

Healthcare Reform and Matching Care to Patient's Needs

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Core Principles

1. “The secret of the care of the patient is caring for the patient.”
--- Francis Peabody, Harvard University, 1921
2. Improving the health care system is prerequisite to caring for our patients, who are the reason for our work.

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Objectives

1. Identify central problems with U.S. health care system
2. Define palliative care and role in health reform through its impact on quality and cost

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First Things First: The Professional Obligations of Doctors

“I will follow that system of regimen which, according to my ability and judgment, I consider ***for the benefit of my patients,*** and abstain from whatever is deleterious and mischievous.”

—Oath of Hippocrates, 400 BC

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Maimonides, 12th century AD

“The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.

May I never see in the patient anything but a fellow creature in pain.”

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Health care in the U.S. (or the Wild West)

- What are the ends of medicine?
 - What are they in the U.S.?
- What should they be? **“To cure sometimes, relieve often, comfort always.”**
- The problem: “The nature of our healthcare system- specifically *its reliance on unregulated fee-for-service and specialty care*- ...explains both increased spending *and* deterioration in survival.”
 - Muenning PA, Glied SA. What changes in survival rates tell us about U.S. health care. Health Affairs 2010;11:1-9.

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How They Think About it in Washington: *The Value Equation-1*

$$\text{Value of health care} = \frac{\text{Quality}}{\text{Cost}}$$

Numerator problems

- 100,000 deaths/year from medical errors
- Millions more harmed by overuse, underuse, and misuse
- Fragmentation
- Medical practice based on evidence <50% of the time
- 50 million Americans (1/8th) without access
- U.S. ranks 40th in quality worldwide

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The Value Equation- 2

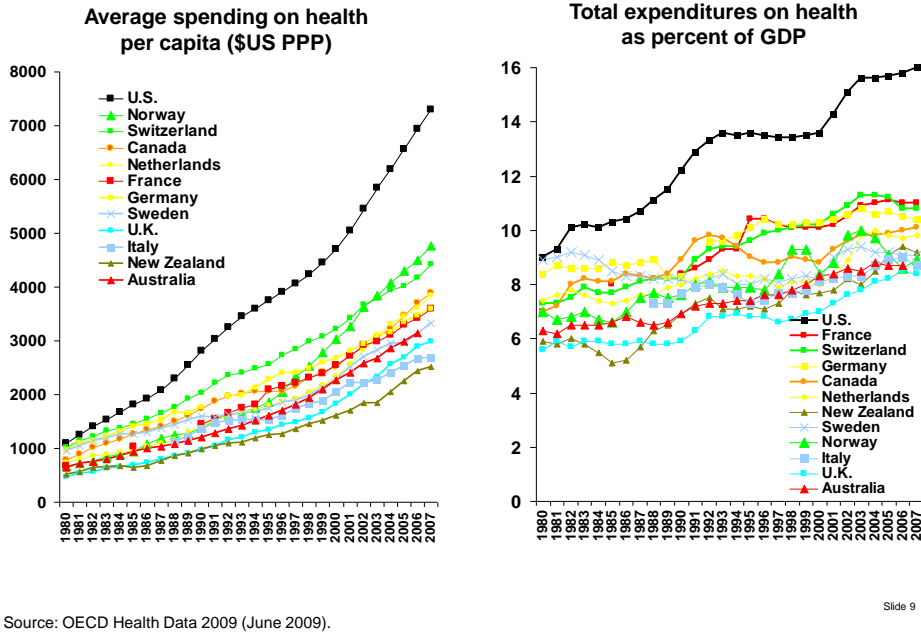
$$\text{Value of health care} = \frac{\text{Quality}}{\text{Cost}}$$

Denominator problems

- Insurance premiums increased by 181% in the last 10 years.
- U.S. spending 18% GDP, >\$7,500 per capita/yr
- Nearing 40% of total State spending
- Despite high spending, 15% of our population has no insurance, and half are underinsured in any given year.
- Health care spending is *the* #1 threat to the American economy and way of life.

