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Community Based Palliative Care

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Palliative Care and DSRIP

- Project 3.g.i:
 - Palliative Care will be integrated into primary care practices
 - Off site consultation flow is acceptable
 - By June 2016 we will develop and adopt clinical guidelines for service eligibility and implement MOLST completion
 - By December 2016 we will implement training on skills, competencies and protocols

The Paradox

‘My patient doesn’t need palliative care – they aren’t dying’.

- Palliative care has traditionally cared for the acutely ill and dying patient.
- This gives the impression that this is the only appropriate area for palliative care involvement.
- You don’t have to be dying to benefit from Palliative Care!

Palliative Care

National standard:

Palliative care is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness, whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. **It is appropriate at any age and at any stage in a serious illness**, including for those who are seeking curative or life prolonging treatments.*

*Center to Advance Palliative Care

What's in it for you?

As the patient:

Patient centered care with medical care that matches goals

Relief of discomforts and suffering

What's in it for you?

As the physician:

A resource to help define patient care goals

Extra support for symptom control

What's in it for you?

As the health care delivery system (hospital, ACO, etc):

Helps deliver the right care at the right time in the right place

What's in it for you?

As the health care services payer (insurer, patient):

Lower cost of care appropriate to patient goals and with patient engagement

What Do We Do?

- Help navigate and provide support through serious illness
- Symptom control (NOT a source for long-term chronic pain management)

What Do We Do?

- Help navigate and provide support through serious illness
- Symptom control (NOT a source for long-term chronic pain management)
- Advance care planning (MOLSTs, proxies)
- Discussion of severity of illness, goals of care and potential referral to Hospice
- Facilitation of family adherence to patient care

Palliative Care and the Law

- Two laws in NY:

New York Palliative Care Information Act

New York Palliative Care Access Act

NY Palliative Care Information Act*

- Providers are legally required to inform patients of limited life expectancy (<6 months)
 - Requires ‘attending’ MDs and NPs to offer terminally ill patients information and counseling about palliative care and end-of-life options.
 - Attending practitioner may arrange for someone else to do this
 - When more than one practitioner shares responsibility for patient care, they ALL have this responsibility unless they document an agreement that one of them will take responsibility

* 2010, Chapter 331, Section 2997-c, health.ny.gov

NY Palliative Care Access Act*

- This Act, effective 2011, states that all institutions must provide access to Palliative Care
 - Applies to:
 - all practitioners (MD and NP)
 - hospitals, nursing homes, assisted living facilities, home care agencies
 - all patients with limited life expectancy but not limited to an expectancy of just <6 months
 - Goes beyond requirement for information and counseling, and requires that the practitioner and residence ‘facilitate access to appropriate palliative care services’

* NY Palliative Care Access Act, PHL Section 2997-d

Why make it a law?

- We don't do it
 - We don't want to be wrong about prognosis
 - We don't want to induce suffering by telling the patient
 - We don't have a palliative care resource to send them to
 - We think we are doing a good enough job at palliative care
 - We don't want to stop treating the patient (don't want to “abandon”)

 - We don't *know* the prognosis

The survey says...

- 76% of elders surveyed ranked independence has higher priority than staying alive (2011 Arch Int Med)
- 70% of patients surveyed said that they wanted to die at home
 - Only 25% do die at home
- Most people will say that they want to die peacefully and without suffering
 - Doing CPR does not allow a peaceful death

Dartmouth Atlas 2012

- In NY:
 - 32.6% died in a hospital (national 22.8%)
 - 17.1% had associated ICU admission
 - Average was 3 days
 - 12.4% spent 7 or more in the ICU
 - Average 1.48 admits in last six months of life
 - Average 12.8 days in the hospital in the last 6 months of life
 - Average \$43k medical cost in last six months
 - National average \$36k

General Cost of Care

Average cost of Medicaid patient admit: \$ 6355

6 weeks of hospice costs about the same

General Cost of Care

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- 50% went to ED in the last month of life

- 75% went to ED in the last 6 months of life
 - (where else can they go?)

