Palliative Care Futurist:
Matching Care to Our Patient's Needs

Diane E. Meier, MD

Director, Center to Advance Palliative Care

diane.meier@mssm.edu

www.capc.org

www.getpalliativecare.org

@dianeemeier

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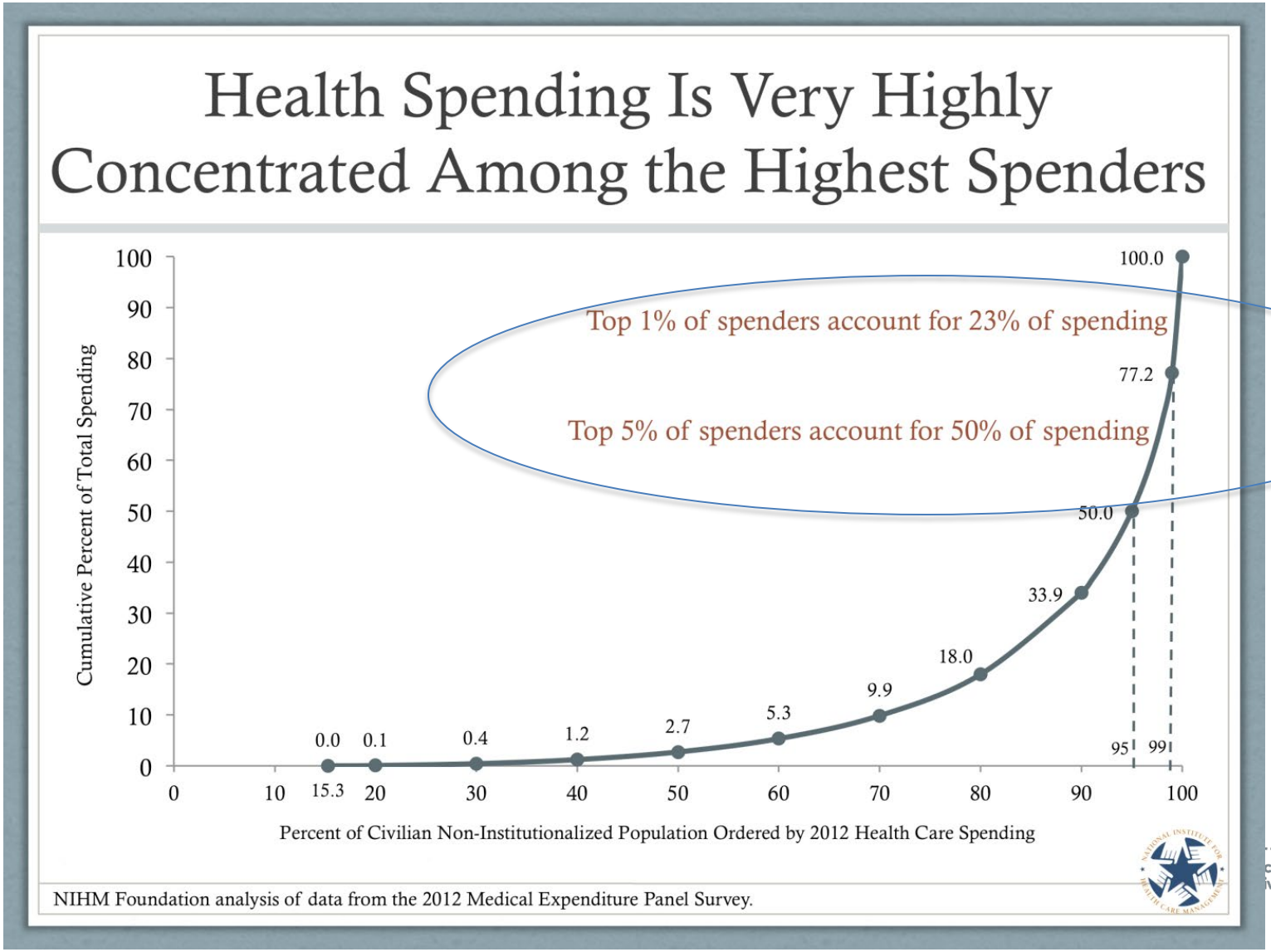
Concentration of Risk/$



Value= Quality/Cost

Because of the Concentration of Risk and Spending, and the Impact of Palliative Care on Quality *and* Cost, its Principles and Practices are Central to Improving Value

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Mr. C.

