Meeting Them Where They Are: How Home Based Palliative Care Can Improve Care for the Seriously Ill

JAMIE BRANT, MD
INTERNAL MEDICINE/PALLIATIVE CARE
AMG SENIOR MEDICAL GROUP MEDICAL DIRECTOR
UNIVERSITY OF UTAH-ADJUNCT ASSISTANT PROFESSOR INTERNAL MEDICINE
Disclosures

- No financial disclosures
Goals of presentation

- Understand the current state of the U.S. healthcare system
- Identify problems of current healthcare delivery
- Understand the changing demographic in the U.S.
- Understand the full palliative assessment
- Know the literature behind the benefits of home based healthcare delivery
- Be inspired to look at creative ways to care for frail, older adults and those living with severe chronic illness
- Develop awareness of potential areas of research.
As medicine was developing, there has been progressively more focus on reacting rather than being pro-active. Now as baby boomers age, we see the need for more upstream discussions about goals of care, prevention of complications due to waiting and meeting patients literally and figuratively where they are.
State of U.S. Medical System

- Progressively more compartmentalized
- Who “owns” the patient-getting orders
- Evidence based
- Litigious
- Overly optimistic in prognostication
- Time limited
- Reactive

- Christakis NA, Lamont EB. Extent and Determinants of Error in Doctor’s Prognoses in Terminally Ill Patients: Prospective Cohort Study. BMJ. 2000; 320:469-472
Demographics are changing

Longer life spans and higher birth rate (baby boomers)
Growth in number of older adults unprecedented
Double the geriatric population over the next 25 years (72 million)
By 2030-olders adults will account for 20% of population
More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions
Treatment for this population accounts for 66% of the country’s health care budget

CDC-State of Aging and Health-2013
In-Home Palliative Geriatric Approach

- Care goals—central guiding light—most important part
- Improve QOL thru symptom management
- Help plan for future with anticipatory guidance
- Follow geriatric tenants of care
Story of Mr. H
Was this a successful final chapter?

- What were the barriers?
The Problem...Difficult Access
The Problem: Fragmented Care
The Problem....Difficult Communication

- Multiple “cooks in the pot.”
- Inconsistent messages
- Difficult to communicate
The Problem….Evidence Based?

- Frail elderly and chronically ill not included in the studies.
- Some Geriatric/palliative specific data but not robust
- May be evidence based specific for geriatrics but not within goals
- More gray area
The Problem....Not Patient Centered
Goals of Care

- Most frail and chronically ill often want to put limitation on care
- POSLT as example
  - Many are DNR
  - Many elect limited interventions
  - Some decline hospitalization
  - Some elect no antibiotics except for comfort
  - Many decline artificial hydration and nutrition
The Problem....Prognosis
Not Considered
Prognosis Combined with Goals
<table>
<thead>
<tr>
<th>Preference</th>
<th>To Prepare:</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of participants said they would want to discuss prognosis with their doctor</td>
<td>Logistically or financially</td>
</tr>
<tr>
<td></td>
<td>Psychologically or spiritually</td>
</tr>
<tr>
<td></td>
<td>Friends and family</td>
</tr>
<tr>
<td></td>
<td>To make the most of the time they have left</td>
</tr>
<tr>
<td></td>
<td>To make medical or health-related decisions</td>
</tr>
<tr>
<td>25% of participants said they would prefer not to discuss prognosis with their doctor</td>
<td>Too emotionally difficult</td>
</tr>
<tr>
<td></td>
<td>Prognostic information is not useful</td>
</tr>
<tr>
<td></td>
<td>Doctors can’t estimate prognosis</td>
</tr>
</tbody>
</table>
How do we Prognosticate?
Shortcomings of Clinical Predictions

- Tend to overestimate patient survival by a factor of between 3 and 5.
- Tend to be more accurate for very short-term prognosis than long-term prognosis.
- 37% would not prognosticate even if asked
- Influenced by relationships

The length of provider-patient relationships increases the odds of making an erroneous prediction.

- Christakas, Annals on Int Med, 2001
Prognostic Pearls

- Trajectory is very important
- Lower PPS is more accurate
- Patients less concerned with accuracy than delivery
- Unified message
- Let patient decide how much information to give
- Discuss in terms of weeks/month/years
- What does this have to do with primary care in the home?