The Case for Lower Cost:

- Inpatient:
 - Good data
 - Savings of \$140 per day from consultation to discharge
 - Lower cost meds, fewer x-rays, less ICU

The Case for Lower Cost:

- Inpatient:
 - Changes direction of care after some costs already incurred
 - Could save even more if the hospitalization was prevented and crisis averted

The Case for Lower Cost

- Outpatient:
 - No standard estimates yet but some good studies
 - VA +MCR home-based care in 2014 demonstrated 11% cost reduction, 25% admission reduction
 - Average cost of an ED visit for Medicaid patient \$221
 - Average cost of a new palliative care consult \$375
 - Based on staffing expense, not billed or collected revenue
 - Staffing expense includes MD, NP, RN and SW

Defining Life-limiting Illness

- No clear 'hospice-defining' condition but still contributing to poor prognosis:
 - Uncontrolled symptoms of chronic disease resulting in 3 or more ED visits or hospital admissions in 6 months
 - Frailty and functional decline associated with weight loss of 10% in 6 months or malnutrition or BMI <22 (failure to thrive)
 - 'not surprised if they die in the next year or two'

Hospice-Defining Illness

- Heart:
 - EF <20% or NYHA Stage IV heart failure
 - Severe or critical valvular heart disease leading to hospital admission
 - Inoperable and symptomatic CAD
- Lung: FEV1 <30% predicted, dyspnea on minimal exertion, hypoxia on room air, pulmonary hypertension or cor pulmonale
- Any stage 4 cancer without treatment elected
- Liver disease: INR >1.6, Albumin <2.5, refractory ascites, recurrent encephalopathy, portal hypertensive bleeding

Hospice-Defining Illness

- ESRD or progressive stage 4-5 CKD without dialysis
- Dementia (bedbound or total assist, speaking fewer than 6 intelligible words), aspiration or UTI or decubitus ulcer
- Acute stroke without recovery of consciousness within 3 days
- Chronic stroke sequelae with loss of function, malnutrition, recurrent aspiration, decubitus ulcer

PC, Hospice and Home Care

	Palliative Care	Hospice Care	Home Care
transitional/short term	Usually	No	Usually
homebound	No	No	Yes
imposed limits on care	No	Yes (DNR)	No
pt cost depends on insurance	Yes	No	Yes
for non-terminal illness	Yes	No	Yes
for terminal illness	±	Yes	±

The Case for DNR Status

- ACLS 'success' rates: survival to discharge
 - In hospital arrest,
 - all ages: 23.9%*
 - Over age 85: 5-8%**
 - 27% get an initial resuscitation then die in the hospital (NEJM 2009)
 - Out of Hospital Arrest
 - All ages: 9.5%*
 - Over age 85: less than 5%**
 - American TV: 70% success without long term sequelae

*American Heart Association web site 2013 data; adults; ** AHA 2012 data

The Case for DNR Status

- Most patients don't know the poor success rates and quality of life for survivors
 - 76% die despite heroic measures
- It's harder to 'pull the plug' than to not plug in

Post Arrest Statistics*

- Average length of stay post-arrest was 8 days
- 42% died within a year
 - 18% within 30 days; 28% within 90 days
- 66% were readmitted within a year
- 52% had neurologic impairment (>'mild')
- 55% discharged to skilled nursing/rehab
- 4.8% discharged to hospice

- Best survival: young, white, female, no neurologic impairment

- * NIH 2013 survival to discharge

The MOLST

- The New York Family Decision HealthCare Act lists the pecking order of legal surrogate decision makers
- Was intended for use ‘in the last year of life’ but can be used more broadly to guide a conversation
- Training on MOLST completion and how to discuss these questions is part of the DSRIP Palliative Care project

Seamless Integration

- A patient seen by PC in the hospital can get outpatient f/u at home or clinic
- A patient seen by PC in outpatient settings gets seen when admitted to ED or hospital
- Full collaboration and effective communication between PC, PCP, specialist(s), home care agency, hospice agency, patient and family
- A patient is seen without significant delay

Seamless Integration

- Who can you refer to now?
- Does anyone have access to pediatric palliative care?

- How will our regional PC referral needs change over time?
- How will we fit the staffing to the need?

CVPH Palliative Care

- Adult Inpatient services available Monday to Friday
 - Notifications of consult being faxed to PCPs
 - 518-562-7998
- Adult Clinic/outpatient services to begin soon
 - NP and MD
 - Limited hours at first with increases according to need and staffing. Details being determined.
 - Urgent visits will be available
 - 518-314-3544 (voicemail and return call for now)

Resources

- Oxford Textbook of Palliative Medicine
- Unipac Series
- National Palliative Care Research Center
 - www.npcrc.org
- Center to Advance Palliative Care
 - www.capc.org
- Compassionandsupport.org

In Summary

- You don't have to be dying to benefit from Palliative Care.
- Palliative Care engagement helps to
 - Document advance planning decisions
 - Facilitate patient care aligned with their goals
 - Support patients and families through serious illness
 - Provide relief of undesirable symptoms
 - Lower cost of care
 - Comply with NY laws regarding palliative care access
 - Discuss prognosis and life limiting illness with patients and families

Thank You