- An 88 year old man with dementia admitted via the ED for management of back pain due to spinal stenosis and arthritis.
- Pain is 8/10 on admission, for which he is taking 5 gm of acetaminophen/day.
- **Admitted 3 times in 2 months for pain (2x), falls, and altered mental status due to constipation.**
- His family (83 year old wife) is overwhelmed.

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Mr. C:

- Mr. C: *"Don't take me to the hospital! Please!"*
- Mrs. C*: "He hates being in the hospital, but what could I do? The pain was terrible and I couldn't reach the doctor. I couldn't even move him myself, so I called the ambulance.* ***It was the only thing I could do.***"

Modified from and with thanks to Dave Casarett

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Before and After

Usual Care

- 4 calls to 911 in a 3 month period, leading to
- 4 ED visits and
- 3 hospitalizations, leading to
- Hospital acquired infection
- Functional decline
- Family distress

Palliative Care

- Housecalls referral
- Pain management
- 24/7 phone coverage
- Support for caregiver
- Meals on Wheels
- Friendly visitor program
- **No 911 calls, ED visits, or hospitalizations in last 18 months**

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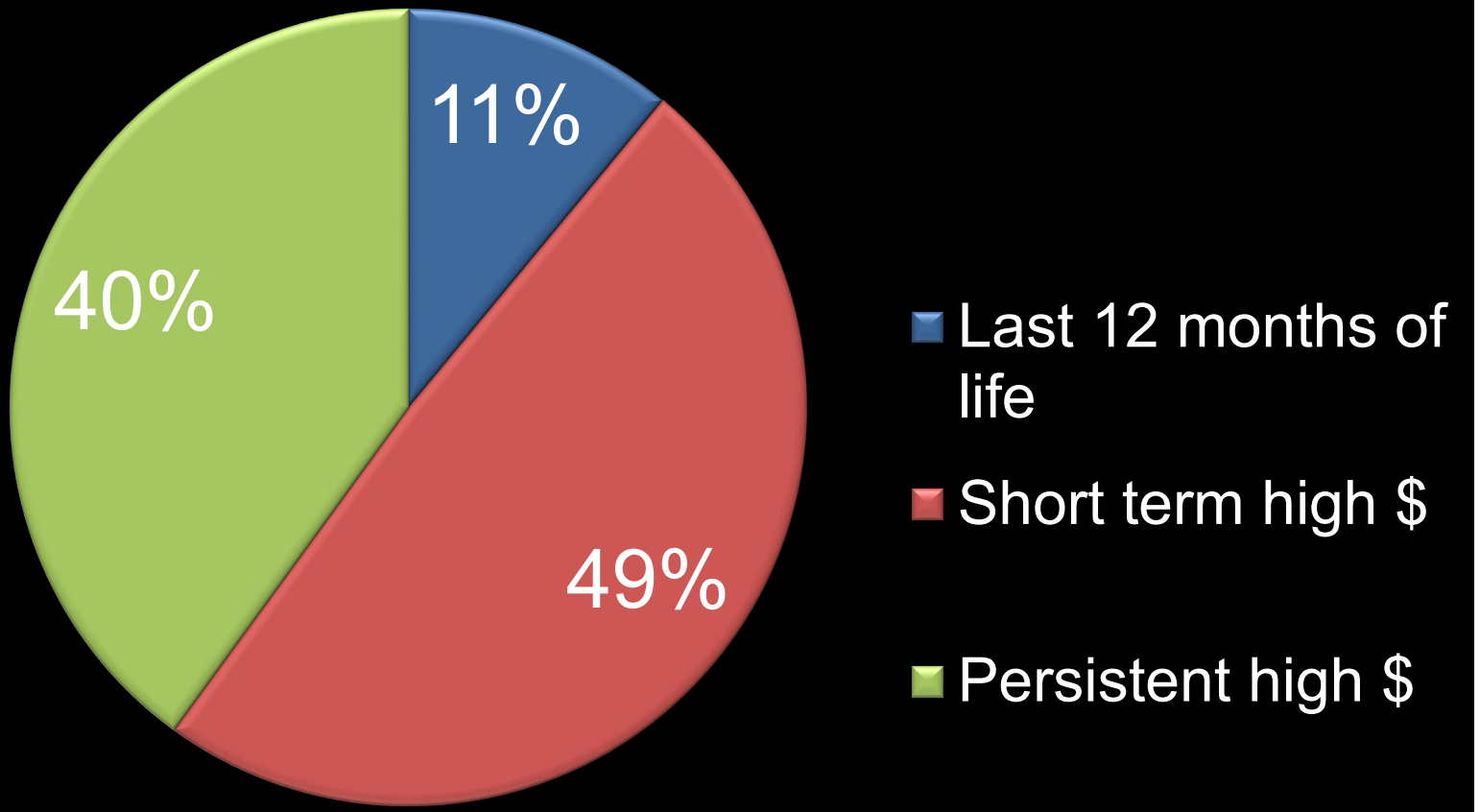
Costliest 5% of Patients