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Cost: International Spending on Health, 1980–2007



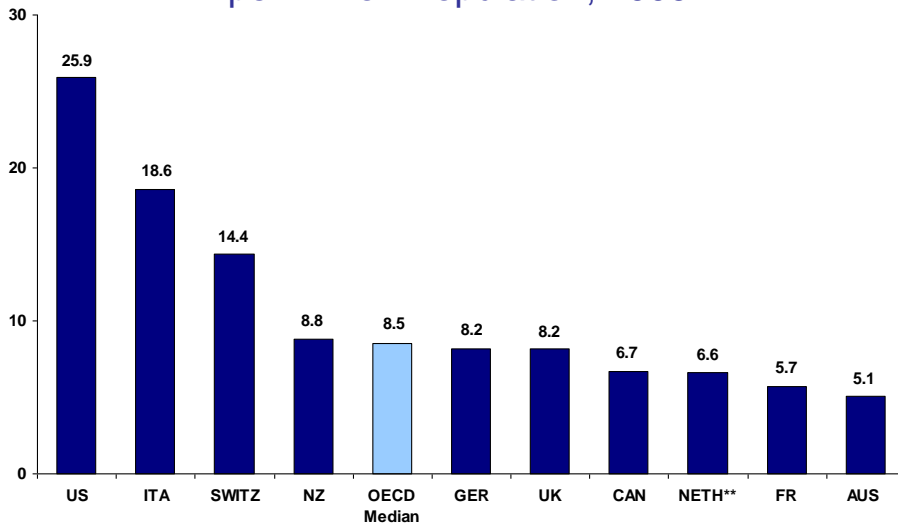
What is this money buying us?

Among the Organization for Economic Development and Cooperation (OECD) member nations, the United States has the:

- Lowest life expectancy at birth.
- Highest mortality preventable by health care.

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Cost and Capacity: MRI Machines per Million Population, 2009

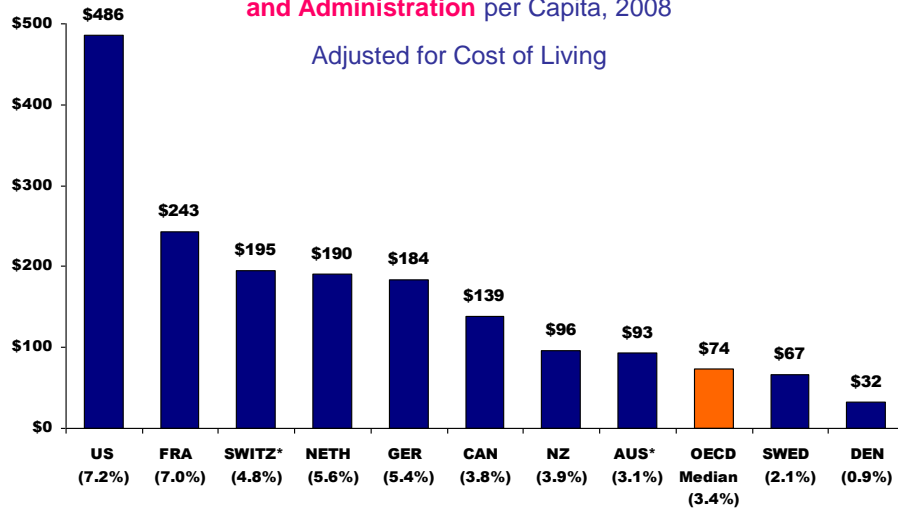


Source: OECD Health Data 2009 (June 2009).

Cost: Where Does the Money Go?

