Life is Too Short to not Relieve Suffering: the impact of Palliative Care

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Why PC? Life is too short !

Objectives

Participants will hear how to:

1. create a hospital-based PC service: the do's & don'ts for success
2. measure the benefits of PC
3. promote patient, family, & staff satisfaction

Outline

1. Goal of medicine – and PC
2. The benefits
   - hospital/community/national
3. Creating & maintaining a service
   - do's & don'ts
4. Satisfaction isn't guaranteed!
   - one successful 'tool'
5. Summary & Pearls

1. The Goal of Medicine [& PC]

To relieve [and prevent] suffering ! [Cassel]

Physician's Traditional Role = PC

- To cure sometimes
- To relieve often
- To comfort always

- anonymous 16th century aphorism [?Hippocrates]

Why PC??

If you are sometimes frustrated with:

- watching seniors suffer in hospital
- rising costs of health care and want to avoid bankrupting Medicare
- society's increasing medicalization with little to show for it ???

Then, PC is a Rx every hospital should fill ! – and we did at ECM!

2. Benefits of PC

[why ECM endorsed it!]

- Quality of life care
- Symptom management
- Reduced costs
- Improved satisfaction
- Increased survival !

Palliative Care Benefits QOL…

- **Improves your quality of life / living**
  - Isn't that "motherhood" ?
  - Don't all medical services do that?

    Reality: Most specialties focus on curing/treating specific disease [attempts to cure one organ may destroy the organism!!!], whereas…
- Uses 'holistic' process to achieve:
  - Goal-focused care – informed choice
  - Symptom soothing – comfort for as long as living
  - Peaceful death with dignity

Definitions ??

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

- It can be offered while receiving usual appropriate medical curative therapies, and
- is NOT only for those who are dying [that's *hospice*]

Hospice: A Medicare benefit providing palliative care for those certified with a terminal disease and less than 6 mo. to live if the disease "runs its usual course".

– It is "palliative care for the last 6 mo. of life."

Palliative = Comfort-focused Care

1) Helps patients clarify their goals in the face of a LLD*, to make informed decisions and avoid non-beneficial treatments; which…
2) Improves their quality of life so they can live comfortably (soothing symptoms) as long as possible; and then,
3) when they are at the very end of life, PC ensures a natural death w/ comfort and dignity.

*LLD = Dementias, cancers, end-stage organ disease (e.g. lung/heart/renal/liver), ALS, AIDS

Published Evidence re PC Benefits

- PC does NOT accelerate dying
  - Cost Savings Impact Study 2009 at ECM
    - patients in both the control group (94%) and the PC consult group (100%) died in the same 12 mo. (while saving hospital $386,000)

and…

- PC improves survival & QOL in lung cancer
  - Patients receiving chemotherapy and PC lived 3mo longer (11.6mo v 8.9mo) than those on just chemoRx. *[Temel. NEJM 2010.]*

and…

…PC Benefits

- Cancer pts who discuss EOLC wishes w/ MD have better QOL and lower costs in final wk of life
  - Less aggressive care/admissions to hospital
  - Improved QOL w/ more peaceful death

  ** Zhang B. Health care costs in the last week of life. Arch Intern Med. 2009*
- Pts who choose hospice live ~29 days longer than those not in hospice

  ** Connor S. Comparing hospice & non-hospice patient survival among patients who die within a three-yr window. J Pain Symptom Manage 2007*

Why is PC so beneficial?

Because, when implement PC principles, we …

- Reduce ‘pill burden’ - Stop non-comfort tx/meds
- **Aggressively control symptoms** - helps them to feel better and eat/socialize/exercise more and fight illness
- Encourage patient/family-driven goals
  - **Avoid futile/unnecessary tx & hospitalizations**
- Encourage EOLC planning [Advance Directives]
  - helps accept limits to life

Attitude may be Barrier to PC

Palliative Care helps avoid "Futile" Care!

Futile Care is:

- "when desired goals not met or desired results cannot be achieved" [qualitative], or
- "clinical care that has a <1 - 5% chance of survival" [quantitative]

[Davila F. The infinite costs of futile care… Physician Exec. 2006.]

[Schneiderman L. Beyond futility to an Ethic of Care. Am J Med. 1994;96: 110-14.]

Avoiding Non-beneficial Care

- "To continue to fight for a cure when there is no reasonable hope for one may cut off the true growth and comfort that can come from going on this journey together with those we love."