IOM Dying in America Appendix E http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx



Who are the high need, high cost group?

- Functional Limitation
- Frailty
- Dementia
- Exhausted overwhelmed family caregivers
- Social + behavioral health challenges
- +/- Serious illness(es)

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What is Palliative Care?

- Specialized medical care for people with **serious illness** and their families
- Focused on **improving quality of life**. Addresses pain, symptoms, stress of serious illness.
- Provided by an interdisciplinary **team** that works with patients, families, and other healthcare professionals to provide **an added layer of support**.
- Appropriate at **any age, for any diagnosis, at any stage** in a serious illness, and provided **together with disease treatments**.

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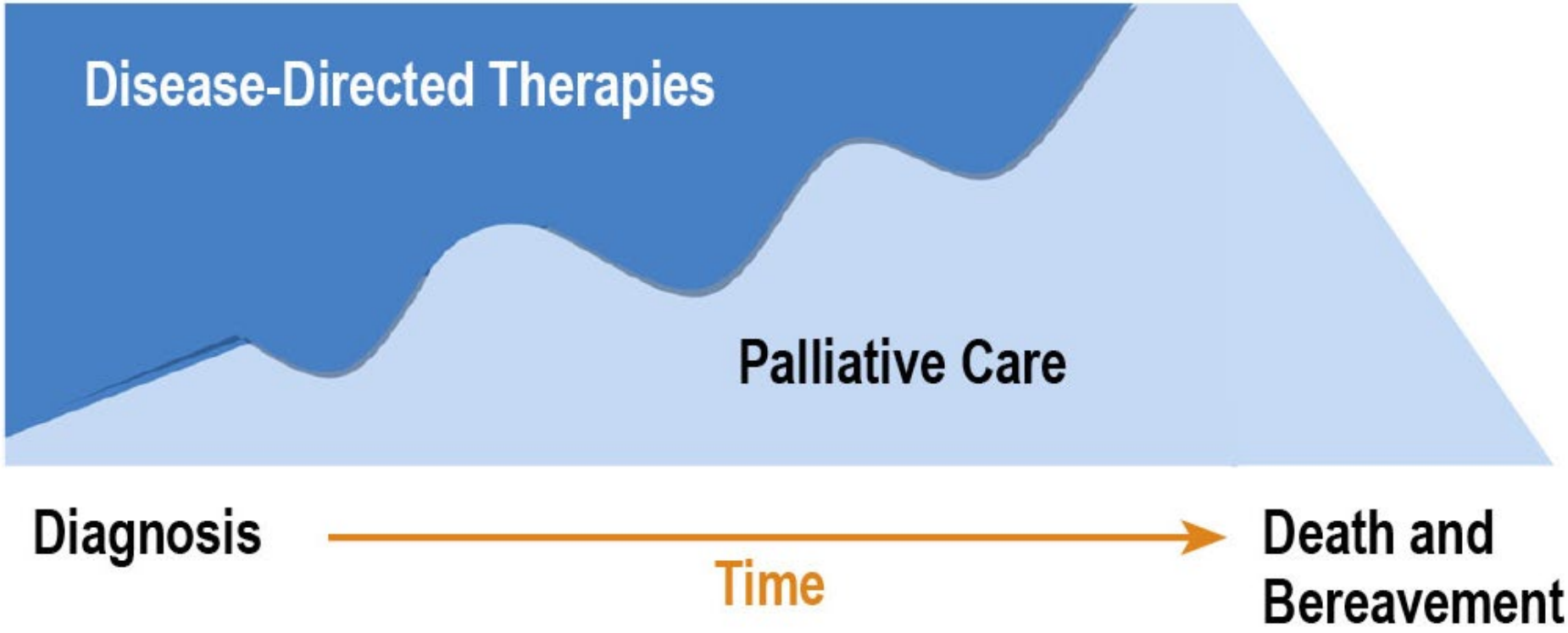
Conceptual Shift for Palliative Care



