Palliative Care for Older Adults in the United States

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Palliative Care in the Elderly
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Mount
Sinai

Outline

- Define palliative care in the United States and explain how it differs from end-of-life care
- Review evidence that palliative care improves care for patients, families, and hospitals
- Describe the new, innovative models for the delivery of palliative care at Mount Sinai

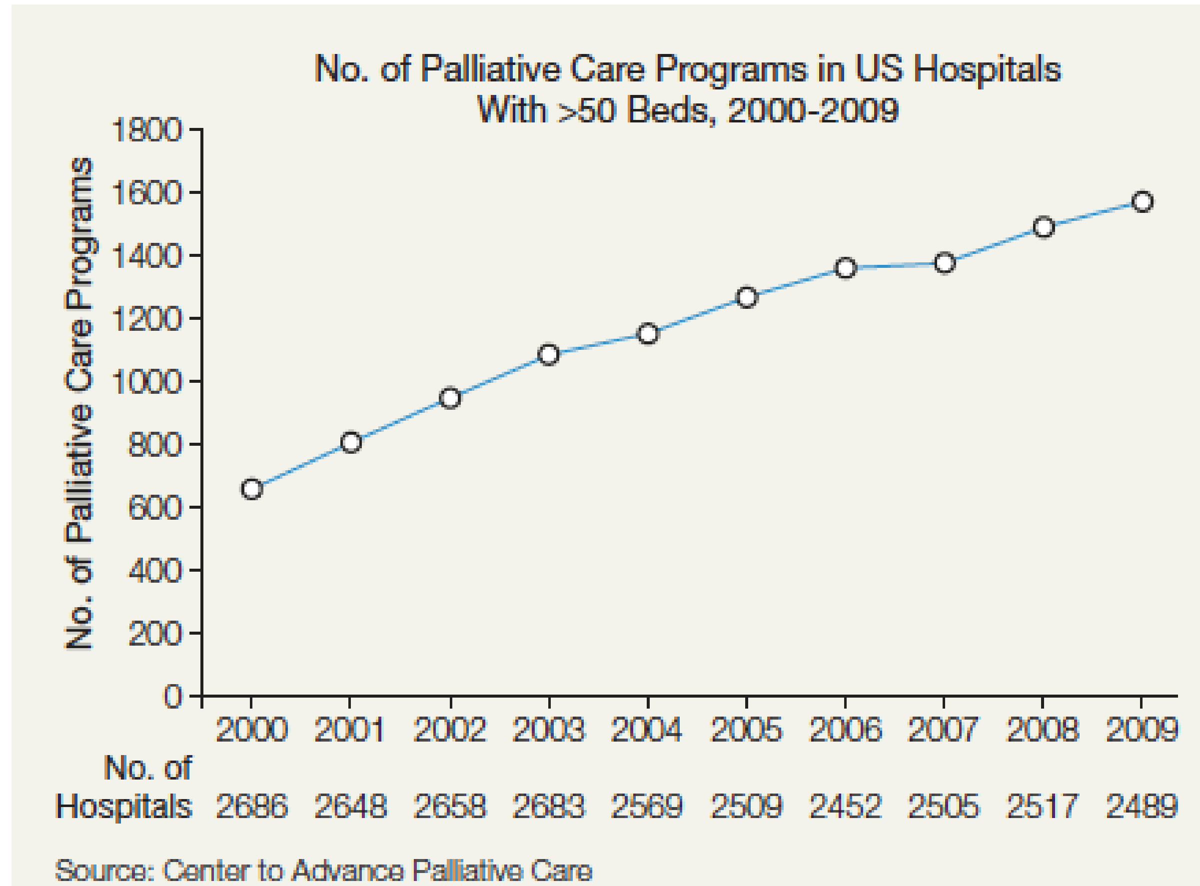
What is Palliative Care?

- Palliative care is specialized medical care for people with serious illnesses whose goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an added layer of support.
- Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative and disease directed treatments
- Not the same as end-of-life care

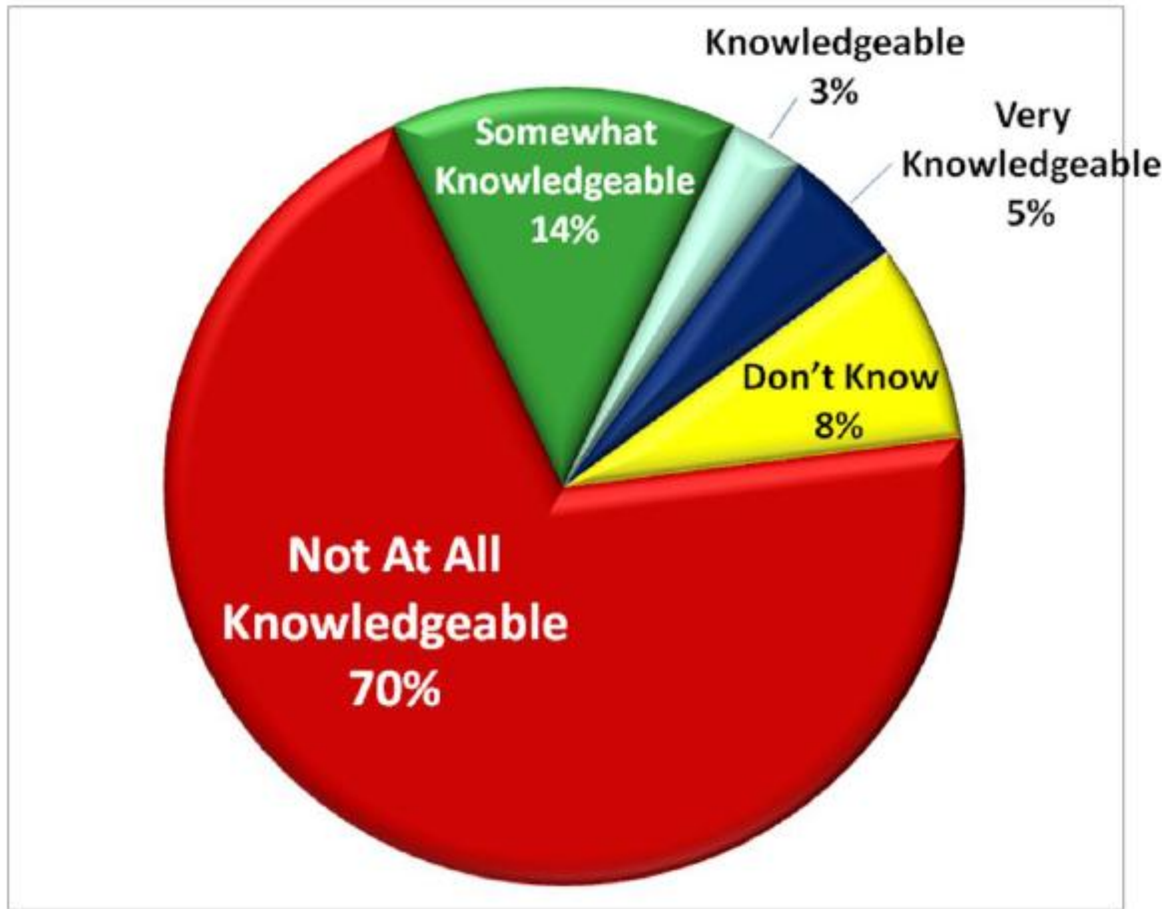
Growth of Palliative Care in the U.S.