Hank Dunn. *Hard Choices for Loving People. 2001*

The only thing worse than "no hope" is "false hope"!

Avoiding Futile Care

- Only 10% people die suddenly
- 90% need a form of terminal [EOLC] care
  - During *Downward Spiral* & EOLC, we can be primary cause of suffering or, primary cause of its relief !

- Thus, we need PC & Hospice to avoid & relieve suffering !

Benefits to Hospital

- 2010 Cost Savings Impact for ECM

  Consults came from screening and unsolicited

  – Total Screened: 174 [using PMPT *]
    - 40 consults
    - 134 no consult = 'controls'
  – Total consults: 190 (40 + 150 w/o screen)
  – Deaths: 74% inpt [consults] v 31% inpt [control]
    - 23% post discharge v 36%

* *Palliative Medicine Prognostic Tool*

…2010 cost savings study

- ALOS: 9.3 d [PC] v. 12.6 days [control]
  - Pre-PC: 6.2 --
  - Post-PC: 3.1 --
- Avg. PMPT score: 13 v. 13
  = "no difference" in two populations
- Avg. $/day: $1,215 [pc] v. $1,586. [control]
  Pre-PC: $1,398/day
  Post-PC: $ 856/day [60% = $542 less]

…2010 Cost savings study

- Actual Savings by PC
  - Net savings = $ 542/day/pt x 3.1 days/pt
  - Total savings [192 x $1680] = **$322,560**.
- Probable Savings for PC consult group [190]

  [Assume ALOS (12.6) would be same for both controls & PC; include 3.3days avoided @$1398/d]
  - Net savings/pt = $6,293
  - Total for 192 pts = **$1,208,256.**

…2010 cost savings study

Interpretation: PC services likely saved ECM $1.2M by avoiding 'unnecessary/non-beneficial' tests/procedures & reducing ALOS [by 3.3d] via discharges to more appropriate care and/or providing education re goal focused care.

* Study methodology based on: *Morrison et al. Cost savings associated with US hospital PC consultation programs. Arch Intern Med. 2008.*

…More 2010 Study Findings

PMPT score >9 = prognosis <6-12mo.

- PC consults [190] – 93% died <12mo.
- Control group [134] – 90 [67%] follow-ups confirmed died <12mo. [+24 presumed dead]