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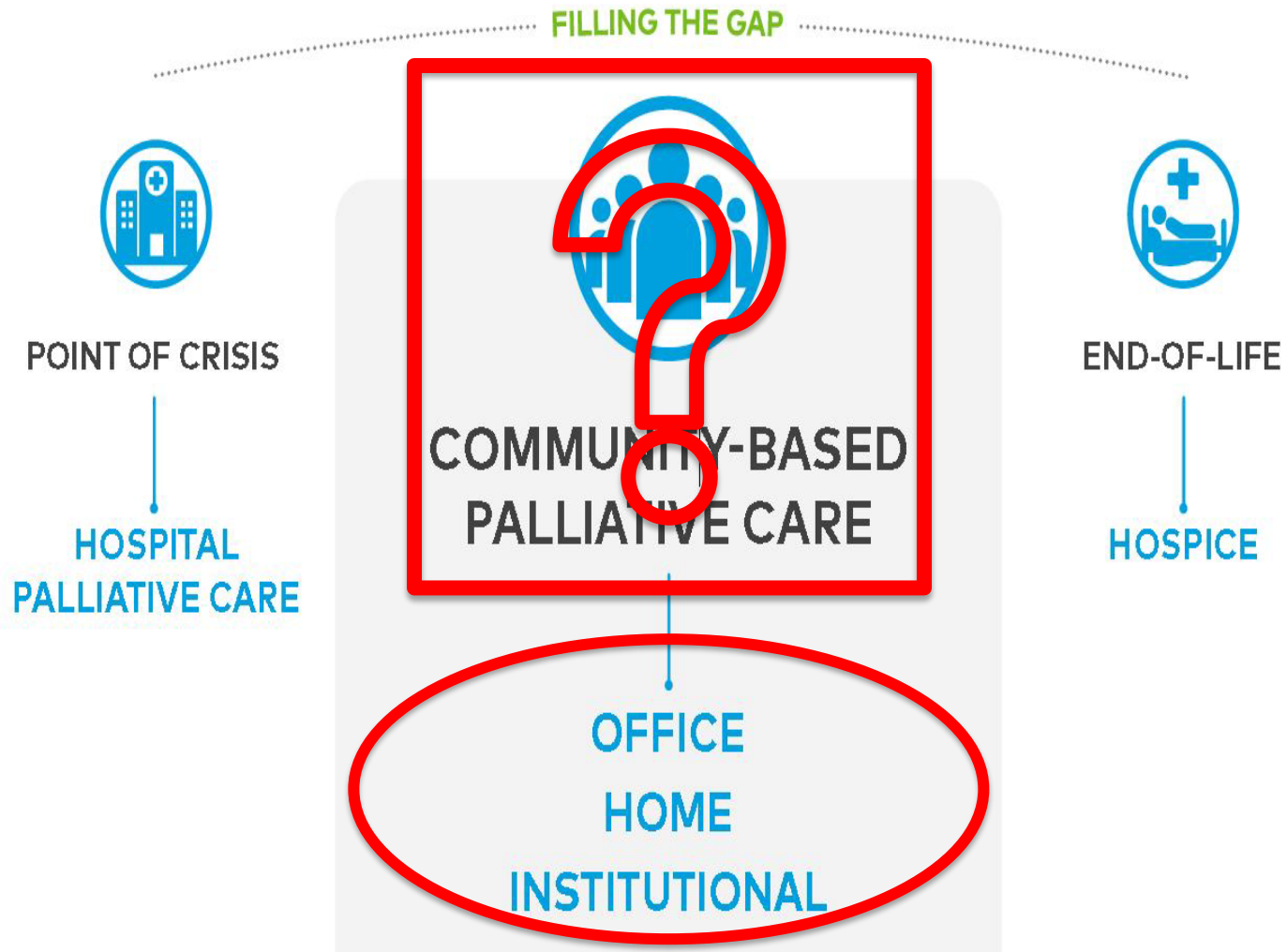
THE CONTINUUM OF PALLIATIVE CARE

Palliative care can be — and must be — available across all settings, offering an array of services in venues that matter most to patients and families, in ways that ensure smooth transitions between settings.



