



Caring for Patients with Advanced and Serious Illnesses: Changing Medical Practice and Patient Expectations

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

Diane E. Meier, MD

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FRIDAY, MARCH 18, 2011

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen
Senate Office Building)*

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As medical treatment and technology have progressed, the lives of people with advanced and serious illnesses have been extended. A number of experts believe that the medical care system is not positioned to adequately address the needs of these people, many of whom live with the continuous physical, functional, mental, and emotional effects of their conditions. Too often, experts say, care for these patients is not well coordinated among their multiple specialists, leaving them with poor symptom control, pain, emotional and physical stress, confusion about their care protocols, and high caregiver burden.

To address current inadequacies and improve patient care, a new field of medicine called palliative care has emerged. Although palliative care is not widely understood, it is aimed at people with advanced and serious illnesses, many of whom may never be “cured” or recover full functionality. Proponents see it as an adjunct to curative medicine and believe the practice of this new specialty can enhance—even transform—the way that care is delivered to these patients, regardless of their immediate prognosis.

DEFINING PALLIATIVE CARE

Palliative care is defined as the medical specialty focused on improving the quality of life for people facing advanced and serious illnesses. It aims to relieve the suffering for these patients and ensure the best possible quality of life for them and their family members.¹ Palliative care emphasizes management of pain and symptoms,² communication among the treating physicians, coordination of medical and supportive services, assistance with patient decision making, and support for caregivers.³ It strives to place patients and their families in the center of the care team and to clarify and carry out patient objectives.

Palliative care is seen as appropriate from the time of diagnosis and for any stage of advanced illness, and can be provided along with curative care.⁴ It can be offered in hospitals, long-term care facilities, or the patient's home, and has generally been part of hospice programs. Palliative care programs treat people with cancer, congestive heart failure, kidney failure, Alzheimer's disease, HIV/AIDS, chronic obstructive pulmonary disease, and others.

Proponents suggest that an interdisciplinary palliative care team work with, but not replace, the patient's physicians and other care professionals. The care team may include physicians, nurses, social

workers, pharmacists, nutritionists, and chaplains, and others who can provide a range of services including management of pain, nausea, fatigue, depression, and other symptoms; help in navigating the health care system; guidance with difficult and complex treatment choices; and emotional and spiritual support. The team would be responsible for providing patient assessment and evaluation, coordinating and managing care, and monitoring and continuous reassessment of care. It also could also provide patient and family education and support with the goal of helping patients and caregivers to manage symptoms and avoid unnecessary hospitalization.

Hospital-based consultation by a team of physicians, nurses, social workers, and others is the predominant delivery model for palliative care services.⁵ Hospital-based palliative care programs provide specialty-level assistance to attending physicians for difficult-to-treat pain and other symptoms, support the attending physician and discharge planning staff with patients' transitions to home and other care settings, and handle time-intensive family meetings.⁶ Outside the hospital, home-based palliative care programs can offer pain management and symptom control and can also teach patients and their caregivers self-management techniques and crisis intervention with the goal of stabilizing the patient and minimizing unnecessary emergency room visits and hospitalizations.⁷

Palliative care programs in hospital settings have grown rather dramatically in recent years, from more than 600 programs in 2000 to more than 1,200 in 2006. Wide geographic variability in palliative care programs exists, with programs more likely to be in placed in larger hospitals with more than 200 beds, teaching hospitals, and those with cancer programs. For-profit and public hospitals are less likely to have programs.⁸

DISTINCTIONS BETWEEN PALLIATIVE CARE AND HOSPICE PROGRAMS

Until about ten years ago, palliative care was primarily provided to patients enrolled in hospice programs. Hospice and palliative care programs often developed together, and some palliative care programs have been developed by leaders of hospice organizations.⁹ Hospice programs were approved as a Medicare benefit in 1982. In 2009, about 1.6 million patients received hospice care, primarily paid by Medicare. In 2009, the median length of service for hospice patients was 21.1 days, and slightly more than one-third of patients died within 7 days of admission to hospice.¹⁰