Use of *AACA** does NOT accelerate death

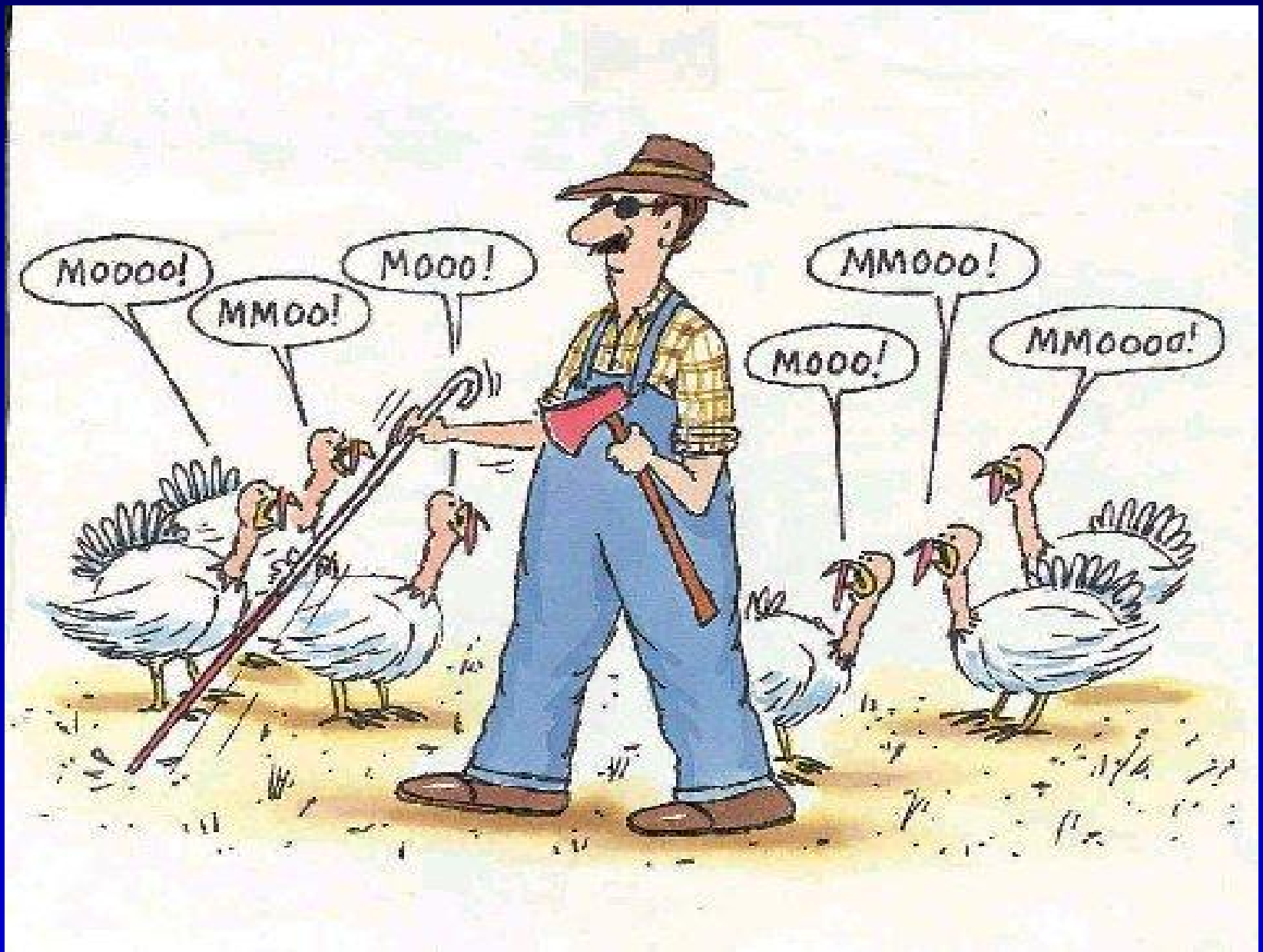
- All 40 PMPT screening consults died
  - 21 [53%] AACA – only 5 died <24hrs; 14 =day 2+; 2 discharged to home/SNF to die later

*[*Authorized Agent Controlled Analgesia]*

Hospitals Need to Control Costs !

- Payers reducing payments
- Providers must control costs to ‘stay alive’
  - 1$ saved = 1$ earned !
- Business model of healthcare invites opportunities for fraudulent practices
  - OIG in CMS increasing vigilance to cut waste and fraud

OIG/CMS cuts out ‘fraud/underperformers’?



PC & Hospice Control Costs

- Hospice = 'hospitality'; for travelers, foundlings, destitute; organized by churches
- First formal program, England 1967
  - St.Christopher's, London
  - Dame Cicely Saunders
    - 1965 - Speaks to Yale School of Nursing – begins efforts in USA to initiate programs

- Medicare Benefit since 1982 - provides palliative care to the terminally ill at "home"

…Hospice & PC History

- 1989 - LTCF recognized as 'home'
  - 22% hospice care in LTCF [2008]
  - 78% NH have hospice care [2004]
- 2006: PC recognized as Specialty
- in 2009: 41% all deaths w/ a "terminal prognosis" in USA were in hospice, in 5000 programs [from 31 in 1984]
- Hospice has reduced gov't HC costs 6%

…Hospice History

- Agency can be for-profit or not-for-profit
- Increasing number for-profit corporations, utilizing business model of care, which may be resulting in higher costs and LOS *[Cefalu CA. The Medicare hospice benefit: a changing philosophy of care? Ann LTC.Jan.2011]*
  - Leading to investigations by OIG – and need for 'stewardship'

Benefits: Stewardship in Healthcare

- Stewardship: "A [fiduciary & ethical] responsibility to take care of something one does not own."
- Stewardship implies avoiding things which are non-beneficial/futile for another person !

[Futile Care: care which will not help a patient reach their goal.]