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Palliative Care Improves Quality of Life and Quality of Care

Quality improves

- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- MD satisfaction

Costs reduced

- Hospital cost/day
- Use of hospital, ICU, ED
- 30 day readmissions
- Hospitality mortality
- Labs, imaging, pharmaceuticals

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Why should Health Systems and Payers Care About Palliative Care?

1. Concentration of risk and spending in the subset of patients with functional and cognitive impairment, frailty, +/- serious illness
2. Evidence that palliative care improves value (improved quality and reduced cost) for this subset
3. Few strategies simultaneously improve quality and reduce spending

How does it work?

Top 6 Characteristics of *Effective* Palliative Care

1. Adequately staffed and educated teams *in the relevant settings*
2. Screen, then target the highest risk people
3. **Ask people what matters most to them**
4. Support family and other caregivers
5. Expert pain/symptom management
6. 24/7 access, all settings

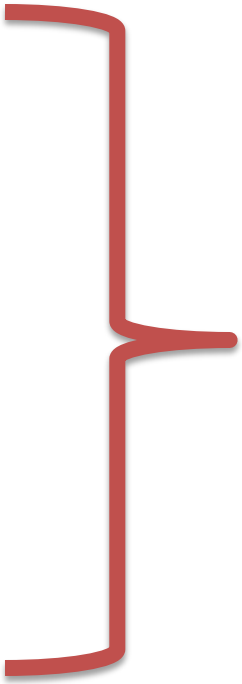
1. Adequately staffed and educated teams *in the relevant settings*

- 24/7 access to palliative care expertise is essential in the home and nursing facility
- Otherwise after-hours problems end up in the emergency department and hospital

2. Screening criteria

Diagnoses *are less helpful* for screening than:

- Functional dependency
- Frailty
- Caregiver burden/exhaustion
- Cognitive impairment
- Symptom distress
- Depression/anxiety



Target Population

3. Goal Setting

Ask the person and family, “What is most important to you?”

3. What is most important?

Survey of Senior Center and Assisted Living subjects, n=357, dementia excluded, no data on function.

Asked to rank order *what's most important:*

1st Independence (76% rank it most important)

2nd Pain and symptom relief

3rd Staying alive.

Fried et al. Arch Int Med 2011;171:1854

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3. Once we know what's most important, we must develop and honor a care plan aligned with those priorities

- Most (though not all) people want to stay home
- To stay home requires meaningful 24/7 access to clinicians with palliative care expertise and prescribing capacity

4. Supporting Families and Caregivers

Family exhaustion/loneliness = top reason for return to hospital

- Assess family caregiver burden, then mobilize social, psychological, financial supports:
  - Volunteers
  - Paid aides
  - Engaging other family/friends
  - Respite care, scheduled breaks
  - Transportation
  - 24/7 phone access to help

5. Pain and Symptoms

Disabling pain and other symptoms reduce independence and quality of life.

HRS- representative sample of 4703 community dwelling older adults 1994-2006

Pain of moderate or greater severity that is ”often troubling” is reported by **46%** of older adults in their **last 4 months of life** and is worst among those with ***arthritis***.

Smith AK et al. Ann Intern Med 2010;153:563-569

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5. Expert pain and symptom management

Families will use the emergency department and hospital if their loved one is in distress, and they can't reach help within 30 minutes.

Clinicians must be trained and competent in management of pain and other sources of distress, and the safe and effective use of opioids.

6. 24/7 access all settings

Helping people know what to expect reduces fear and anxiety

NARRATIVE MATTERS

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

HealthAffairs

DOI: 10.1377/HLTHAFF.2013.0517

'I Don't Want Jenny To Think I'm Abandoning Her': Views On

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“I don’t want Jenny to think I’m abandoning her.”

Response to my question asking an oncologist what he hoped to accomplish through intrathecal chemotherapy for a patient with brain metastases from lung cancer.