- 63% of all hospitals and 85% of mid-large size hospitals report a palliative care team

- 100% of cancer centers report a palliative care team



American Public's Knowledge of Palliative Care



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

Mount Sinai Palliative Care Service

- Four teams – two general consult teams, a specialty consult team, and a Palliative Care Unit Team
  - 4 Attending Physicians (pool of ~12)
  - 4 Nurse Practitioners (pool of 5)
  - 1 Registered Nurse (triage nurse)
  - 3 Social Workers
  - 7 Fellows
  - Chaplain
  - Massage Therapist(s), Yoga Therapist, Art Therapist, Music Therapist
  - 2-3 Third Year Medical Students
  - 1-2 Other Rotators

Inpatient Palliative Care Unit

Inpatient Palliative Care Unit

Palliative Care in Practice

- Expert control of pain and symptoms
- Uses the crisis of the hospitalization to facilitate communication and decisions about goals of care with patient and family
- Coordinates care and transitions across fragmented medical system
- Provides practical support for family and other caregivers (+ clinicians)

Goal Setting in Patients with Advanced Illness

- Instead of focusing on treatments, focus on outcomes and overall goals
  - What is the desired outcome?
  - What is the "fate worse than death"?

- Some common goals
  - Be able to interact in meaningful way
  - Be free of pain
  - Live as long as possible

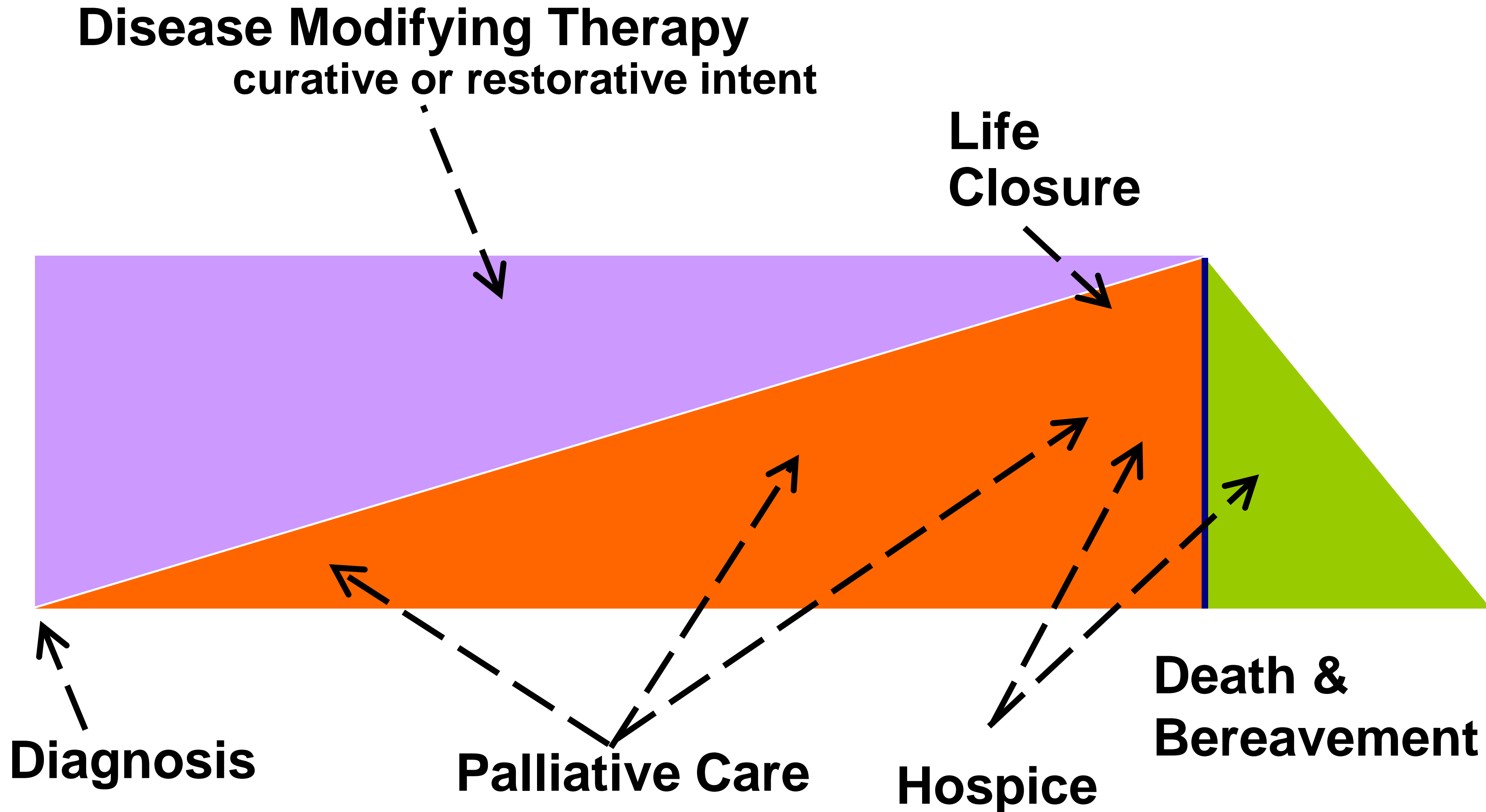
The Cure - Care Model:
The **Old** System