Spending on Health Insurance
and Administration per Capita, 2008

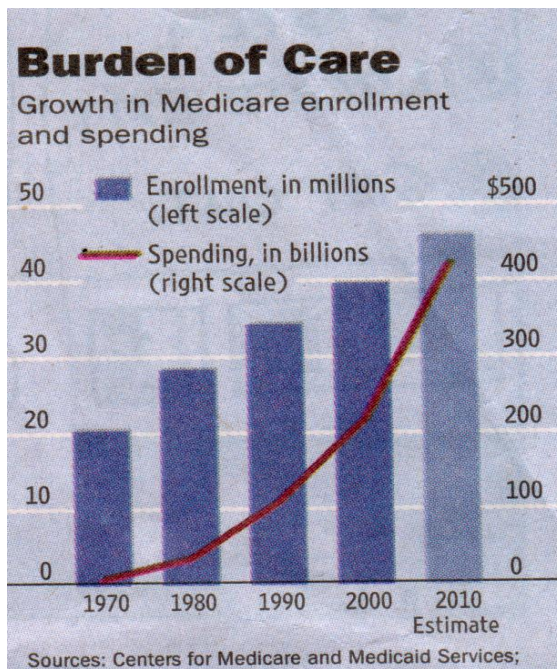
Adjusted for Cost of Living



(Percent of total health expenditure)

Note: Total health care spending on health insurance administration includes insurer costs only.
Data: Organization for Economic Cooperation + Development- Health Data 2008 (June 2008).

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Medical Spending in the U.S. \$2.9 trillion in 2010

- 17% GNP, rising to 20% by 2015

Medicare Payment Policy: Report to Congress. Medpac 2009 www.medpac.gov
Health Affairs 2005;24:903-14.

CBO May 2009 High Cost Medicare Beneficiaries www.cbo.gov
nchc.org/facts/cost.shtml



U.S. Health Care Policy's "Original Sin"

*"Providers and patients still largely determine what care is needed without a **budgetary framework to consider both benefit and costs**. This is the original sin of health policy and no reform can be adequate without addressing it."*

— Steurle and Bovbjerg Health Affairs 2008;27:633-44.

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Consequences of Healthcare's Original Sin: The Medical-Industrial Complex

- Health care has become a marketplace, not a system
- Patients have become a means to another's end (\$) rather than an end in themselves.
- Health professionals have been compromised by this environment
- Examples:
 - Order more imaging studies, get salary bonus
 - 5X increase in 'concierge' medicine
 - 67% of cardiologists writing professional practice guidelines are on the payroll of manufacturers they are recommending
 - 'Free' samples, 'free' lunch: MD and nurse as product middleman, the needed "hand with the pen", a critical intermediary between industry and payer.

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And yet more consequences . . .

- Health care uses 1/5th of our economy, >2X our nearest neighbor
- Patients suffer –some have called it "medical torture"-
- Families suffer (bankruptcy, post traumatic stress disorder, Prolonged Grief Disorder, illness, death)
- No resources for other social goods
- Declining health professional values
- Medical/nursing school debt and its consequences
 - Top medical students choosing plastic surgery, neuroradiology and dermatology- 30 years ago it was primary care or research.

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What can be done?

How policy makers think about putting
the healthcare system and its professionals
through detox from fee for service

Two options to “bend the cost curve.”

1. **Stop paying** for things that don't help patients
 - Determine best yield per dollar via Comparative Effectiveness Research
2. **Capitation** or setting some limit on what we will spend.
 - Accountable care, bundled payments, medical homes

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Option 1: Paying for Value via Comparative Effectiveness Research

- Requires scientific comparison and willingness to implement the findings
- Means someone loses money
- Political football, labeled “rationing” and “death panels.”
- Death panel caricatures have made this topic politically untouchable.
- *“American political discourse is not yet mature enough to support realistic discussion about difficult subjects.”*

— Wachter RM. JHM 2010;5:197-199.

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Option 2: Setting Limits

Putting our health care system on a budget- *at risk*:

- HMOs in 1990's reduced spending
- Modern “integrated systems” such as the VA, Kaiser, Geisinger, Mayo, Cleveland Clinics get more quality per health care dollar
- Characteristics of success: large delivery system, advanced information technology, strong primary care infrastructure, and tight integration between physicians and the organizations.
- **Still politically radioactive**