Meier DE. Health Affairs 2014;33:895-8

Oncologist Offers Intrathecal Chemo (aka most important lesson of my career so far)

- Jenny asks what I think. I tell her I'll call the oncologist.
- I ask "I don't have much experience with this procedure. What are you hoping we can accomplish with it?"
- He says, "It won't help her." Long pause.
- I ask, "Do you want me to encourage her to go ahead with it?"
- He says, ***"I don't want Jenny to think I am abandoning her."***

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Conclusion

Problem?

- Lack of Training

Solution?

- **Training**

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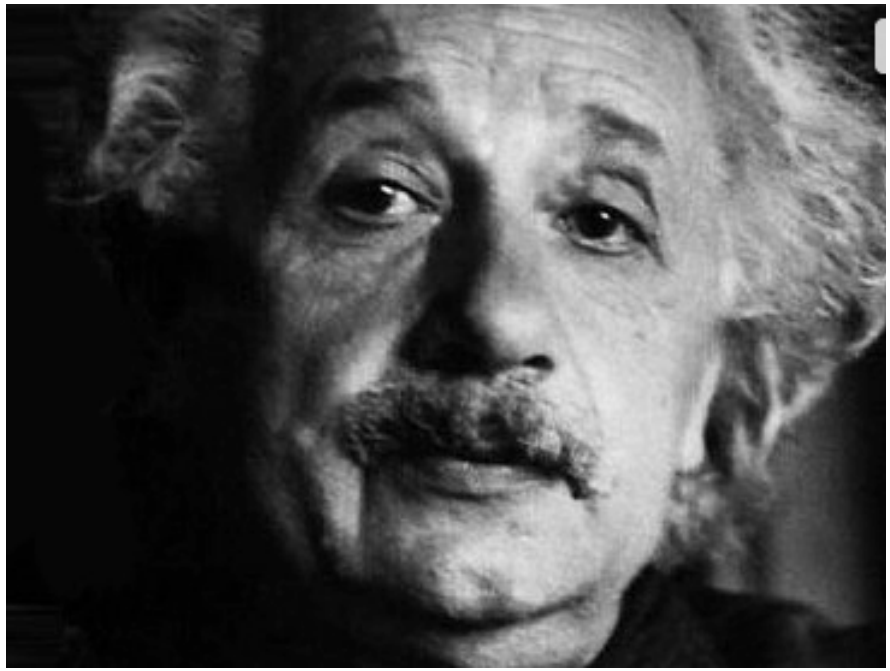
In Loving Memory

Palliative Care

"Every day I remind myself that my inner and outer life are based on the labors of other men [and women], living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving."



Albert Einstein, 1935

The World As I See It

THANK YOU!!

