HOSPICE AND PALLIATIVE MEDICINE

Sandra Sanchez-Reilly, MD, AGSF
Associate Professor
Division of Geriatrics, Gerontology and Palliative Medicine
The University of Texas Health Science Center at San Antonio
South Texas Veterans Health Care System
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OBJECTIVES

• To introduce the concept of Palliative Care for all patients with chronic disease,
• To define hospice and palliative medicine as a sub-specialty
• To discuss benefits of and barriers to the delivery of palliative care
Clinical Case: My father in law

- 74 years old
- Moderate AD
- COPD
- CHF
- Active Smoker
- Hypertension
- Not compliant with doctor’s visits
CLINICAL CASE: MR REILLY

• Previously very “functional”
• Lives with his wife (50 years), has 2 sons
• Pt started experiencing increased urinary frequency
• Pt fell going to the bathroom and broke his L hip
• Pt admitted to hospital: Pre-op
• Underwent surgery
• Complications: Post-op delirium, urinary retention (Foley), restraints, UTI, hospital acquired pneumonia, pressure ulcers
CLINICAL CASE: MR. REILLY

- Pt was very confused, weak, unable to walk or transfer due to pain
- Requires assistance with all ADLs
- Requires 24 hour supervision
- Depression (GDS)
- Inpatient Rehab, more complications: GU mass
- Ideal Interventions: Pain management, anxiety management, depression treatment, advance care planning discussions
- Interdisciplinary team approach (social work, psychology, nursing, nutrition, medicine)
- Passed away 2 months after surgery
What is Palliative Care?

Interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.

It is offered simultaneously with all other appropriate medical treatment.
Goals of Palliative Care…

• To relieve physical and emotional suffering
• To improve patient-professional communication and decision-making
• To coordinate continuity of care across settings
• To match care to patient needs
The Cure - Care Model:
The Old System

Life
Prolonging Care

Palliative/Hospice Care

Disease Progression

DEATH
Palliative Care’s Place in the Course of Illness

- Diagnosis of serious illness
- Life Prolonging Therapy
- Palliative Care
- Medicare Hospice Benefit
- Death
Palliative Care

“Modern Medicine”

Hospice
PALLIATIVE CARE TEAM IS ESSENTIAL
PALLIATIVE CARE

- Symptom management (i.e. pain)
- Advance Care Planning
- Family Meetings
- Ethical Issues
- End of life issues (near dying experience)
- End of life communication issues
- IDT Care
- Discharge planning
WHY PALLIATIVE CARE?
WHY PALLIATIVE CARE?

1. PATIENT AND CAREGIVER BURDEN

2. COST
WHY PALLIATIVE CARE?

PATIENT AND CAREGIVER BURDEN
Symptom Burden of Patients With Serious Illness at 5 U.S. Academic Medical Centers

Patients With Mod-Severe Pain Between Hospital Days 8-12

Colon cancer 60%
Liver failure 60%
Lung cancer 57%
Multisystem organ failure + cancer 53%
Multisystem organ failure + sepsis 52%
COPD 44%
CHF 43%

Desbiens & Wu. JAGS 2000
Family Satisfaction with Hospitals as the Last Place of Care
2000 Mortality follow-back survey, n=1578 decedents

Not enough contact with MD: 78%
Not enough emotional support (pt): 51%
Not enough information about what to expect with the dying process: 50%
Not enough emotional support (family): 38%
Not enough help with symptoms: 19%

Teno et al. JAMA 2004;291:88-93
The Family Burden of Serious Illness

- Needed large amount of family caregiving: 34%
- Lost most family savings: 31%
- Lost major source of income: 29%
- Major life change for family member: 20%
- Other family illness from stress: 12%
- At least one of the above: 55%

Covinsky et al, JAMA, 1994
The Family Burden of Serious Illness

- 25 million caregivers deliver care at home to a seriously ill older relative
  - Mean hours caregiving per week: 18
  - 60% work full time
  - 61% are women
  - 33% over age 65
  - 33% in poor health themselves
  - 87% state they need more help
- Stressed caregivers are at significantly increased risk of death and major depression
- Cost equivalent of uncompensated care: 450 billion dollars (assume $10/hr)

WHY PALLIATIVE CARE?

$$$$$$$$$$$$$$$$$$
Variation and Overuse of Medical Resources in the Seriously Ill

![Graph showing variation and overuse of medical resources in the seriously ill.]