Life
Prolonging
Care

Palliative/
Hospice
Care

D
E
A
T
H

A New Vision of Care



Palliative Care

Disease-Directed Therapies

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A.,
Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H.,
Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N.,
Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H.,
J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

Aug 19 2010;363(8):733-42.

Palliative Care
“Modern Medicine”
Hospice

Palliative Care Is

- ✓ Excellent, evidence-based
  medical treatment
- ✓ Vigorous care of pain and symptoms throughout illness
- ✓ Care that patients want *at the same time* as efforts to cure or prolong life

Palliative Care Is NOT

- ✗ Not "giving up" on a patient
- ✗ Not in place of curative or life-prolonging care
- ✗ Not the same as hospice or end-of-life care

Why is hospital palliative care growing so rapidly in the United States?

Hospital-based Palliative Care: The 4 Main Arguments

1. Clinical Quality
2. Patient and Family Preferences
3. Demographics
4. Financial

Why palliative care?

1. The Clinical Imperative

Everybody with serious illness spends at least some time in a hospital...

- 98% of Medicare decedents spent *at least some time* in a hospital in the year before death.

- 15-55% of decedents had *at least one stay* in an ICU in the 6 months before death. Average length of stay in the ICU is 2-11 days.

Dartmouth Atlas of Health Care 1999 & 2006

Symptom Burden of Patients Hospitalized With Serious Illness at 5 U.S. Academic Medical Centers

% of 5176 patients reporting moderate to severe pain between days 8-12 of admission

Colon Cancer	60%
Liver Failure	60%
Lung Cancer	57%
COPD	44%
CHF	43%

Desbiens & Wu. JAGS 2000;48:S183-186.

Why palliative care?

2. Concordance with patient and family wishes

What Do Patients with Serious Illness Want?

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Singer et al. *JAMA* 1999;281(2):163-168.

“Difficult” Conversations Improve Outcomes

- Multisite, longitudinal study of 332 patient-family dyads
- 37% of patients reported having prognosis discussion at baseline
- These patients had lower use of aggressive treatments, better quality of life, and longer hospice stays
- Family after-death interviews showed better psychological coping for those with conversations as compared to those without

Wright et al. JAMA 2008 300(14):1665-1673.

What Do Family Caregivers Want?

Study of 475 family members 1-2 years after bereavement

- Loved one's wishes honored
- Inclusion in decision processes
- Support/assistance at home
- Practical help (transportation, medicines, equipment)
- Personal care needs (bathing, feeding, toileting)
- Honest information
- 24/7 access
- To be listened to
- Privacy
- To be remembered and contacted after the death

Tolle et al. Oregon report card.1999 www.ohsu.edu/ethics

Families Want to Talk About Prognosis

- Qualitative interviews with 179 surrogate decision makers of ICU patients
- 93% of surrogates felt that avoiding discussions about prognosis is an unacceptable way to maintain hope
- Information is essential to allow family members to prepare emotionally and logistically for the possibility of a patient's death.
- Other themes:
  - moral aversion to the idea of false hope
  - physicians have an obligation to discuss prognosis
  - surrogates look to physicians primarily for truth and seek hope elsewhere

Apatira et al. *Ann Intern Med.* 2008;149(12):861-8

Why palliative care?

3. The demographic imperative

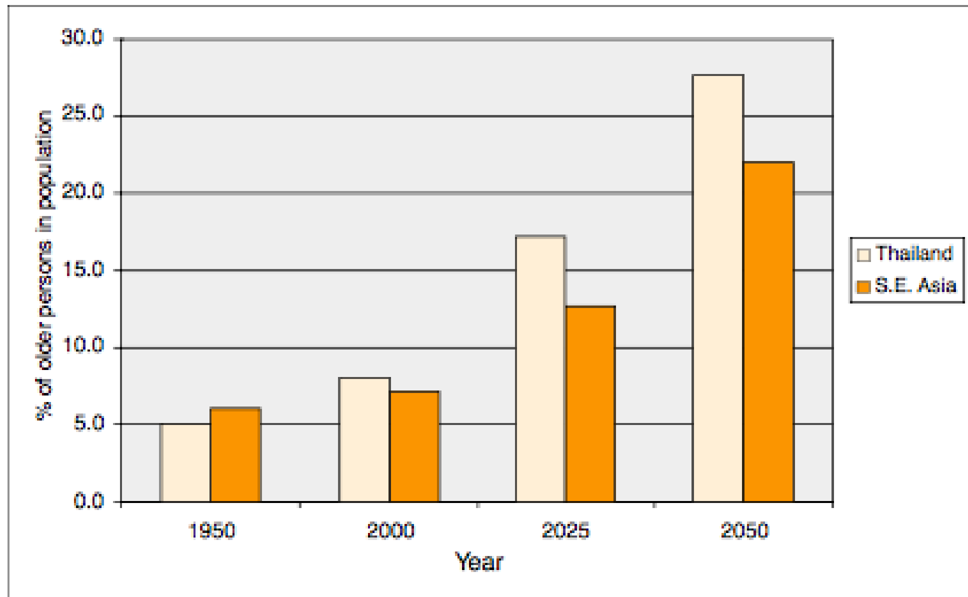
Chronically Ill, Aging Population Is Growing

