

**Palliative Care: Essential to the Patient, the Family, and the Public's Health**

**University at Albany School of Public Health's Public Health Live**

**Thursday**

**March 4, 2010**

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**Palliative Care**

- Interdisciplinary care that aims to relieve suffering and promote quality of life *simultaneously* with all other appropriate treatment for patients with advanced illness and their families
- Major concerns are pain and symptom management, information sharing and advance care planning, psychosocial and spiritual support, and coordination of care

## History of Palliative Care

- Late 1950's and 60's studies published on the care of terminal cancer patients.
- 1967 – Dr Cicely Saunders, St Christopher's Hospice
- 1974 – Dr Balfour Mont, Montreal, coins the term palliative care
- 1974 – First hospice opens in New Haven, CT.
- 1976 – 1st hospital support team for terminal cancer patients at St Thomas Hospital, London.
- 1982 – Medicare Hospice benefit established
- 1987 – Established as a subspecialty of medicine in England
- 2006 – 115 of 234 countries have hospice-palliative care services.
- 2008 – subspecialty status in U.S.

## “Palliative care has a branding issue.”

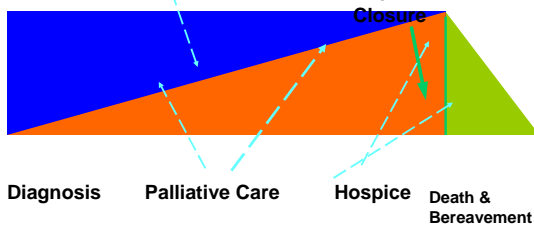
Dr. Elaine Schattner, 2010

- Not limited to end-of-life care
- Studies show that most people living with a serious illness experience inadequately treated symptoms; fragmented care; poor communication with their doctors; and enormous strains on their family caregivers
- Frank discussion of illness and advanced care planning is needed farther upstream, at the first possible opportunity after a serious diagnosis is given

## A New Vision of Palliative Care



**Disease Modifying Therapy**  
Curative, or restorative intent



NHWG; Adapted from work of the Canadian Palliative Care Association & Frank Ferris, MD

## Case Study

- 88 year old female
- Dementia, HBP, osteoporosis, hyperlipidemia, anemia, arthritis, impaired nutrition
- Assisted living facility
- June 2008 sent to ER for increased confusion
- Neuro consult: MRI / EEG / carotid US
- iron, folic acid, esomeprazole, amlodipine, alendronate, simvastatin, levofloxacin, donepezil, aspirin

## Sept 2008 Returns to ER for Lethargy

- Vomited digested blood and aspiration pneumonia
- GI consult EGD – severe esophagitis
- Pulmonary consult CT, thoracentesis
- IV antibiotics
- Simvastatin, Donepezil, Esomeprazole, Diltiazem, Alendronate

## November 2008 – lethargy, UTI

Bedbound, noncommunicative  
4 pressure sores  
Fetal position

“A diagnostic and therapeutic procedure is performed”

### Family Contacted

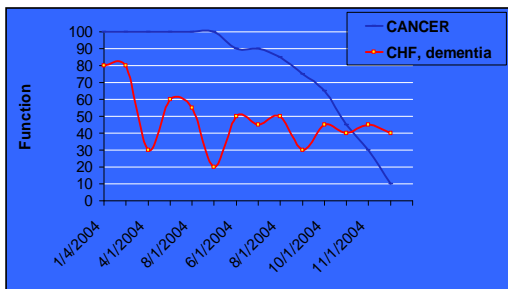
HC Proxy and Living Will reviewed  
Comfort and staying at “home”  
Streamlined medication list  
Started RTC pain medicine  
Wound care  
Allowed to eat as tolerated  
Hospice referral  
NonHospital DNR completed



3 months post discharge

### The Reality of the Last Years of Life: Death Is Not Predictable

(slide courtesy of Joanne Lynn, MD Rand Corp.)  
Covinsky et al. JAGS 2003;  
Lynn & Adamson RAND 2003.  
Morrison & Meier N Engl J Med 2002.



### The Demographic Imperative: Chronically Ill, Aging Population Is Growing



- The number of people over age 85 will double to 10 million by the year 2030.
- The 23% of Medicare patients with >4 chronic conditions account for 68% of all Medicare spending.