Palliative care may be offered as part of hospice services, but palliative care programs differ from the Medicare hospice benefit in a number of ways. Hospice programs are designed to care only for terminally ill patients, and referral is likely to occur late in a patient's illness and close to the expected time of death. Medicare reimbursement is available if physicians certify that the patient is expected to die within six months if his or her disease runs its normal course. Unlike palliative care, Medicare hospice patients must agree to forgo coverage for life-prolonging and curative treatments related to their terminal illnesses. One insurer, Aetna, incorporated a form of palliative care into its hospice benefit after a study revealed improved satisfaction and lower costs. The study provided extended hospice services to people with a prognosis of 12 months' life expectancy and allowed them to receive curative care.¹¹

EFFECT ON PATIENT CARE AND COSTS

A number of studies have demonstrated positive effects of both hospital- and home-based palliative care programs on patient and family satisfaction and quality of care. Palliative care programs have been shown to control patient symptoms and provide greater emotional support to patients and families than usual care. Some research has shown that use of palliative care interventions is more likely to allow patients to die at home, a desire of many patients who do not wish to die in acute or long-term care settings.¹²

Use of palliative care is seen as a way to reduce reliance on care in hospitals and often futile procedures, potentially resulting in lower costs. Often, the highest medical costs accrue during the last stages of life, with increased use of tests and more physician and hospital visits. Some research has demonstrated lower use of emergency rooms and fewer hospitalizations and visits to physicians among palliative care patients compared with patients not receiving such care.¹³

Hospitals' interest in palliative care programs may stem from reductions in their costs during a hospital stay. A study of almost 3,000 palliative care patients in eight U.S. hospitals with established palliative care programs found savings to the hospitals ranging from about \$1,700 to almost \$5,000 per admission, depending on the patient mix. Cost savings were achieved primarily through reduced use of intensive care units (ICUs) and lowered pharmacy costs. This study suggests that palliative care consultation fundamentally shifts the course of care off a typical hospital pathway by discontinuing some treatments in accordance with patient goals.¹⁴

BARRIERS TO BROAD ADOPTION

Palliative care is already available in many hospitals. However, proponents point out that palliative care protocols could be used in more hospital and other care settings and that more seriously ill patients and their families should be informed about their benefits. Often, patients and families are not aware of the benefits of this type of care and do not know how to access it. Some recommend more opportunities for medical workforce training in palliative care, increased opportunities for palliative care training as part of graduate medical education, and greater penetration of programs in hospitals, long-term care facilities, and home care.

SPEAKERS

Diane E. Meier, MD, director of the Center to Advance Palliative Care and the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine, will begin the discussion by providing an overview of palliative care; sort out the differences between palliative and hospice care; discuss how palliative care is related to effective care for seriously ill patients; and describe available evidence on patient outcomes and costs and on barriers to broad adoption. **Kyle R. Allen, DO**, chief of the Division of Geriatric Medicine at Summa Health System, will discuss the palliative care program at Summa within the context of its other geriatric care programs; how the program coordinates its services with other organizations, such as area agency on aging and the state PASSPORT programs; and how both medical and social service teams work together to coordinate care for seriously ill patients. **Marcia Wade, MD**, senior medical director, Aetna Medicare, will discuss Aetna's coverage and financing for care of patients with advanced illnesses, the role of palliative care and case management for Medicare patients, and the effects of palliative care on Medicare patients, costs, and outcomes.

KEY QUESTIONS

- What is palliative care? How does palliative care differ from hospice care? How does palliative care differ from care coordination models, like medical homes, that seek to improve patient outcomes and reduce costs?
- What do patients want when confronting advanced illness? For which patients is palliative care appropriate? When should palliative

care be initiated? Is palliative care useful for patients whose conditions are advanced but unpredictable?