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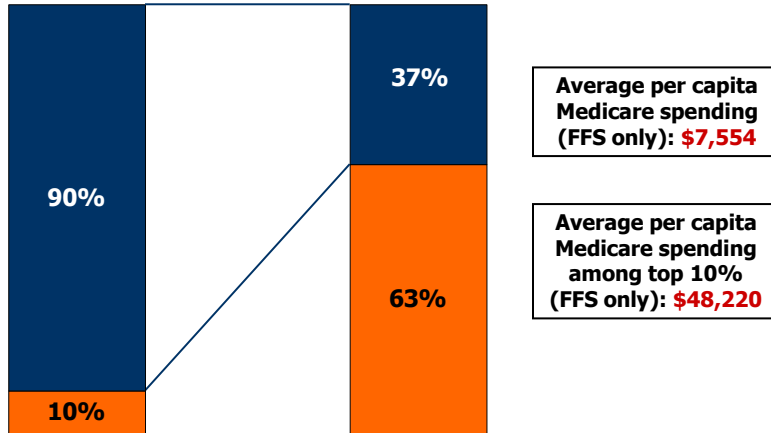
Palliative Care is Central to the Success of Health Care Reform

- >95% of all health care spending is for the chronically ill
- 64% of all Medicare spending goes to the 10% of beneficiaries with 5 or more chronic conditions
- Despite high spending, poor quality of care

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Target Population for Palliative Care

Distribution of Total Medicare Beneficiaries and Spending, 2009



Total Number of FFS Beneficiaries: 37.5 million **Total Medicare Spending:** \$417 billion

NOTE: FFS is fee-for-service. Includes non-institutionalized and institutionalized Medicare fee-for-service beneficiaries, excluding Medicare managed care enrollees.

SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost & Use file, 2009. Slide 26

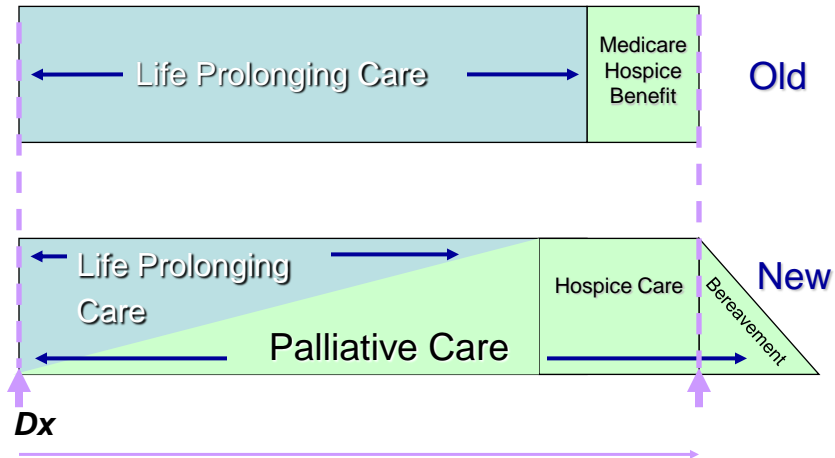
What is Palliative Care?

Palliative care means **patient and family-centered care** that **optimizes quality of life** by anticipating, preventing, and treating suffering. **Palliative care throughout the continuum of illness** involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

— 73 FR 32204, June 5, 2008
Medicare Hospice Conditions of Participation – Final Rule

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Conceptual Shift for Palliative Care



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Palliative Care Teams Address 3 Domains

1. Physical, emotional, and spiritual distress
2. Patient-family-professional communication about achievable goals for care and the decision-making that follows
3. Coordinated, communicated, continuity of care and support for practical needs of both patients and families across settings

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How Palliative Care Improves Value

- **Quality improves:**
 - Improves patient quality/length of life
 - Reduces pain, depression and other symptoms
 - In several studies *prolongs* life
 - Improves family satisfaction and well-being
- **Costs reduced:**
 - Reduces resource utilization and costs in every setting studied (home, office, hospital)
 - and does so for the sickest 5%-10% of Medicare and Medicaid beneficiaries driving over half of tax-payer supported healthcare costs.