- The number of people over age 85 in the United States 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.
- Even with insurance, costs of care are expensive and can have serious effect on patients and families

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

Older Population in Thailand

Thailand is ageing faster than others in South-East Asia



Sources: Institute for Population and Social Research, Mahidol University, *Population Projections for Thailand, 2005-2025, 2006;* and United Nations, Department of Economic and Social Affairs Division, *World Population Ageing 1950-2050,* Population Division, New York. 2002.

For the first time in the history of Thailand, the population of older persons will exceed the population of children around 2020.

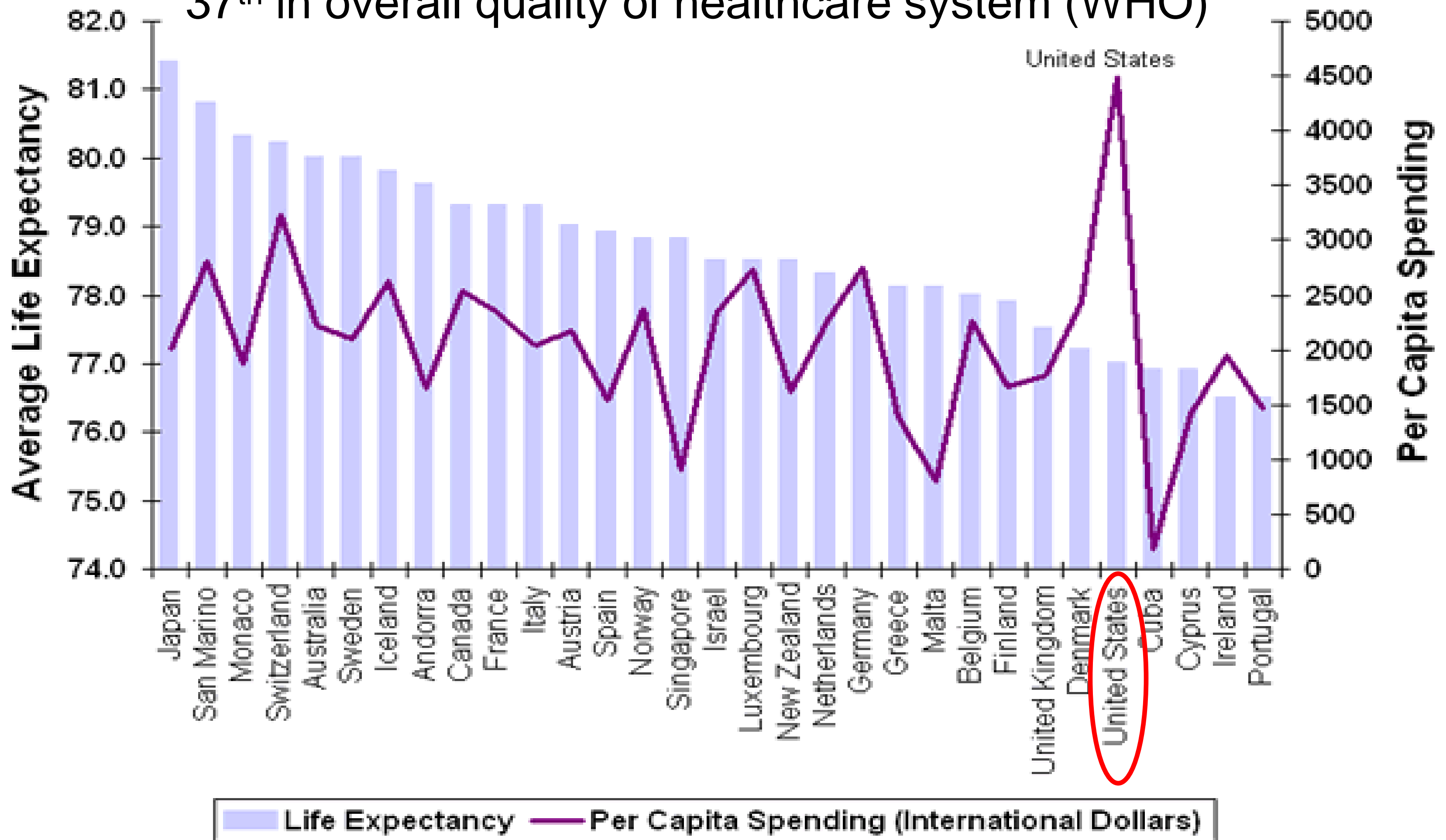
United Nations Population Fund Report on Population Ageing in Thailand 2006

Healthcare Spending and Quality

U.S. leads the world in per capita spending

27th in life expectancy

37th in overall quality of healthcare system (WHO)



