State Report Card

To learn more about palliative care, visit: getPalliativecare.org

To read the study, visit: **Journal of Palliative Medicine**

Hospice and Pall. Medicine Workforce

- Lupu D; American Academy of Hospice and Palliative Medicine Workforce Task Force. Estimate of current hospice and palliative medicine physician workforce shortage. J Pain Symptom Manage. 2010 Dec;40(6):899-911.
- American Academy of Hospice and Palliative Medicine (AAHPM) appointed a Workforce Task Force in 2008 to assess whether a physician shortage existed and to develop an estimate of the optimal number of HPM physicians needed.

Hospice and Pall. Medicine Workforce

- Objectives: Develop estimates of the current supply and current need for HPM physicians. Determine whether a shortage exists and estimate size of shortage in full-time equivalents (FTEs) and individual physicians needed.

Hospice and Pall. Medicine Workforce

- Results:
  - 4400 current HPM MDs (Board certified or AAHPM members)
  - Estimated physician workforce level from 1700 FTEs to 3300 FTEs
  - 4487 hospice and 10,810 palliative care physician FTEs are needed to staff the current number of hospice- and hospital-based palliative care programs at appropriate levels

Hospice and Pall. Medicine Workforce

- Results:
  - estimated gap- 2787 FTEs to 7510 FTEs
  - equivalent to 6000–18,000 individual physicians, depending on what proportion of time each physician devotes to HPM practice.
  - current capacity of fellowship programs is insufficient

Translation to WFBMC

- Ongoing efforts to increase fellowship positions (currently 1/yr)
- Approval to hire another MD through EOLC Task Force plan
- Recent advocacy on Capitol Hill
  - PCHETA (Palliative Care Health Education and Training Act) Bill
    - In development by Senator Wyden (D-OR)

How Do We Make Things Better at WFBMC???

Ethics Committee: EOL Care Task Force charged by Dr. Sibert (July, 2010)

Members:	Jay Foster, DMin, co-chair
	Morgan Bain, MD, co-chair
	Bev Essick, RN
	Cathy Jones, MD
	Dee Leahman
	Kate Mewhinney, JD
	Terrie Michaels, RN
	Preston Miller, MD
	John Moskop, PhD

EOLC Task Force Executive Summary

1. Development and implementation of clinical indicators
2. Increase access to Palliative Care services
3. Integration of advance care planning in outpatient and inpatient settings (*Respecting Choices*)
4. Strengthening of the clinical ethics consultation service
5. Development of professional and family bereavement support services
6. Education for MDs and other providers about issues related to EOLC (*EPEC, ELNEC*)

IMQUIP EOL Committee

Members:

Richard McQuellon, PhD (chair)
Blake Long, MD (vice-chair)
Morgan Bain, MD
Anthony Bleyer, MD
Jennifer Cooper, MD
Beverly Essick, RN
Jay Foster, DMin
Barbara Lehman
GiGi MacDonald, MD
Seema Naik, MD
Theresa Taylor

IMQUIP EOL Committee- Recommendations

- Living Will, HCPOA, and EOL desires should be addressed for every patient on the H&P if appropriate, code status should be discussed
- Encourage use of EMR for ADs
- Ensure documents (MOST & portable DNR) are available in clinics
- Outpatient yearly review of EOLP documents or at time of serious illness

IMQUIP EOL Committee- Recommendations

- Require education for all staff
- Utilize Best Health AD Classes
- Utilize ethics living will module in Centricity
- Discuss available Palliative services
- Optimize referrals to Hospice Care
- Refer to pastoral care

Is Palliative Care Timely?

Timing of Referrals to Hospice and Palliative Care is Late

- Median length of stay in hospice = 18 days
- 35% of hospice patients receive care for < 1 week before death
- 9.2% >180 days
- Median LOS in hospital before palliative care consultation = 14 days

www.nhpco.org and Mount Sinai Hospital Palliative Care Consult Service data

Goss Lake, Available:
http://www.google.com/imgres?q=fishing+in+a+lake&hl=en&qscrl=1&nord=1&rlz=1T4GGHP_enUS426US426&biw=1280&bih=757&tbm=isch&tbnid=K_Axbjy7YwVEIM:&imgrefurl=http:/
/www.celebratebig.com/whidbey-island/goss-lake-coupeville-fort-ebey-deception-pass/index.htm&docid=cCUdmIlVa-COCM&w=640&h=426&ei=RXNvTu2PO8fD0AH3zYjlCQ&zoom=1
September 13, 2011

Words of Wisdom

- *In Switzerland I was educated in line with the basic premise: work work work. You are only a valuable human being if you work. This is utterly wrong. Half working, half dancing - that is the right mixture. I myself have danced and played too little.*

-Elisabeth Kubler-Ross