Munson Hospice & Palliative Care: The Right Care at the Right Time

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Jan. 6, 2014

Palliative Care

Whole-person care for patients of all ages who are experiencing debilitating, chronic, or life-threatening illness or condition, can be concurrent with curative treatment

Palliative Care at Munson is **Not**:

Home Care

Home-based Primary Care

Chronic Pain Service

Hospice

- End of Life care
- Must have two physicians certify a 6 month or less life expectancy if the hospice diagnosis follows its typical course
- Symptom management
- Must forego curative treatment
- Must meet admission criteria/Medicare

The Hospice Benefit

- Must be eligible for Medicare Part A
- Must have a 6 month or less life expectancy
- Is a 100% coverage for hospice diagnosis services
- Patient waives traditional Medicare Part A and elects the Medicare Hospice benefit for coverage of all healthcare services related to the terminal diagnosis, including medications
- Traditional Medicare continues to cover services for care unrelated to the terminal diagnosis

Palliative Care Goals

- Symptom relief: pain, dyspnea, psychosocial distress, spiritual issues and practical needs
- Patient and family education regarding illness, prognosis, and treatment options
- Coordination of care
- Provide an opportunity for a patient to prepare for approaching death
- Assistance with end of life decisions and management of care, POLST

Palliative Care Referral Triggers

- Would you be surprised if your patient died within the next year?
- Does your patient have ineffective symptom management with current therapy?
- Does current care seem inconsistent with the patient’s wishes?

PC Triggers, cont.

- Does it seem the care being provided is futile?
- Has your patient been readmitted for symptom management within a short period?
- Does your patient need assistance with Advance Care Planning?

Benefits of Palliative Care: CAPC

- Lower costs for hospitals and payers
- Systematic approach to care management
- Supports primary care
- Meets needs of aging populations

- Center to Advance Palliative Care, 2013

Palliative Care Lowers Costs

- Reduces lengths of stay, including ICU LOS
- Reduces costs by avoiding redundant, unnecessary, or ineffective treatments
- Decreases costs for testing, pharmaceuticals
- About 68% of Medicare costs are related to patients with four or more chronic conditions

Palliative Care Impacts

- **Data from 8 hospitals, 2966 palliative care patients matched to 2124 usual care patients**
- **Patients discharged alive had adjusted net savings $1696 in direct costs per admission(P= .004) and direct costs $279 per day (P<.001)**
- **Patients who died had adjusted net savings of $4098 in direct costs per admission (P= .003) and $374 in direct costs per day (P<.001)**
- **Significant reductions in pharmacy, laboratory, and ICU costs.**

Cost Savings Associated With US Hospital Palliative Care Consultation Programs. *R. Sean Morrison, MD, et. Al. Arch Intern Med. 2008; 168 (16): 1783-1790.*

Palliative Care Enhances Quality

- Palliative Care involvement results in higher levels of satisfaction with care team, physicians, and hospitals
- Patients at right level of care, at the right time
- Literature shows improved pain control
- Fewer bereavement issues after ICU admission

Palliative Care

- Symptom control (e.g., pain)improved with PC consultation, $P < 0.001$
- Per diem costs 10.7% less for all PC cases, 20.5% less with PC on case for > 50% of hospital days

- Hanson, LC, et al. Clinical and Economic Impact of Palliative Care Consultation. Pain Symptom Manage. 2008; 35: 340-346

Early Palliative Care

- Standard care vs. standard care with Palliative Care in metastatic NSC Lung Cancer
- PC group had measurably better quality of life, fewer symptoms of depression
- PC group received less aggressive care
- PC group median survival 11.6 months vs. 8.9 months in standard group

- Temel, J, et.al. Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer N Engl J Med 2010; 363:733-742, August 19, 2010

Early PC Involvement

- Newly diagnosed, N=151, with/without PC
- Overall number of chemotherapy regimens similar
- PC group half the odds of receiving chemo within 60 days of death
- Higher enrollment in hospice for longer than 1 week
- Optimized timing of final chemo and hospice enrollment, key measures of quality EOL care

- Greer JA, Pirl WF, Jackson VA et al.   Effects of Early Palliative Care in Patients with Metastatic Non-Small-Cell Lung Cancer. J Clin Oncol 2012; 30(4): 394-400

Supports Primary Care By Providing:

- Time; care coordination and time intensive communications regarding goals of care
- Expertise; pain and symptom management in complex cases
- Coordination of care; primary physician's orders, develop and initiate effective discharge planning, coordination of community services

Refer Early

- Earlier referral benefits the patient, caregivers, and our Hospice and Palliative Care programs
- Palliative Medicine is a valuable benefit for the patient
- Provides multidisciplinary support of symptoms and psychosocial issues
- Hospice is required to provide bereavement services for one year after a patient’s death

NPO Data

>1 Hospitalization last 30 days of life: 29%

Dying in hospital: 31%

Hospice admission last 1-30 days of life: 29%

> 10 health care providers last 60 days of life: 77-85%

Data base: limited population from specific commercial payer

Difficult Conversations

- 1. With myself
- 2. With my colleagues
- 3. With our patient

Palliative Care Skills in Primary Care

- Basic management of pain, symptoms, depression and anxiety
- Basic discussions about prognosis, goals, treatment
- Address code status and MI-POST form

Specialty Palliative Care Services

- Management of complex symptoms, anxiety, grief
- Management of refractory pain
- Conflict Resolution associated with goals and treatment: patients, families, staff, treatment teams
- Assistance with issues surrounding futile care

Collaboration

- Currently not enough palliative care specialists
- Need to improve basic Palliative Care curriculum in medical training
- Enhance Primary Care basic palliative care skills
- Generalist-plus-specialist palliative care addresses PC specialist shortage, maintains meaningful relationships across continuum of care, controls costs

- Quill, T, Abernethy, A. Generalist plus Specialist Palliative Care-Creating a More Sustainable Model. NEJM 2013; 368: 1173-1175, March 28, 2013

Munson Palliative Care Admission Criteria

- Patient has a local PCP who remains involved in care
- Patient has a life-limiting illness with probable life expectancy of 1 year or less, and/or
- Patient needs assistance with physical and/or psychosocial symptom management, and/or
- Patient needs assistance with establishing goals/limitations of medical treatment
- Patient must reside within Munson Palliative Care service area
- Must have an order from a physician, or nurse practitioner, or physician's assistant

Munson Palliative Care Discharge Criteria

- Goals met
- Admitted to ECF for long term management
- Hospice admission
- Death
- Moves out of service area
- Patient requests discharge
- Patient non-adherence to plan of care

Current Model

- Redefining our PC program
- Consultative vs. Co-management
- Expanding Inpatient involvement with One Call system
- Moving to OP Clinic model

Munson Palliative Care Goals

- JCAHO certification
- Clinics
- Practitioner certification
- Electronic medical record

Palliative Care at Munson

- Developing a closer collaboration between Home Care and Palliative Care
- Developing a continuum of care between Palliative Care and Hospice
- Establishing a One Call system for Palliative Care referral within the Munson service area

Palliative Care at Munson

- Current PC OP care delivery based on home visit model is an unsustainable model
- Clinics: embedded vs. free standing
- Thoracic Cancer Clinic
- Munson Family Practice
- Paul Oliver, MPB, Suttons Bay, KMH?

Summary

- Palliative Care improves QOC and decreases costs
- Early referral to Hospice benefits the patient and caregivers
- Munson can provide seamless EOL care