Data from World Bank

http://ucatlas.ucsc.edu/spend.php

Family Caregivers and the SUPPORT Study

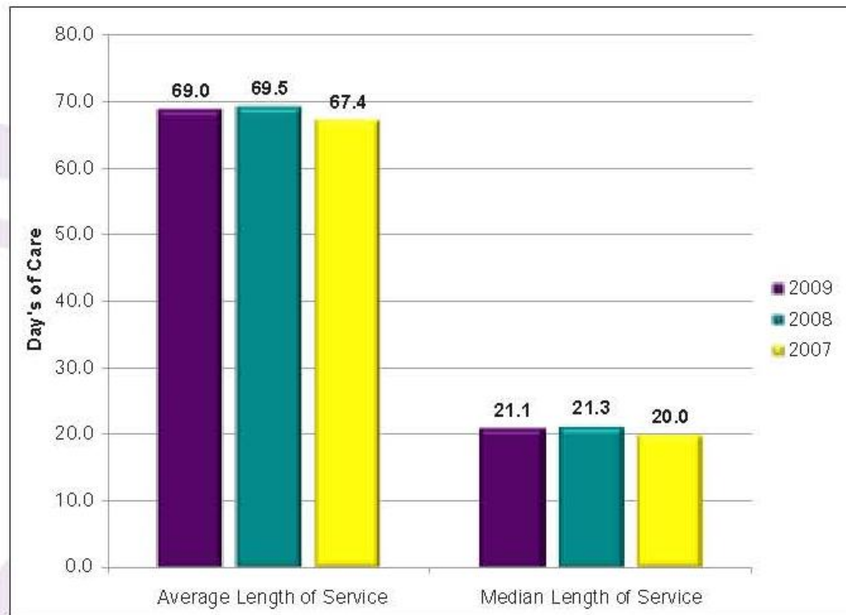
Patient needed large amount of family caregiving:	34%
Lost most family savings:	31%
Lost major source of income:	29%
Major life change in family:	20%
Other family illness from stress:	12%
At least one of the above:	***55%***

JAMA 1995; 272:1839

Hospice Benefit

- In the US, Hospice is a philosophy and an insurance benefit
  - Holistic care, centered at home, provides doctors, nurses, social workers, volunteers, and medications to patients near the end of life
- Prognosis *of 6 months or less* if disease follows its usual course
- Willingness to forego regular services focused on life-prolongation or cure for primary illness

Are we getting the message out to patients and families about the benefits of hospice?



NHPCO Facts and Figures, 2010

(using data from 2009)

Why palliative care?

4. The fiscal imperative

How Palliative Care Reduces Length of Stay and Cost

Palliative care:

- Clarifies goals of care with patients/families
- Helps to select medical treatments and care settings that meet goals
- Assists with decisions to leave the hospital, or to withhold or withdraw treatments that don't help to meet goals
- Palliative care improves patient care and make sure patients get treatments they want – a *side effect* of this is cost savings

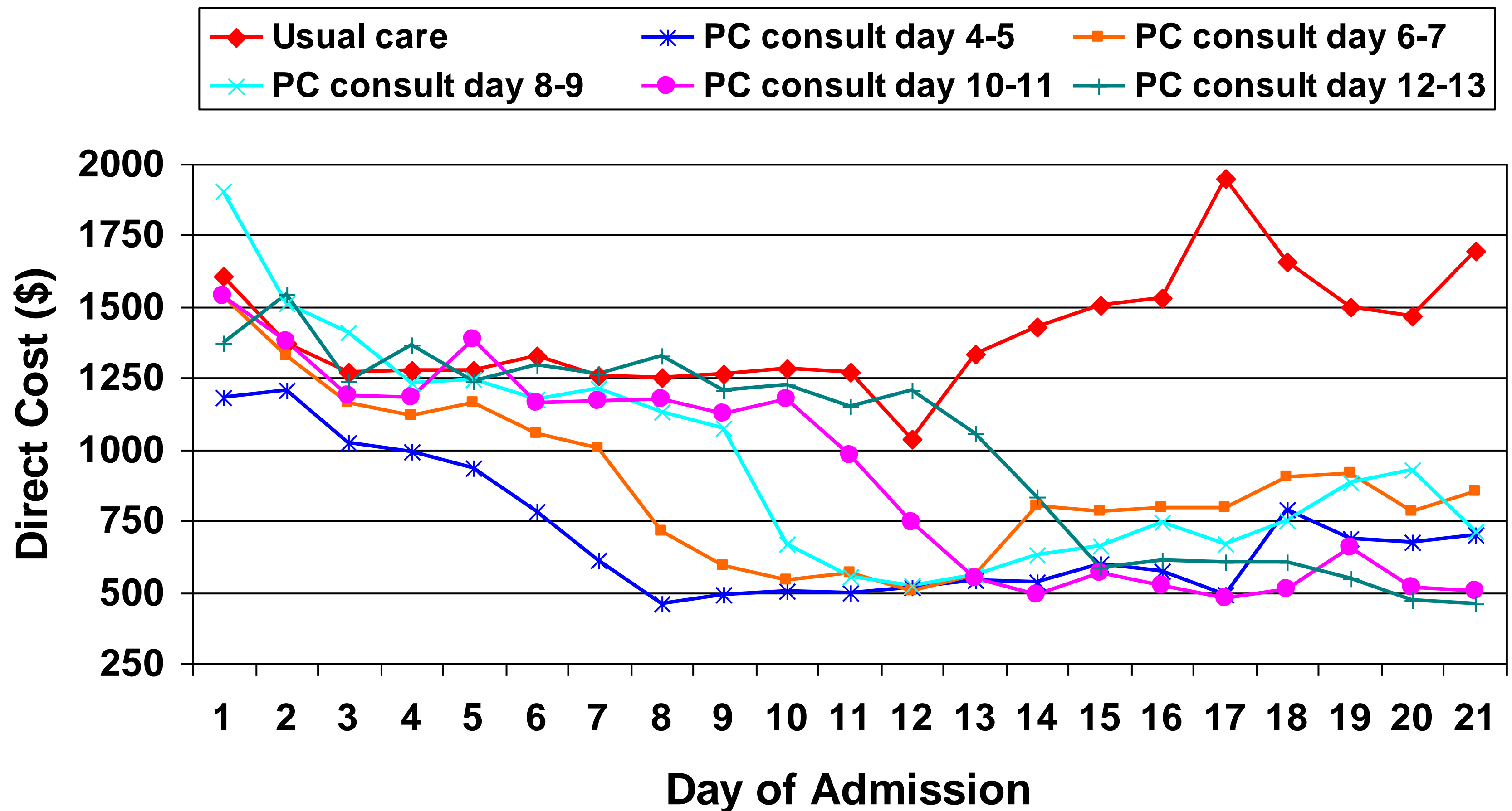
Costs and Outcomes Associated with Hospital Palliative Care Consultation 8-hospital study