Casarett, DJ, Quill, TE. I’m not ready for hospice: Strategies for timely and effective hospice discussions. Ann Int Med; 2001 146: 443-449
Barriers to discussion

- Lack of time
- Fear of taking away hope
- Discomfort with the discussion
- Denial in patients
- Cognitive decline

Lenherr, Gabriel, et al. To speak or not to speak-do clinicians speak about dying and death with geriatric patients at the end of life? Eur J Medical Sciences. 2012. 142: 1-7
The Problem... No Time!

- Greater time crunch to make sure we are meeting all quality measures
- Volume in clinic is immense
- Creates a culture of reactivity for end of life.
The Problem......COST

- 27% of Medicare dollars are spent in the last 1 year of life
- 50% of dollars are spent on most costly 5%
- 18% of the total expenditure is patient out of pocket
- 2.8 % of Medicare dollars are spent on hospice

Centers for Medicare & Medicaid Services, Office of the Actuary
Summary of Problem

- Lots of patients getting lots of intensive medical care that they don’t want at an astronomical cost!!
- Rapidly growing number of Medicare recipients
- Those who are the most ill/frail have the greatest difficulty getting the care they need.
- Limitations of our current medical system create roadblocks for patients to remain in the driver seat

Home based primary/palliative care
Patient Centric
(Guiding Light are Goals and Values)
Components of home based PC visit

- Goals of care
- Focus on geriatric tenents-5-10% of admits due to medications
- Strong consideration of prognosis-qualify for admit on best day-how are you going to keep them out of the hospital.
- Excellent communication w/ facilities, family, HH and subspecialty/acute care MD’s
- More time spent but lower overhead
Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders

K. Eric De Jonge, MD,* Naminah Janshed, MBBS, * Daniel Gilden, MS,* Joanna Kubisiak, MPH,† Stephanie R. Bruce, MD,* and George Taler, MD*

[See Editorial Comments by Peter A. Boling and Bruce Leff, pp 1974–1976]
Components of Intervention

- Physician/NP services delivered in home
- Availability of in-home labs and other diagnostics
- Focus on eliciting goals and values with Advance Care Planning
- Strong Consideration of Prognosis
- Avoidance of polypharmacy
- Excellent communication among patients and families
- Excellent communication in acute setting and with subspecialists
- Care continued into the inpatient setting
Outcomes of the Intervention

- Highest quartile of frailty had greatest cost savings
- 17% lower costs over 2 years compared with control group
- Less hospital, skilled nursing, subspecialist visits
- More home health, hospice and primary care expenditures
- No difference in mortality or average time to death
- Improved satisfaction
Palliative Home Nursing

- Staffed by hospice nurses
- Biweekly interdisciplinary team meetings
- Team consists of nurse, physician, chaplain, and social worker.
- Telephone triage line that provides 24-hour access to RN
- No requirement that goal is comfort care
- No requirement to forego life prolonging treatment

Can Palliative Home Care Reduce 30-Day Readmissions?

- Palliative care patients had 9.1% 30-day readmission compared to 17.2%
- Controlled for known predictors of readmission (ex: presence of IV)
- Mean visit frequency was 0.74 visits/day versus 0.23 visits per day on standard home care

Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care

Richard Brumley, MD, * Susan Enguidanos, PhD, MPH, † Paula Jamison, BA, ‡ Rae Seitz, MD, † Nora Morgenstern, MD, § Sherry Saito, MD, † Jan McIlwane, MSW, § Kristine Hillary, RNP, * and Jorge Gonzalez, BA †
Kaiser Permanente-Home Based Palliative Care

- CHF, COPD and cancer
- Improved satisfaction (30 days and 90 days)
- Fewer ER visits
- Fewer hospitalizations
- Fewer skilled days
- 45% reduction in cost
- No change in mortality
Independence at Home

- CMS demonstration project
- 14 participating sites across US
- Three year study (on year 2)
- Outcomes are patient experience through quality measure and cost savings
- Requirements—already established home-based primary care
- Payment is fee for service (FFS) plus bonus for meeting quality measures
Patient inclusion criteria
- 2+ chronic conditions
- Have traditional medicare fee for service coverage
- Need assistance with 2+ ADL’s
- Have had a non-elective hospital admission in the last 12 months
- Have received acute or subacute rehabilitation services in the last year
Independence at home

- Practice inclusion criteria
  - Led by MD or NP’s
  - Are organized for the purpose of providing physician services
  - Have experience providing home-based primary care
  - Serve at least 200 eligible beneficiaries
  - Teams often include PA’s, pharmacists, social workers and other staff
Independence at home