<table>
<thead>
<tr>
<th>Highest state</th>
<th>Outpatient</th>
<th>Inpatient</th>
<th>SNF</th>
<th>Home health</th>
<th>Hospice</th>
<th>LTC/RH</th>
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</thead>
<tbody>
<tr>
<td>$9,219</td>
<td>$37,040</td>
<td>$9,332</td>
<td>$4,201</td>
<td>$4,481</td>
<td>$6,567</td>
<td></td>
</tr>
<tr>
<td>U.S. average</td>
<td>$7,257</td>
<td>$25,376</td>
<td>$5,400</td>
<td>$2,282</td>
<td>$2,336</td>
<td>$1,373</td>
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<tr>
<td>Lowest state</td>
<td>$5,532</td>
<td>$17,135</td>
<td>$3,067</td>
<td>$877</td>
<td>$662</td>
<td>$64</td>
</tr>
<tr>
<td>Extremal ratio</td>
<td>1.67</td>
<td>2.16</td>
<td>3.02</td>
<td>4.79</td>
<td>6.77</td>
<td>112.81</td>
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<tr>
<td>Interquartile ratio</td>
<td>1.15</td>
<td>1.25</td>
<td>1.37</td>
<td>1.51</td>
<td>1.42</td>
<td>2.64</td>
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<tr>
<td>Coefficient of variation</td>
<td>10.9</td>
<td>20.3</td>
<td>25.9</td>
<td>36.3</td>
<td>37.5</td>
<td>100.7</td>
</tr>
</tbody>
</table>

Figure 2.5. Medicare Spending by Sector During the Last Two Years of Life for Patients with At Least One of Nine Chronic Conditions Among States (Deaths Occurring 2001–05)

Dartmouth Atlas, 2008
Medical Spending in the U.S.

- 2.2 trillion dollars in 2007
- 15% Gross National Product (GNP), rising to 20% by 2015
- Highest per capita spending, but ranks 20th in quality indices among developed nations
- The 63% of Medicare patients with 2 or more chronic conditions account for 95% of Medicare spending
- The costliest 5% account for 43% of Medicare spending
Care For the Seriously Ill at the Turn of the Century (2000)

- Unprecedented gains in life expectancy: exponential rise in number and needs of frail elderly
- Cause of death shifted from acute sudden illness to chronic episodic disease
- Untreated physical symptoms
- Unmet patient/family needs
- Disparities in access to care
- Inadequately trained health care professionals
- An unresponsive health care system facing enormous and increasing expenditures
The Reality of the Last Year of Life

Lunney, J. R. et al. JAMA 2003
Cost Savings from Palliative Care at 8 U.S. Hospitals

Live Discharges

In-Hospital Deaths

Trend line for average daily costs for usual care patients over the same time frame

## Cost Savings from Palliative Care at 8 U.S. Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Live Discharges</th>
<th>Hospital Deaths</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Usual Care (n=18427)</td>
<td>Usual Care (n=2124)</td>
</tr>
<tr>
<td></td>
<td>Palliative Care (n=2630)</td>
<td>Palliative Care (n=2278)</td>
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<tr>
<td>Admission</td>
<td>$12,089</td>
<td>$23,682</td>
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<tr>
<td></td>
<td>$10,608</td>
<td>$16,543</td>
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<tr>
<td>Laboratory</td>
<td>$1,413</td>
<td>$3,026</td>
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<tr>
<td></td>
<td>$999</td>
<td>$1,835</td>
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<tr>
<td>ICU</td>
<td>$6,974</td>
<td>$15,531</td>
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<tr>
<td></td>
<td>$1,726</td>
<td>$7,755</td>
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<tr>
<td>Pharmacy</td>
<td>$2,651</td>
<td>$6,148</td>
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<td></td>
<td>$2,534</td>
<td>$3,684</td>
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<td>Imaging</td>
<td>$901</td>
<td>$1,789</td>
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<tr>
<td></td>
<td>$997</td>
<td>$1,346</td>
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<tr>
<td>Died in ICU</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>18%</td>
</tr>
<tr>
<td></td>
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<td>4%</td>
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</tbody>
</table>

Palliative Care Is Cost-Saving, supports transitions to more appropriate care settings

• Palliative care lowers costs (for hospitals and payers) by reducing hospital and ICU length of stay, and direct (such as pharmacy) costs.
• Palliative care improves continuity between settings and increases hospice/homecare/nursing home referral by supporting appropriate transition management.

Growth of Palliative Care Program in Hospitals (>50 Beds)

Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

Palliative-Care Unit Offers Painkillers and Support, Fewer Tests, Treatments

53% of Americans die in hospital
Half spend time in ICU
Half have mod to severe pain
The Clinical State of the Field: 2009

- Hospital palliative care programs: 1,294
- ABHPM certified MDs: 2,100
- ABMS certified MD’s: 1,400 approximately
- HPNA certified nurses: 15,133
- Medicare certified hospices: 4,160
- Hospice patients/year: 1.2 million
  - 30% of total U.S. deaths
  - 82% over age 65
  - 23% of hospice patients are in nursing homes
But…

• Lack of a solid evidence base to guide clinical care
  – Pain, symptoms, bereavement

• Lack of health services research to guide delivery of care
  – Hospitals, Hospice, NHs, Ambulatory Care
  – Cancer, COPD, CHF, AD

• Lack NIH funding to support research and investigators

NIH State of the Science Conference, 2004
NIH Funding for Palliative Care (2001-2005)

- 418 Funded Grants
  - 189 (45%) were funded by NCI
    - 0.4% of all NCI grants
  - 94 (22%) by NINR
    - 3% of all NINR grants
  - 74 (18%) by NIA
    - 0.5% of all NIA grants
  - 21 (5%) by NIMH
    - 0.1% of all NIMH grants
  - 40 (10%) were funded by 8 other Institutes
    - NIDDK did not fund a single grant in palliative care

Why the Lack of Research Funding?