	Live Discharges			Hospital Deaths		
Costs	**Usual Care**	**Palliative Care**	**P**	**Usual Care**	**Palliative Care**	**P**
Total Per Day	$1,450	$1,171	<.001	$2,468	$1,918	<.001
Directs Per Admission	$11,1240	$9,445	.004	$22,674	$17,765	.003
Laboratory	$1,227	$803	<.001	$2,765	$1,838	<.001
ICU	$7,096	$1,917	<.001	$15,542	$7,929	<.001
Pharmacy	$2,190	$2,001	.12	$5,625	$4,081	.04
Imaging	$890	$949	.52	$1,673	$1,540	.21
Died in ICU	X	X	X	18%	4%	<.001

Adjusted results, n>20,000 patients

Morrison et al. Arch Internal Med. 2008. 168 (16).

8 Hospital Study: Costs/day for patients who died with palliative care vs. matched usual care patients



New Models of Care

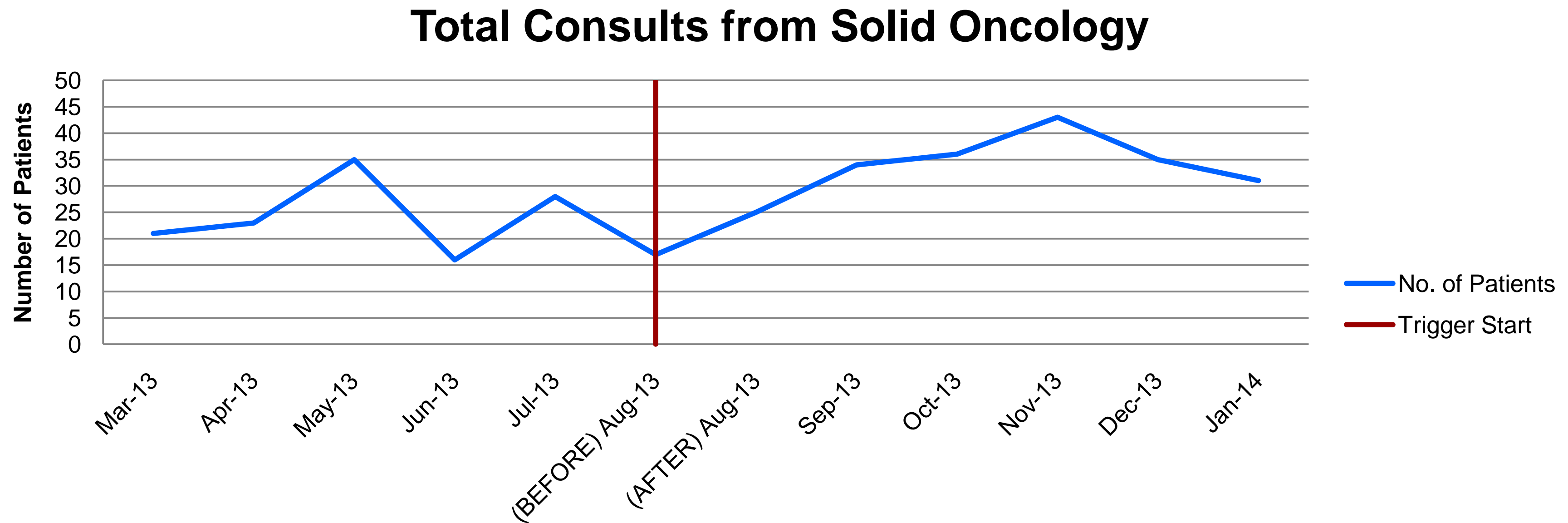
- Inpatient Oncology Consultation
- Outpatient Oncology Clinic
- Emergency Department Consults
- Heart Failure and Palliative Care

Solid Oncology Triggers for Patients in the Hospital

One of the following must be present:

- Any solid tumor patient with a hospitalization >7 days
- Stage IV solid malignancy or Stage III lung or pancreatic cancer
- Any solid tumor patient with uncontrolled symptoms (pain, nausea/vomiting, dyspnea, delirium, psychological distress)
- Any solid tumor patient hospitalized in the last 30 days (not including routine chemotherapy)

Change in Oncology Consults

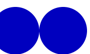


- Reduction in hospitalizations and Emergency Visits
- Increase in hospice utilization

