PALLIATIVE CARE, DEATH PANELS, AND RATIONING RESOURCES

Gobi Paramanandam, MD, MHSM
Arizona Palliative Home Care

Learning Objectives:

- Describe Palliative Medicine and why it is needed.
- Discuss how Palliative Medicine contributes to quality care for patients.
- Discuss how Palliative Medicine contributes to cost-efficiency by reducing health care costs.

DISCLOSURE OF COMMERCIAL SUPPORT
Gobi Paramanandam, MD, MHSM does not have a significant financial interest or other relationship with manufacturer(s) of commercial product(s) and /or provider(s) of commercial services discussed in this presentation.
Palliative Care, Death Panels, and Rationing Resources

Gobi Paramanandam MD, MHSM
Arizona Palliative Home Care

Media

PBS
USA Today

The information in this document may not be reproduced or disclosed to unauthorized parties without the prior consent of the Arizona Geriatrics Society.
2013 Arizona Geriatrics Society All Rights Reserved
Objectives

- Describe Palliative Medicine and why it is needed
- Discuss how Palliative Medicine contributes to quality care for patients
- Discuss how Palliative Medicine contributes to cost-efficiency by reducing health care costs

Definition

- Goal of palliative care is to relieve the pain, symptoms and stress of serious illness regardless of prognosis
- Can be delivered along with treatments that are meant to cure
The need
- Aging is profoundly challenging our health care system
- 2005 – U.S. life expectancy rose to a record 77.8 years*
- 2000 – 10.4% aged 65 and older
  1.5% over 80
- 2050 – 18.6% aged 65 and older*
  4% over 80

The need
- 100 years ago people died of acute illness
- Now most people suffer from one or more chronic illnesses prior to death
  - 70% Americans die of a chronic illness
  - 90% of the Medicare population die 1/9 chronic diseases

The need
- All Americans will have a period of serious illness and disability at some point prior to death
- Most likely experience pain and symptoms from disease or its treatments
- Dearth of clinical programs with the workforce and infrastructure required to provide the full complement of services needed by people with these common chronic conditions
Pain and symptom management

- Role of Palliative Medicine is to relieve suffering and not just physical pain
- Nausea/vomiting
- Depression
- Constipation
- Asthenia
- Anorexia/cachexia

Foster communication

- Between family
- Between providers
  › Almost a third of Californians see 10 or more physicians in the final six months of their lives (Dartmouth Atlas of Health Care, 2007)
- Education on disease process and prognosis

Goals of care

- What do patients want to achieve from the healthcare system
- Match treatment to those goals
- Knowledge of all options
- Understand anticipated impact of each option on:
  – Quantity of their remaining lives
  – Quality of their remaining lives
- Advanced directives/CPR
**Results**

- Eliminate misutilization
- Increased patient satisfaction
- Lessen family/caregiver distress

**Quality**

- 107 patients with metastatic non-small cell lung cancer
- Group met with a Palliative caregiver once/month till death vs. standard oncologic care


**Quality**

- Better quality of life
  - FACT-L scale = 98.0 vs. 91.5; *P* = 0.03
- Patients receiving early palliative care had longer median survival
  - 12 months vs 9 months; *P* = .02
- Fewer patients received aggressive end-of-life care
  - 33% vs 54%; *P* = .05
The costs

- 95% health care spending spent on nine chronic illnesses
- Patients with chronic illness in last two years of life account for about 32% of Medicare spending
- Acute care in the final six months of life account for more than 70% of costs incurred in the final year

Dartmouth Atlas 2008
Health Affairs 2005;24:903-914

Why

- Repeated hospitalizations
- Frequent ER visits
  - A study of the deaths of 5,158 elderly by UC San Francisco's Dr. Alexander Smith found that more than half had gone to the ER in the last month of their lives. Two-thirds went in their final six months.
    - (Health Affairs, June 2012)
- Fragmented care
  - NEJM 2009;360:1418-1428

Lack of transitional care*
- Twenty one percent of patients hospitalized for chronic medical conditions are re-hospitalized within 30 days
- Nearly 50% of those re-hospitalized at 30 days have not yet seen a physician in follow-up

Increased care not leading to better health outcomes

NEJM 2009;360:1418-1428
Palliative care programs and cost savings

- Eight hospitals from 2002-2004
- Affect of Palliative Medicine consultations
- Discharged alive
  - Adjusted net savings in direct costs of $1,696 per admission
  - Savings of $279 per day
- Died in hospital
  - Adjusted net savings in direct costs of $4,908 per admission
  - Savings of $374 per day


Why

- Aligned care with patient’s goals
- Realistic discussions regarding prognosis
- Decreased pharmacy costs, lab costs, and ICU costs

Palliative care programs and cost savings

- Patients enrolled in Medicaid at four New York State hospitals
- 2004–07
- Determine effect on hospital costs of palliative care team consultations

Morrison R. Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries. *Health Affairs.* 2011
Palliative care programs and cost savings

- Palliative care group had $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care
- Discharged alive
  - Savings of $4,098 in hospital costs per admission
- Died in hospital
  - Savings of $7,563 in hospital costs per admission

Palliative care programs and cost savings

- Consistent with the goals of a majority of patients and their families:
  - spent less time in intensive care
  - less likely to die in intensive care units
  - more likely to receive hospice referrals
- Estimated reduction in Medicaid hospital spending in New York State could eventually range from $84 million to $252 million annually

AZPHC

- Home based palliative care
- Involves Nurse CM, SW, CNA
- Bridging health care services
- Concurrent care model

The information in this document may not be reproduced or disclosed to unauthorized parties without the prior consent of the Arizona Geriatrics Society.

2013 Arizona Geriatrics Society  All Rights Reserved
**Why?**

- Homes provide clues:
  - Are the rooms clean and under control?
  - Is there fresh food?
  - Are medicines collected and stored in an easy-to-reach place?
- These signs and others can translate into better and more informed care than the typical 15-minute doctor’s office visit

**Evidence**

- Higher costs
- Few patient benefits

**What?**

- Home care is not a medical or invasive intervention
  - Unlikely to affect physiological change
  - Does not improve physical function
- Affect knowledge, attitudes, and behavior
  - Hospitalizations involving death
  - Hospitalizations involving nursing home placement

The information in this document may not be reproduced or disclosed to unauthorized parties without the prior consent of the Arizona Geriatrics Society.
Evidence

- Home care does not reduce costs unless it is targeted to the most disabled patients

  Greene, 2005
  Greene, Lovely, Miller, & Ondrich, 1995
  Greene, Ondrich, & Laditka, 1998

Quote

“Modern medicine has become so good at keeping the terminally ill alive by treating The complications of underlying disease that the inevitable process of dying has become much harder and is often Prolonged unnecessarily.”

- Ira Byock

“Actually, I’m still on life support. I just came by to do a feasibility study.”