Stewardship

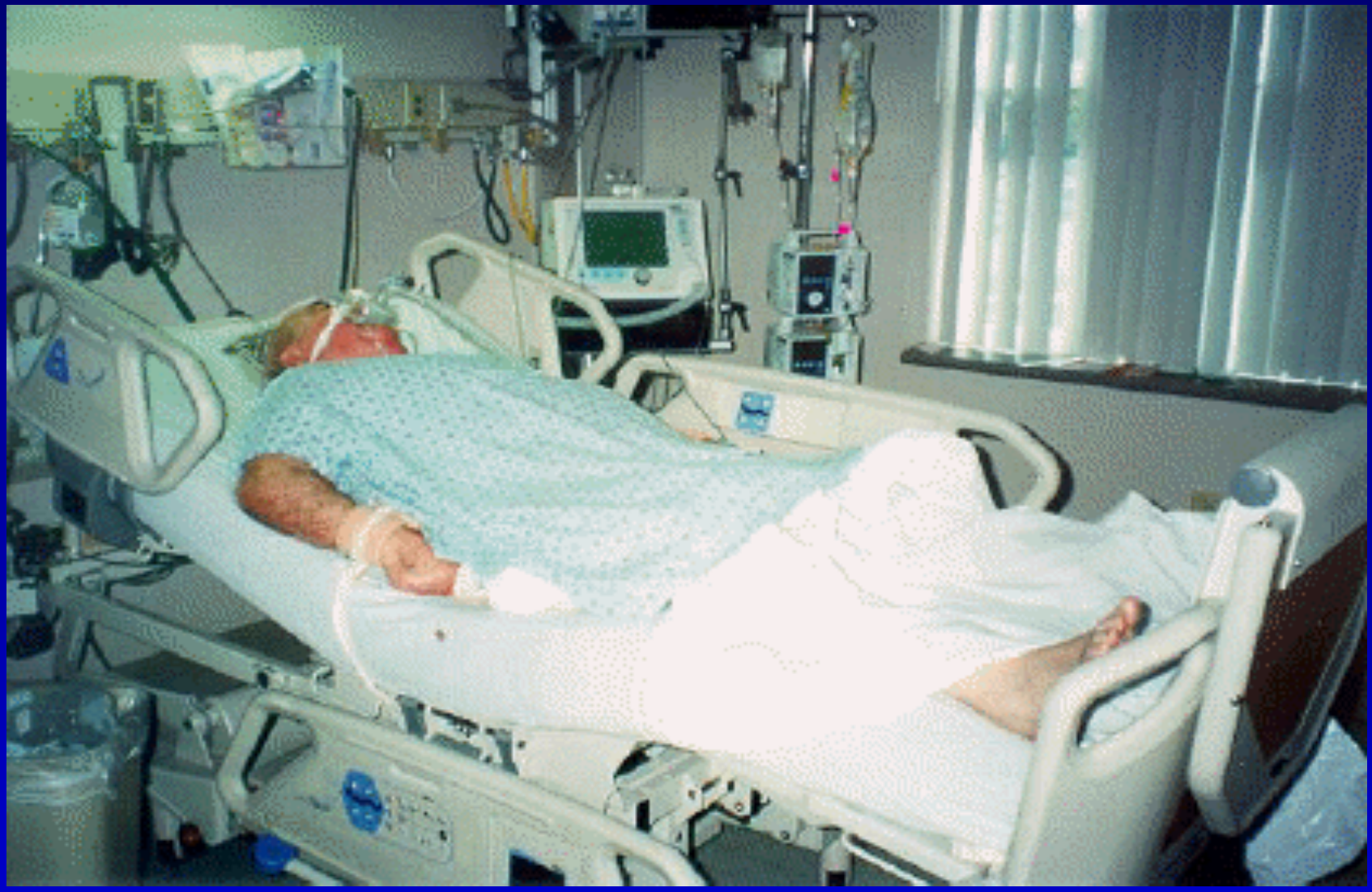
- 5% of Medicare beneficiaries die each year
- 30% of budget [total = $461B in '08] is for last year of life [i.e. ~$140B]
- Of those dying, 50%-80% of costs spent on last 2 mo. of life [w/ no "gain in quality"]
- Do we (providers **&** patients) not have a stewardship responsibility – to avoid futile or non-beneficial care?

* *1. USA Today; 2. J. Lubitz, DHHS, report to US Congress 2004; 3. LA Times 2010; 4. Alliance for Health Reform 2010.*

Could PC be Medicare's Salvation?

- By focusing on **quality** of life rather than quantity of years, suffering, futile care, and inappropriate costs - can be reduced
- Important to think about how you want to
  - **DIE**?
    - Be **"kept alive"**
  - **LIVE** ?