• Symptoms are unimportant
  – Interesting in so far as they guide the astute clinician to a diagnosis
  – Will go away when the disease is cured

• Difficult population to study
  – Multiple symptoms and concurrent problems
  – Very sick population with limited tolerance for lengthy protocols and instruments
  – High mortality rate
  – Missing data from death and disease burden
  – Difficult outcomes to study

• Population that is not amenable to traditional research methodologies (RCT)
The Result:

• Current palliative care practice is guided by:
  – Data from other populations
  – Results from small series of patients from single institutions
  – Anecdote and hearsay

• Is this the type of care that we want for our parents or for ourselves?
The Educational State of the Field: 2009

- ABMS-approved subspecialty
  - First ABIM certifying exam in fall 2008
  - 10 boards sponsoring
- 65 active fellowship programs (with several in development), 149 fellowship positions including 21 research slots
- 32 programs have been accredited by the Palliative Medicine Review Committee (PMRC)
- ACGME Accreditation for 50 fellowship programs (January 2009)
Deficiencies in Medical Education

- 74% of residencies in U.S. offer no training in end of life care.
- 83% of residencies offer no hospice rotation.
- 41% of medical students never witnessed an attending talking with a dying person or his family, and 35% never discussed the care of a dying patient with a teaching Physician.

Billings & Block JAMA 1997;278:733.
The Good News:
Palliative Care Education Is Improving

• Medical school LCME requirement:
  “Clinical instruction must include important aspects of … end of life care.”

• Residency ACGME requirements for internal medicine and internal medicine subspecialties:
  “Each resident should receive instruction in the principles of palliative care… it is desirable that residents participate in hospice and home care… The program must evaluate residents’ technical proficiency,… communication, humanistic qualities, and professional attitudes and behavior…”
UTHSCSA

• Few lectures on Death and Dying
• Elective Course in Geriatric Palliative Care
• Clinical Electives
• Center for Ethics and Humanities
UTHSCSA INITIATIVE

- UT Academy of Health Science Education Innovations Program: An Educational Intervention Project in End-of-Life for UT medical students and primary care residents
- Longitudinal Curriculum
- Increase numbers in fellowship positions
- Geriatrics rotation mandatory for IM residents, rehab, psychiatry
- Pain fellows, oncology fellows
The Administrative State of the Field: 2009

• Joint Commission has created voluntary accreditation for palliative care programs

• VA has mandated palliative care to be one of their performance measures
University of Texas Health Science Center at San Antonio and The South Texas Veterans Health Care System

Palliative Care Program:
  Fellowship
  Consultation Service
  Inpatient Hospice Unit
  Community Home Hospices
  Clinic
  Pediatric Palliative Care
Geriatrics and Palliative Care

What is the Relationship?
Why is palliative medicine important in geriatrics?

- Physical and emotional suffering
- Burden on family caregivers
- Widespread dissatisfaction
- Overuse
- Mismatch of current system to patient needs
## Geriatrics and Palliative Care

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<tr>
<th>FACTS</th>
<th>Geriatrics</th>
<th>Palliative Care</th>
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<tr>
<td>Population</td>
<td>Older</td>
<td>Everyone: Many Older Adults</td>
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<tr>
<td>Quality of Life</td>
<td>Very Important</td>
<td>Very Important</td>
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<tr>
<td>Geriatric Syndromes</td>
<td>Mental Status Changes, Pain, Falls, Weakness</td>
<td>Many Symptoms</td>
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<tr>
<td>Family</td>
<td>Very Important</td>
<td>Very Important</td>
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<tr>
<td>Sub-Specialty</td>
<td>Yes</td>
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<tr>
<td>Functional Status</td>
<td>Very Important</td>
<td>Comfort and Quality of Life</td>
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# Palliative Care and Urology

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<th>Urology</th>
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<td>Everyone: Many older adults</td>
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<td>Sub-specialty</td>
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<tr>
<td>Functional Status</td>
<td>Important, comfort and quality of life</td>
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QUESTIONS?

Sandra Sanchez-Reilly, M.D.
sanchezreill@uthscsa.edu
210-617-5237