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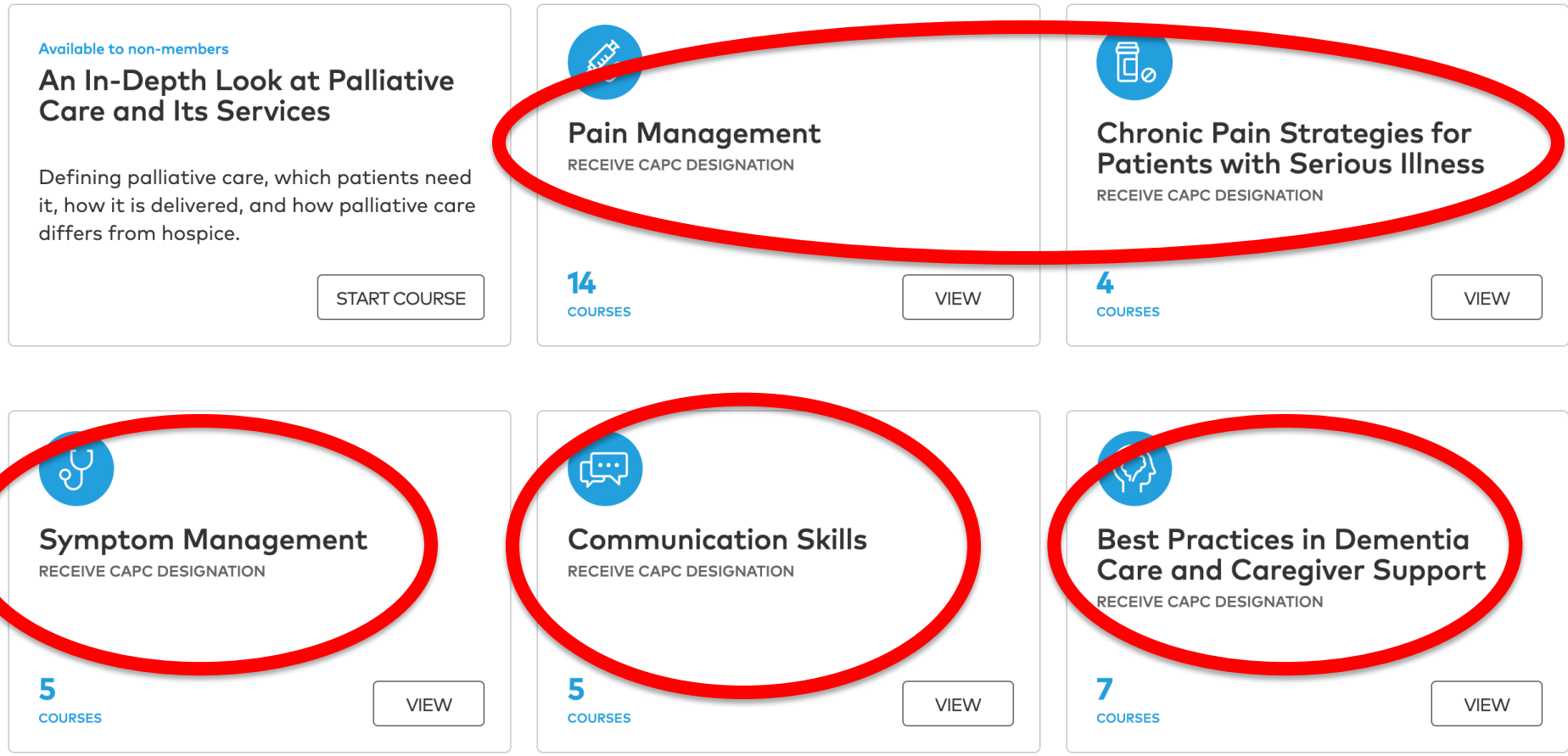
Resources

Clinical Training



https://www.capc.org/training

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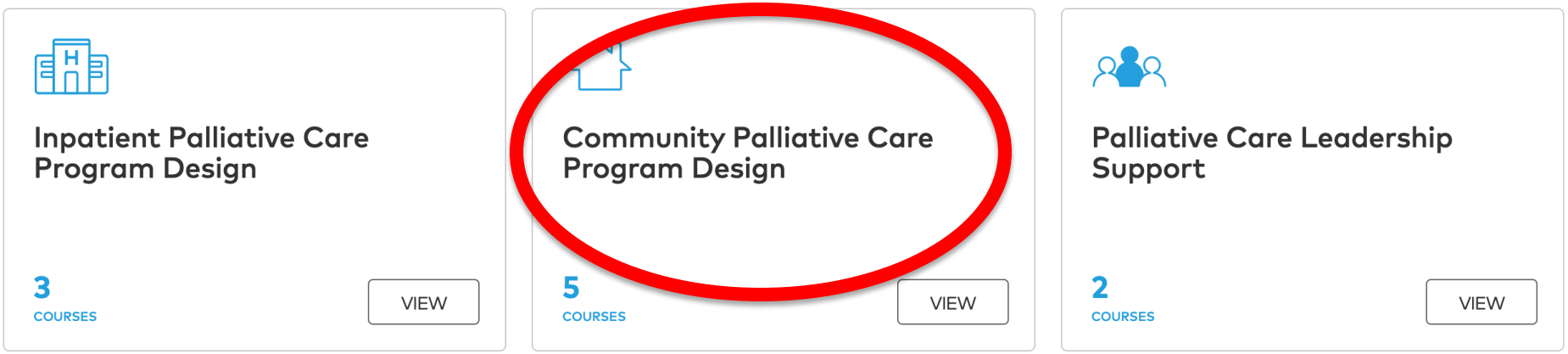
Operational Training

Operational Courses for Palliative Care Teams

CAPC's operational courses provide training for palliative care leaders in program design (including both hospital and community palliative care), as well as key skills for strengthening the effectiveness of the palliative care team.

Looking for clinical training? CAPC's clinical curriculum covers communication, pain and symptom management, caregiver support, and more. Learn more about CAPC's CAPC continuing education mission and policy.

Questions about CAPC online courses or continuing education? Read our FAQ.



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