Futility – how do you want to die?



3. Creating a PC Service

- History/timeline
- Key aspects
  - Admin + MEC support
  - Physician champion
  - MD & RN trained – EPEC/ELNEC
- Type of service – consult only v. inpt unit + consult
- Joint commission certification – worth it?

Timeline / History at ECM

- Pilot study 2004/05 preceded launch date
  - ICU – one MD's patients; data driven
  - Showed benefits – ALOS, satisfaction, costs
- Launched Service 2005
  - Consultation service and Inpatient Admissions
- PCU Opened: 4 suites/rooms 6West July 1, 2006
  - NOT a 'closed' unit, but MD must use PC EOLC Order Set and have AND/DNR documentation
- JC Certification Dec. 2012 [only one in AL to date]
- PC Service now is "Supportive Care Services" [includes PC, Bereavement Support, Geriatrics/OASIS]

…History at ECM

- Staffing – "Supportive Care Services"
  - 1 MD consultant (AAHPM Board Certified; EPEC trainer certified) [R.Webb]
  - 1 RN – coordinator (ELNEC trainer certified) [C. Shelton]

  [Also 'coordinate' OASIS & Grief Support programs]
- Training – 'annual' 2 day course [open]
  - ELNEC/EPEC 'certification' taught by above
    - Annual on-line re-cert.
  - PCU RN's gain $0.50/hr wage if 'certified'

…History: PC Service Consults

- 2005 - 35 patients
- 2006 - 109
- 2008 - 186
- 2010 - 192
- 2012 - 248
- 2013 - 318 [28% increase]
- 2014 - 153 to June 30 [306 for year?]

Start-up: Key Points/Pearls

- Physician Advisory Group prior to launch
  - Education in-services – pick 'supporters' [~10]
    - Multiple specialties
  - Find 1 or 2 physician champions for support
- Administration & MEC support
- Start w/ pilot project or study involving 1-2 physician champion/supporters?

Finding patients: Screening for PC

- PMPT – Palliative Medicine Prognostic Tool [handout]
  - From CAPC tool [Center to Advance PC]
  - Now called *"Discussion of Goals & Prognosis Tool"*
    - Avoiding term "palliative" !?
- Six Sections/components – point scoring
  - I. Poor prognosis already
  - II. Prognosis 6-12 mo.
  - III. Diseases
  - IV. Symptoms uncontrolled
  - V. Functional Status anticipated
  - VI. Psychosocial issues

…Screening for PC

- Coordinator and/or case mgr make daily rounds in all critical care units and place tool on appropriate charts for MD to see
- Score 10+ = likely die <6-12mo.
  - Encourages MD to have goals and EOLC discussion w/ patient/family [??];
  - or consult PC

Using PMPT to screen for PC

- 2013 Total Consults: 318
  - Consults w/o PMPT: 272 [86%]
  - Consults from PMPT: 46 [14%]

- PMPT screenings: 164
  - Resulted in consult: 46 [28%]
  - No consult [i.e. control group]: 118

More consults before PMPT placed—because staff more knowledgeable??

…Screening for PC w/ PMPT

[Info at top of form]

Comfort focused care (Palliative care) *is appropriate at any point in a serious illness and can be provided at the same time as curative treatment for patients with difficult to control symptoms or who may be approaching end-of-life. The prognostic tool helps identify patients who may benefit from goal focused care or end of life education earlier in the course of the disease.*

[RN, Case Mgr, MD can complete this]

…Screening

1) If **one** of these are present

- Admitted to ICU from extended care facility
- Documented prognosis *grave, grim, or poor*
- Hospice patient prior to admission
- Has expressed wish not to have life prolonging treatment

Then, MD should discuss goals & AND/DNR

…PMPT Screening

2) Would you be surprised if this patient were still alive in 6-12 mo?