US Census Bureau, CDC, 2003. Anderson GF. NEJM 2005;353:305  
CBO High Cost Medicare Beneficiaries May 2005

### Better Care Needed From the Day of Diagnosis of Any Serious Illness

- People need better care throughout the **multi-year** course of advanced illness.
- Medicare Hospice Benefit developed to care for those dying soon: payment regulations require 6 month prognosis and decision to forego insurance coverage for life prolonging care.
- Additional approaches are needed for much larger numbers of persons with chronic, progressive illness, years to live, continued benefit from disease modifying therapy, and obvious palliative care needs.

### The Fiscal Imperative

- Exponentially rising costs with effective new technologies, aging population-
- 10.9% growth in Medicare hospital payments in 2008
- 72% of 2008 Medicare budget spent on hospital care (\$272 billion)
- 35% Medicare expenses are in last 6 months of life, 30% of this in last month of life
- Hospital of the future will have to efficiently and effectively treat chronically and seriously ill in order to survive

## Why palliative care?



### Clinical imperative:

The need for a better quality of care for persons with serious and complex illnesses

Diane E. Meier, 2006

## Program Overview – Home Connections Palliative Care Program

- Provides home-based care and support to assist patients and their families facing chronic, serious illness.
- The program facilitates the completion of advance directives, as well as advocating and teaching patients how to avoid ER visits and hospitalizations.

## Program Overview – Home Connections Palliative Care Program

- Patient & Caregiver Satisfaction
- Program Outcomes:
  - 1) Hospice Referrals
  - 2) ED Visits
  - 3) Hospitalization Rates
  - 4) Advance Directives

## Program Outcomes Hospice Referrals



## Program Outcomes Hospice Referrals

Figure 2: Cost Savings



## Program Outcomes Hospice Referrals

- Earlier referral to hospice creates more opportunities for cost avoidance
  - Chemotherapy
  - Radiation
  - CAT/MRI
  - ED visits
  - ICU/Hospital Days

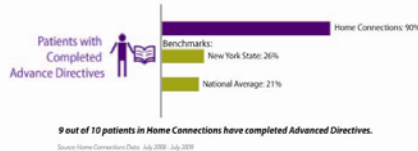
## Program Outcomes ED Visits

Figure 3: Emergency Room Visits



## Program Outcomes Advance Directives

Figure 5: Creation of Advance Directives

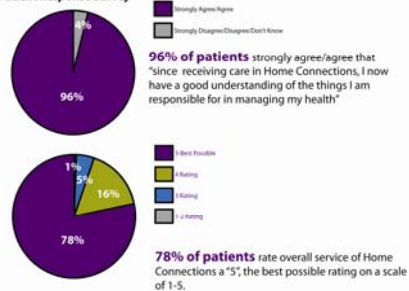


## Patient Narratives

- Emphysema patient has no ER or hospital visits in 14 months and lives safely at home
- Home Connections empowers young man to avoid unwanted care and live on his terms

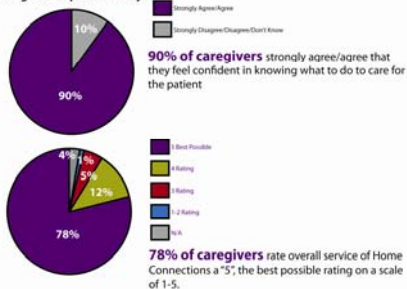
## Patient Satisfaction Survey

Patient Response Survey



## Caregiver Satisfaction Survey

Caregiver Response Survey



## Summary Home Connections Palliative Care

- High patient and caregiver satisfaction
  - ↑ referrals to Hospice
  - ↓ ER visits
  - ↓ Hospitalizations
  - ↑ Advance Directives
  - Good communication with physicians
- all ↓ costs

## Role of Primary Provider

- Palliative care is a team approach to patient care. The primary doctor will continue to direct care and play an active part in treatment. The palliative care team provides support to and works in partnership with the primary doctor.

Center to Advance Palliative Care

## The Primary Care MD

It would take a physician with a typical patient panel

- 7.4 hours/day for preventive services

**AND**

- 10.6 hours/day for long-term care services

Bodenheimer, NEJM March 2008

## Palliative Care in Primary Care Office

- Let the patient set the agenda
- Encourage completion of advance directives
- “Hope for the best but be prepared for the worst”

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