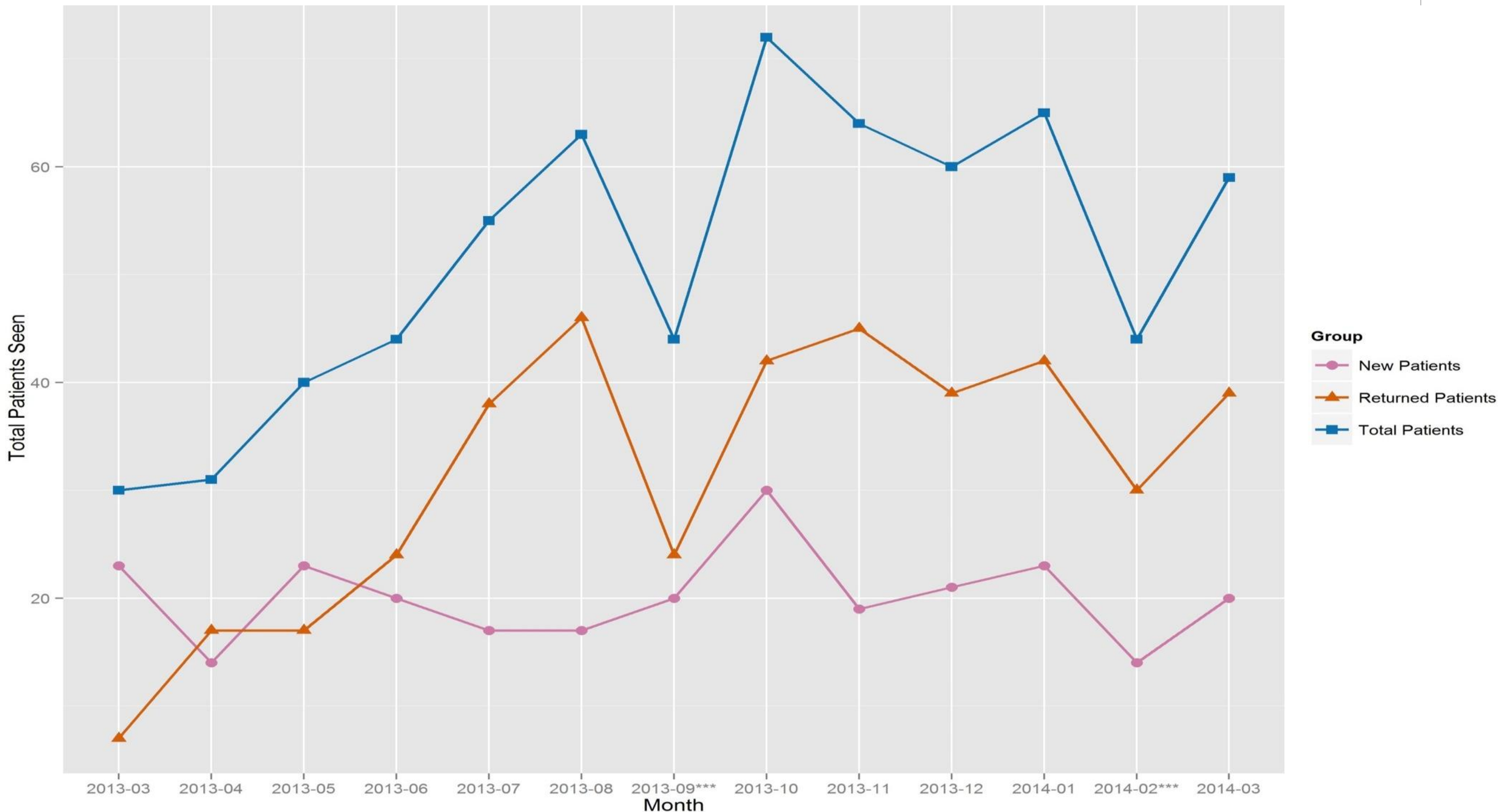
Supportive Oncology*

- One full time physician and one RN physically located in oncology clinic – has 9 sessions / week seeing oncology patients
- 88% of patients are being referred for symptom management
- 14% of patients have had at least one discussion about goals of care