- Yes - Score 3 points * [*consider hospice referral*]
- No - Score 0

…PMPT Screening

3) Basic Disease Process **Score 2 points each**

a. Cancer stage IV (metastatic/recurrent) *

b. Advanced COPD (requires home oxygen) *

c. Acute CVA/Altered Mental Status [NIHSS score >16] *

d. End stage renal disease [Stage 4-5, considering dialysis] *

e. Advanced congestive heart failure [Class III-IV] *

f. >3 hospitalizations or ED visits for incurable disease in past year

g. Other terminal or incurable disease causing significant symptoms

h. Dementia or Multiple medical problems [CAD/CHF/CKD/COPD/CVA]

* Hospice eligible likely

…PMPT Screening

4) Uncontrolled Symptoms/Clinical Conditions

Score 2 points each

a. Pain
b. Dyspnea
c. Nausea
d. Weakness
e. Depression/Anxiety
f. Weight loss.
g. Constipation.
h. Other

Score 1pt each

i. Prolonged vent. Support
j. Delirium
k. ICU >7days

…PMPT Screening

5) Anticipated Functional Status at Discharge

ECOG Performance Status (Eastern Coop. Oncology Group) Scale

- Fully active, able to carry on all pre-disease activities with min. restrictions = 0 pts
- Ambulatory, capable of most self-care. Up & about >50% of waking hours = 1 pt
- Capable of limited self care: confined to bed or chair >50% waking hours = 3 pts
- Bedbound = 4 pts

…PMPT Screening

6) Psychosocial issues (patient or family)

- Complex family/social issues = consider PC consult
- Spiritual distress = consider chaplain referral

Scoring :

- **If >10: use available guideline to discuss goals, AND/DNR, hospice.**
- Score >10 indicates high risk of dying in <6mo.

Alz.Dem. w/ Hip Fx + Delirium: what's her score?

- Sctn 1: [poor prognosis]
- Sctn 2: 3 [alive in 1 yr?]
- Sctn 3: 2+2 [CHF + dementia]
- Sctn 4: 2+2+1 [pain + weakness + delirium]
- Sctn 5: 3 [ADL: bed/chair >50%]
- Sctn 6: [AND + goals]

Total: 15 [core sctns 2-5]

4. Satisfaction (not) Guaranteed…

What do you need to do to for success?

- Emphasize & clarify goals [must be team effort by all staff & MDs]
- Control symptoms; [e.g. versed for pain?]
- Educate & involve family [and the primary attendings!!] [information folder, website]

Symptom management essential

- EOLC order set
- AACA – Authorized Agent Controlled Analgesia
  - What is it
  - Family & Staff satisfaction high – 99%

EOLC Order Set

- Dr. writes: *EOLC Orders*. [Standardized orders for pts dying within 1-2wks]
  - Symptom based
  - Pain, dyspnea, secretions, nausea, etc.
- Allows 'certified' RN to choose options
  - Except Opioid & benzo dosing must be specified by MD [but guideline provided]

AACA

- Authorized Agent Controlled Analgesia
  - "PCA by proxy"
- Opioids used: morphine, hydromorphone [Dilaudid]
- Family educated – they select who can 'click' dose of med.
- Info. Handouts – education + log sheet
- Indications: dyspnea, pain, terminal delirium

…AACA

- Why offer AACA:
  - Rapid control [subQ usually]
    - Don’t have to ‘chase’ after a nurse
  - Family involved - can “do something”
- Results:
  - 99-100% family satisfaction

Summary & Pearls

- PC improves QOL and QOD [Quality of Dying] – because it's comfort-focused
- Educate patients/families - goals of care
- Gain admin support - cost savings
- Find physician champion/supporters
  - Start with a pilot project
- Use a screening tool to encourage 'the talk' & consults, and collect data
- Use AACA protocol & order set

Resources for Palliative Care

- You're Sick, It's Serious [aahpm]
- **Comfortcarechoices.com** [RJ Webb's website – has this slide show]
- The Five Wishes – agingwithdignity.org
- OneSlideProject – engagewithgrace.org
- Patient Decision Aids - http://www.npc.nhs.uk/patient_decision_aids/pda.php
- *It's Ok to Die* – Dr. Monica Williams Murphy

Success & Aging

Hospice offers Hope. Like hope, definition of success changes as we age: life is a circle.

- At age 4, success is…not peeing your pants
- At age 12, success is…having friends
- At age 16, success is…a driver's license
- At age 20, it's…having sex
- At age 35, it's having money

Success cont'd

- At age 50, success is…having money
- At age 60, it's…having sex
- At age 70, it's…having a driver's license
- At age 75, it's…having friends
- At age 80, success is not peeing your pants!

As you slide down the banister of life, may all the slivers point down!

- Maxine

Grow'n old ain't for sissies !

- Betty Davis

So, enjoy yourself while you can !

Thank You !