- What are the key palliative care services? Beyond pain relief, what are the benefits of palliative care to patients and their families?
- Can the same physicians who provide curative care also provide palliative care? Should there be an expectation that primary care physicians be trained for and perform palliative care for their patients? Is a separate and distinct provider or team needed to provide palliative care? What is the relationship between the palliative care provider(s) and the patient's primary or attending physician?
- What effect does palliative care have on patient outcomes, satisfaction, and quality of care? What effect does palliative care have on costs: overall health care costs; payer costs, including Medicare and private insurance; and providers' own costs, including hospitals?
- How is palliative care paid for in different settings and within fee-for-service or capitation under Medicare, Medicaid, and other insurance?
- How accessible are palliative care programs to patients and their families? What motivates hospitals to implement these programs?
- What is the status of palliative care training and credentialing for medical personnel? Should more physicians receive palliative care training?
- What are the major policy and practice barriers to broad adoption and availability of palliative care programs?

ENDNOTES

1. Diane E. Meier, "The Development, Status, and Future of Palliative Care," in Diane E. Meier, Steven L. Isaacs, and Robert G. Hughes, *Palliative Care, Transforming the Care of Serious Illness* (Princeton, New Jersey: Robert Wood Johnson Foundation, 2010), p. 4.
2. Section 4305 of the Patient Protection and Affordable Care Act (PPACA) contains a number of provisions regarding pain care management, including requiring the Secretary of the Department of Health and Human Services to seek an agreement with the Institute of Medicine (IOM) (or another appropriate entity if the IOM declines) to convene a Conference on Pain and to increase the recognition of pain as a significant public health problem in the United States; encouraging the director of the National Institute of Health to continue and expand an aggressive program of research on the causes of and potential treatment for pain; and authorizing the Secretary to establish a program to train health professionals in pain care.
3. Center to Advance Palliative Care, "What is Palliative Care," available at www.getpalliativecare.org/whatis.

4. Center to Advance Palliative Care, "What is Palliative Care."
5. Meier, "The Development, Status, and Future of Palliative Care," p. 36.
6. Center to Advance Palliative Care, "The Case for Hospital Palliative Care: Improving Quality. Reducing Cost." available at www.capc.org/support-from-capc/capc_publications/making-the-case.pdf.
7. Richard D. Brumley, Susan Enguidanos, and David A. Cherin, "Effectiveness of a Home-Based Palliative Care Program for End-of-Life," *Journal of Palliative Medicine*, 6, no. 5 (2003): pp. 715–724.
8. B. Goldsmith *et al.*, "Variability in Access to Hospital Palliative Care in the United States," *Journal of Palliative Medicine*, 11, no. 8 (October 2008): pp. 1094–1102.
9. Meier, "The Development, Status, and Future of Palliative Care."
10. National Hospice and Palliative Care Organization, "NHPCO Facts and Figures, Hospice Care in America," 2010 Edition; available at www.nhpc.org/files/public/Statistics_Research/Hospice_Facts_Figures_Oct-2010.pdf.
11. In the Aetna pilot that led to coverage for its insured population, Aetna liberalized the definition of hospice for so that life expectancy was expanded to 12 months and patients could continue curative care. Case management was provided via telephone by nurses trained to deal with patients with advanced illnesses. Randall Krakauer, "Opportunities to Improve the Quality of Care for Advanced Illness," *Health Affairs*, 28, no. 5 (September/October 2009): pp. 1357–1359; also see Clair M. Spettell *et al.*, "A Comprehensive Case Management Program to Improve Palliative Care," *Journal of Palliative Medicine*, 12, no. 9, (September 2009): pp 837–832.
12. For example, see David Casarett *et al.*, "Do Palliative Care Consultations Improve Patient Outcomes?" *Journal of the American Geriatrics Society*, 56, issue 4 (April 2008): pp. 593–599; Richard Brumley *et al.*, "Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care," *Journal of the American Geriatrics Society*, 55, no. 7 (2007): pp. 993–1000; and Brumley, Enguidanos, and Cherin, "Effectiveness of a Home-Based Palliative Care Program for End-of-Life."
13. Brumley, Enguidanos, and Cherin, "Effectiveness of a Home-Based Palliative Care Program for End-of-Life."
14. R. Sean Morrison *et al.*, "Cost Savings Associated With US Hospital Palliative Care Consultation Programs," *Archives of Internal Medicine*, 168, no. 16 (September 8, 2008): pp. 1783–1790.