Better Care and Lower Costs With Proactive Palliative Care

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What is Palliative Care?

- Palliative care is *specialized medical care* for people with *serious illnesses*. This type of care is focused on providing patients with relief from the symptoms, pain, and *stress* of a serious illness *whatever the diagnosis*.

- The goal is to improve *quality of life* for both the *patient and the family*. Palliative care is provided by a *team* of doctors, nurses, and other specialists who *work with a patient's other doctors* to provide an *extra layer of support*. Palliative care is appropriate at any age and at any stage in a serious illness, and can be *provided together with curative treatment*.
What We All Want

- Better Health for the Population
- Better Care for Individuals
- Lower Cost Through Improvement
What We Want vs. What We Get

70% prefer to die at home, but too many still die in the hospital.

Percentage who died in hospitals:
- California 2003: 34%
- California 2010: 29%
- National Average 2010: 25%

PUT IT IN WRITING

57% of Californians say it is “extremely important” that their medical care wishes are followed.

However, only 23% put their wishes in writing.

California HealthCare Foundation, 2013
In 2011, 63% of patients got hospice for less than 30 days

California HeathCare Foundation, 2013
National Hospice & Palliative Care Organization, 2012
Unwanted Care is Expensive

32% of all Medicare spending goes to care for beneficiaries in the last two years of life

Center to Advance Palliative Care, 2014
Dartmouth Atlas of Health Care, 2015
Pattern of Decline in Different Chronic Illnesses

- **Cancer**
- **Organ failure**
- **Dementia/frailty**
What are Mr. Lee’s options?
Safety Net Providers See Cancer Patients Late...

SFGH Oncology: New Diagnosis Cancer Site and Stage 2011

45% of patients present with Stage III or IV disease
What “Early” Palliative Care Can Do

• Multiple studies demonstrating impact
  – Improved quality of life
  – Increased satisfaction with care
  – Fewer hospitalizations, ED visits

• Landmark study in lung cancer patients
  – Less depression
  – More advance directive completion
  – Fewer end of life hospitalizations
  – Longer survival

Temel, NEJM 2010
Early-PC associated with better performance on EOL quality measures

Scibetta, Kerr, McGuire, Rabow, 2015
Early-PC = less escalation in utilization

Average direct cost per inpatient admission by month, final 6 months of life; 290 solid tumor cancer patients

Month preceding death

Direct costs per admission

Early PC

Late PC

Scibetta, Kerr, McGuire, Rabow, 2015
SFGH Motivation: Getting the right care for our patients

• Inpatient palliative care team well-established, able to impact patients near end of life, in crisis

• Cancer patients who receive “early” palliative care have better outcomes and avoid unnecessary costs

• In order to have greater impact on QOL and utilization patterns, patients need access to palliative care in the community
Feasibility Study: Community-Based Palliative Care for Cancer Patients

• **GOAL:** Determine potential impact and feasibility of Community-Based Palliative Care (CBPC) services for oncology patients

• **METHOD:** Retrospective study of cancer patients’ utilization of services in last 6 months of life

• **QUESTIONS:**
  – Would CBPC be able to impact utilization?
  – What could we expect in terms of financial impact?
Oncology Utilization Study: Details

• Identified all cancer patients who died in 3-year period (2010-2013)
• Reviewed inpatient and outpatient utilization in last 6 months of life
• Assessed whether patients had contact with inpatient palliative care service
• Used data to forecast the expected impact of early palliative care intervention
Oncology Study: Findings

Utilization among 403 cancer patients cared for at SFGH

- 47% had ED visits in the final month of life, including 11% with multiple visits
- 16% had a stay in an Intensive Care Unit in the final month of life
- **Average direct costs per final month of life admission $25,800**
- **Direct costs for inpatient admissions in the final month of life (only) > 4.7mil**

Harris H et al., Making the Case: Is Outpatient Palliative Care for Oncology Patients Feasible within the Safety Net?
2014 AAHPM/HPNA Annual Assembly
Results: Palliative Care utilization

• About half of all patients were seen by inpatient palliative care team
  – 44% of entire decedent population
  – 58% of all patients who were hospitalized

• Patients usually seen by inpatient team within weeks of death
  – Number of days between first IP PC contact and death
    • Median 22.5, Average 41.57, range 0->180
    – 60% of patients had their initial contact with PC team in the final month of life
Results: Summary

• Cancer patients often present late
  – Advanced disease
  – Heavy symptom burden
• Most patients are hospitalized -- usually about twice in last 6 months of life
• Many are seen by inpatient palliative care, but too late in disease course to make a significant impact on utilization pattern or end of life experience
Translating the Analysis into a Business Plan

• Leverage existing evidence regarding benefits of early palliative care
  – Earlier PC (almost always outpatient) associated with better outcomes and reduced costs
  – Published and local findings (UCSF): 40% decrease in use of inpatient services in final months of life

• CAVEAT: PC has greatest potential for impact when patients are seen >90 days before death
We Can Make an Impact!

- About 1/3 of patients who die of cancer present early enough (>3 months prior to death) for OP PC to make a significant impact.
- Based on analysis, OP PC clinic could expect to make a significant impact on 50 patients/year.

Expect 40% reduction in inpatient utilization (38 admissions, $25,814/ea)

Expected cost avoidance: $980,932
The Cost of Doing Business

- Would only need 0.2 FTE for team to see expected patient volume in 2 half-day clinics/week
- Salary for MD, RN, SW + 17% Benefits = $88,290

$980,932 Direct costs avoided

$88,290 Staffing Cost

>10x ROI!!
Proposed Model for New SFGH Palliative Care Team

Full-Time Inpatient-to-Outpatient Oncology-Focused Palliative Care Team

- **STAFFING:** NP & SW ($235,764)
- **STRUCTURE:**
  - 2 half-days of clinic
  - Meet and screen newly diagnosed patients while hospitalized, expedite outpatient follow-up
  - Remote patient follow-up between visits
  - Continuity when patients rehospitalized
  - Direct collaboration with oncology (clinic, patient care conferences)

**Cost savings:** $745,168
Looking Ahead

• Meeting needs of non-cancer patients
  – Approaching local Medicaid payers
  – Comprehensive needs assessment of SF Health Network

• Serving as a model for 16 other safety net hospitals in California
Take-Home Points

• Many patients end up getting aggressive end-of-life care, even if they didn’t think they wanted it
• Early palliative care interventions have been shown to improve quality and significantly lower costs toward the end of life
• Early palliative care interventions are feasible and cost-effective in safety net hospitals
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Questions?