Quality Measures

- Hospitalizations and Emergency Room Visits
- 30 day hospital readmission rates
- Medication reconciliation in the home within 48 hours of discharge (50%)
- In-home follow-up or phone follow-up within 48 hours of discharge from hospital or ER (50%)
- Patient preferences for treatment documented (80%)
Independence at Home

Outcomes Year 1

- Fewer hospital admissions within 30 days
- Follow-up contact from their provider within 48 hours of hospital admission, discharge or ED visit
- Medications reconciled by their provider within 48 hours of discharge
- Preferences documented by their provider
- Used less inpatient hospital and ER for certain conditions (avoidable) such as DM, HTN, asthma, pneumonia or UTI.
Independence at Home

- Outcomes year 1
  - All 17 practices improved quality in at least 3 quality measures
  - 4 practices met all six
  - Cost savings-25 million or around $3000 per beneficiary
  - One practice saved $1000/month on service.
Cost Savings: Summary

- VA-24% lower VA cost and 11% lower Medicare cost
- Kaiser Permanente-45% decrease in total costs
- FFS model for HBPC-17% lower Medicare Costs
- Current study is Independence at Home (Medicare pilot) in the fee for service arena-so far 25 million in savings
- All showed improvement in satisfaction
- None showed shorter length of life.

- Independence at Home Demonstration Project section 3024 of the Affordable Care Act
- Rabow, Michael et al. Moving Upstream: A Review of the Evidence of the Impact of Outpatient Palliative Care
- DeJonge et al. Effects of Home Based Primary Care on Medicare Costs in High Risk Elders. JAGS 2014
Who benefits the most?

- Frail elderly
- Those with severe, chronic illness with frequent exacerbations
- Those with limited access to care
- Bimodal peak?
- Healthcare utilization inversely proportional to prognosis?
Unintended consequences

- Lower cost
- Better communication
- Better anticipatory guidance
- More appropriate care that is consistent with goals
- Improved patient satisfaction
Current and Predicted reimbursement ratios - FFS vs alternative

- 2014-20% alternative/innovative reimbursement
- 2016-30% alternative/innovative reimbursement
- 2018-50% alternative/innovative reimbursement
- Most FFS will be linked with performance and quality

CMS.gov. Affordable Care Act payment model saves more than 25 million in first performance year. June 18, 2015
How do we pay for this?

- Fee for service in private residence-challenging due to driving time but several practices are doing this
- Fee for service but in assisted living only
- Innovative approaches:
  - Medicare pilot projects
  - Grant funding-often short lived
  - Partnership with insurance plan
  - Insurance plan owned programs
  - ACO-% of cost savings.
Back to Mr. H

How could this have gone differently?
Mr. H—Important part

- He was married 58 yrs and lost his wife 1 year ago
- He was the CEO of large company prior to retiring at age 68
- He has had a lifelong love of learning
- He moved to ALF after his wife died
- He has children but all were out of state
Mr. H-Care goals/values

- He values functional and cognitive independence which he feels he has lost
- Reports current QOL to be poor
- He misses his wife terribly
- He doesn’t want to prolong his life in any way.
- He is ready to die and be with his wife.
- NO ONE HAS ASKED AND NO ONE KNOWS HIS WISHES!!
Prolonging life?
Prolonging death?
Mr. H-choose your own adventure:

- Goals of care discussed prior to illness
- Hospice either initiated prior or discussed hospice to start if there is acute decline
- Mr. H died at his assisted living on his own terms
- Less complicated grief for family
Mr. H desperately wanted to attend his granddaughters wedding.
He was able to do so because of his hospitalization.
He had the first dance from his wheelchair.
Any amount of suffering was worth that moment.
In home geriatrics/palliative care benefits

- Coordination w/ subspecialists is extensive
- In home evaluation provides important information
- Ease of obtaining care
- Provider serves as a QB
- Experts in geriatric and palliative care, polypharmacy, falls etc.
- Advance Care Planning is central theme
- Improved satisfaction
UPSTREAM EXAMPLES

- Fall mitigation
- Less polypharmacy
- GOALS OF CARE – AVOID FUTILE CARE AND HONOR GOALS
- Improved access
- Cohesive care upstream with better communication/coordination
But the glass is half full!!

- Debbie downer no longer!!
- Slow but steady change—finances influence as focus is on cost savings but ultimately this may encourage more discussions
- New reimbursement models support this type of healthcare delivery
- HBPC tends to do this already