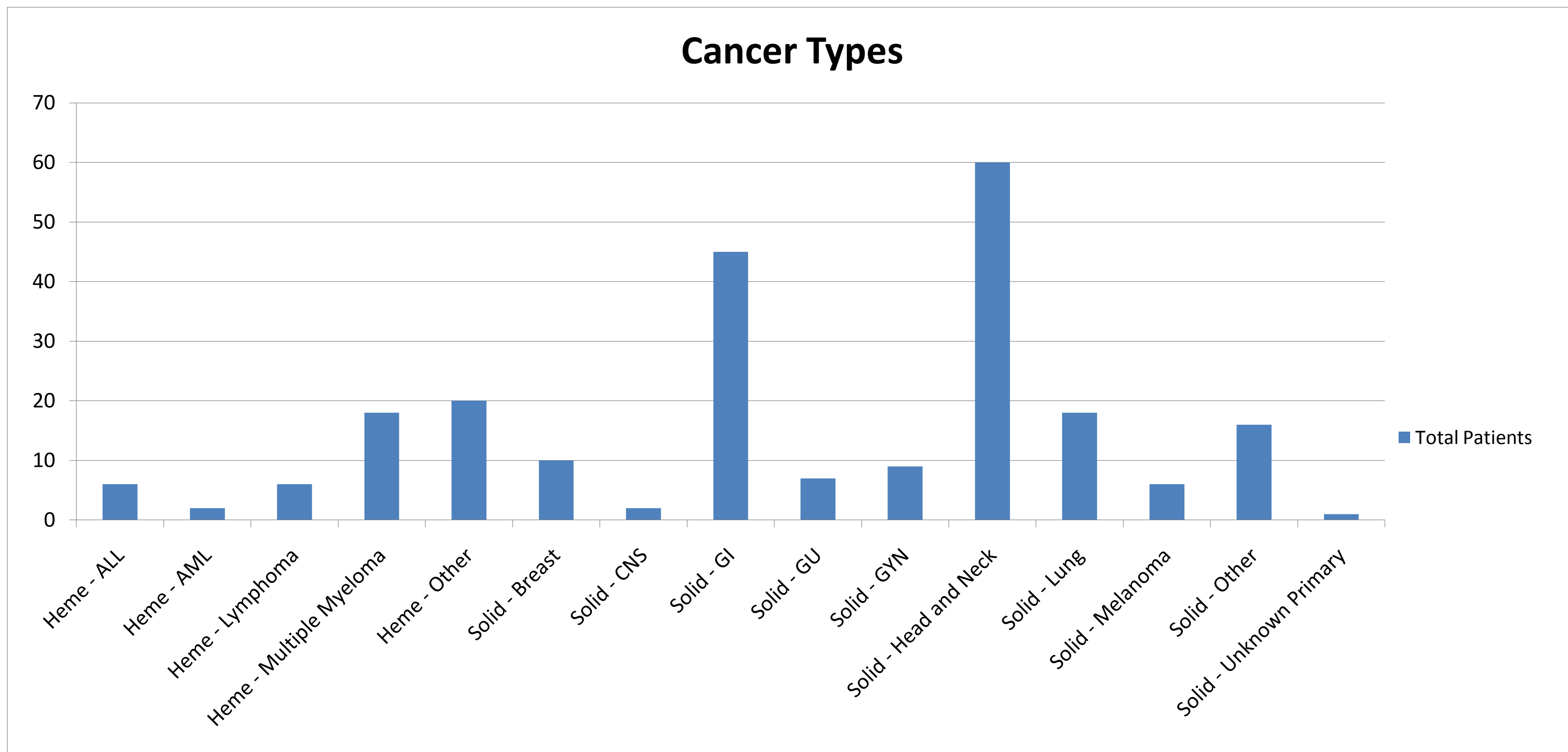
*Not called Palliative Care clinic



Supportive Oncology

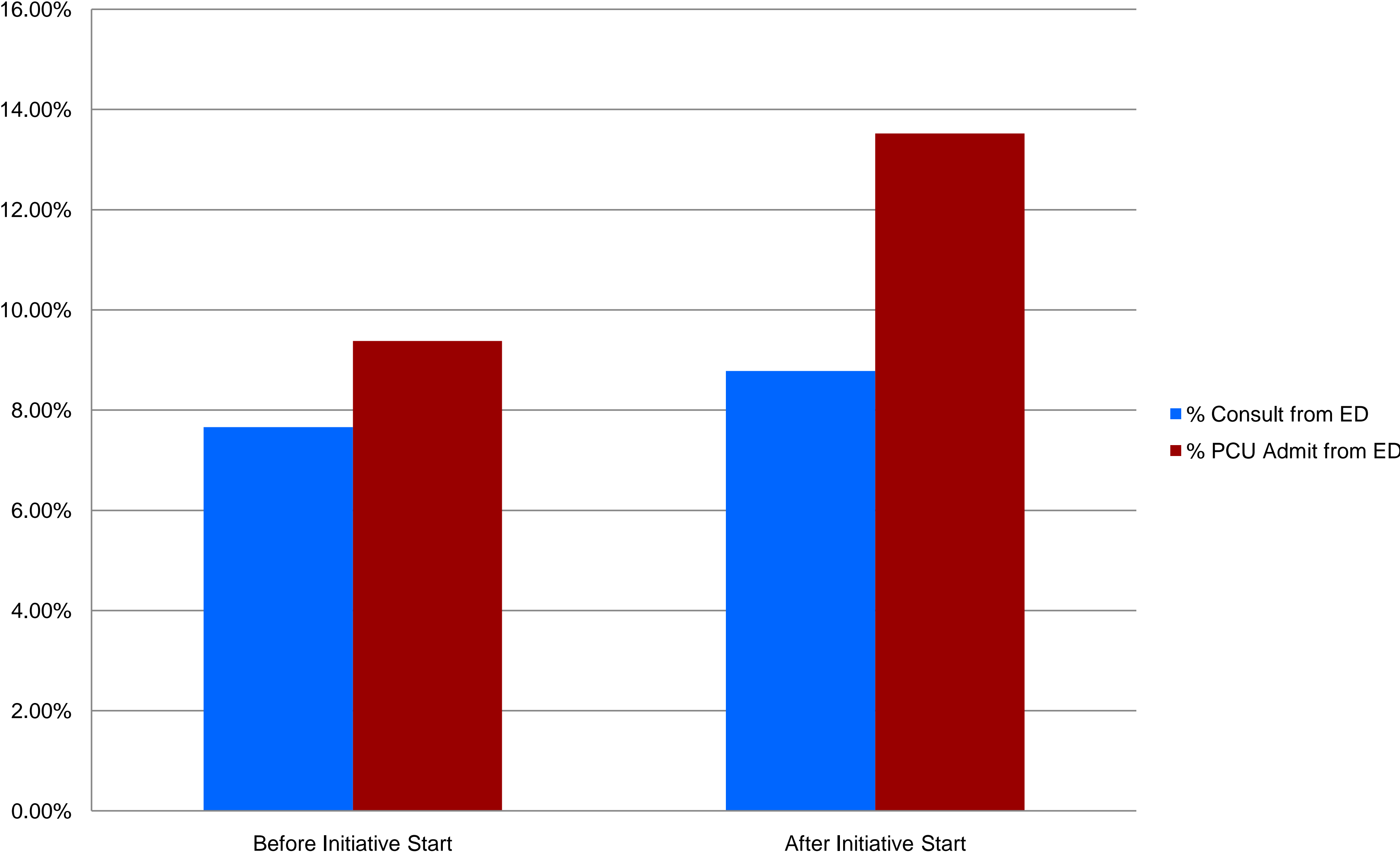


Referral by Site of Disease



Emergency Department

- Mini-consults on patients with advanced dementia or actively dying in Emergency Department to assess for previous goals of care conversation
- Palliative care begins discussion if has not been raised previously
- Goal is to increase admits directly to PCU (with hospice) or prevent admission by discharge with hospice



Palliative Care from ED
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Before Initiative Start
After Initiative Start
% Consult from ED
% PCU Admit from ED

Heart Failure

- Palliative care attends weekly rounds where we discuss patients who are candidates for Heart Transplant or Ventricular Assist Device
- Start a new research project where we teach our advanced practice nurses primary palliative care
  - Symptom management
  - Conversations about goals of care

Summary

- Palliative care improves quality of care for our sickest and most vulnerable patients and families.
- Multiple models to improve the quality of care and quality of life for patients with advanced illness and their families
- Serious illness is a universal human experience and palliation is a universal health professional obligation.

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