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Conversations about Goals Improve Healthcare Value

In a prospective multicenter study of 332 cancer patients,

family recall of occurrence of a prognostic/goals

conversation was associated with:

- Better quality of care
- Less hospital/ICU, lower costs
- Lower risk complicated grief + bereavement among family caregivers

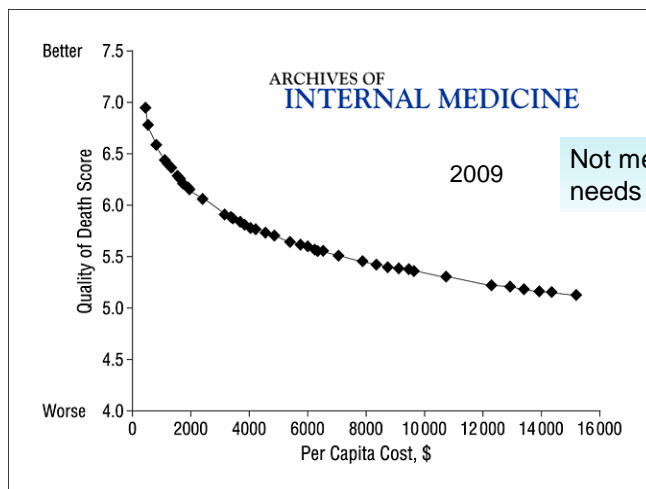


— Zhang et al. Arch Int Med 2009;169:480-8.

— Wright et al. JAMA 2008;300:1665-73.

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Inverse Association Between Cost and Quality



Copyright restrictions may apply.

— Zhang, B. et al. Arch Intern Med 2009;169:480-488.

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Consequences of Late Referral to Palliative Care

Serious Adverse Outcomes for Bereaved Caregivers:

Compared to care at home with hospice,

- Care in ICU associated with 5X family risk of Post Traumatic Stress Disorder; and
- Care in hospital associated with 8.8X family risk of prolonged grief disorder

— Wright A et al. Place of death: Correlation with quality of life of patients with cancer and predictors of bereaved caregivers mental health. JCO 2010; Sept 13 epub ahead of print



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Palliative Care Improves Quality in Office Setting

Randomized trial simultaneous standard cancer care with palliative care co-management from diagnosis versus control group receiving standard cancer care only:

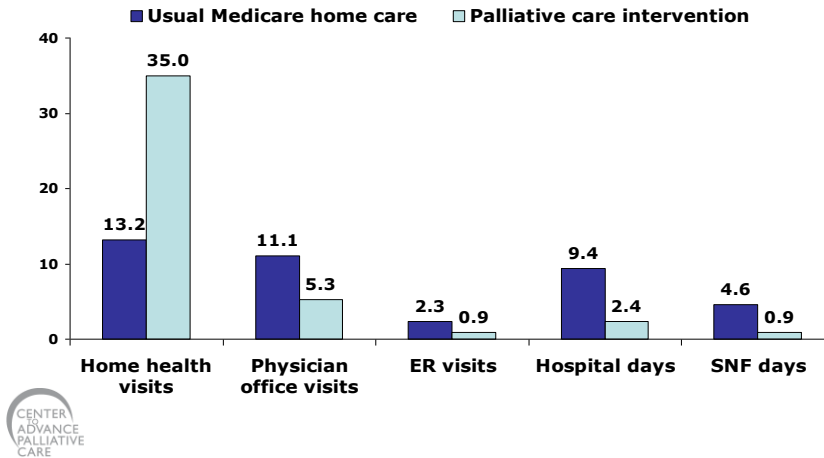
- Improved quality of life
- Reduced major depression
- Reduced ‘aggressiveness’ (less chemo < 14d before death, more likely to get hospice, less likely to be hospitalized in last month)
- **Improved survival** (11.6 mos. vs. 8.9 mos., $p < 0.02$)

- Temel et al. Early palliative care for patients with non-small-cell lung cancer
NEJM2010;363:733-42.

Palliative Care at Home for the Chronically Ill Improves Quality, Markedly Reduces Cost

RCT of Service Use Among Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer Patients While Enrolled in a Home Palliative Care Intervention or Receiving Usual Home Care, 1999–2000

- KP Study Brumley, R.D. et al. JAGS 2007



RCT of Nurse-Led Telephonic Palliative Care Intervention

- N= 322 advanced cancer patients in rural NH+VT
- Improved quality of life and less depression (p=0.02)
- Trend towards reduced symptom intensity (p=0.06)
- No difference in utilization, (but v. low in both groups)
- Median survival: intervention group 14 months, control group 8.5 months, p = 0.14

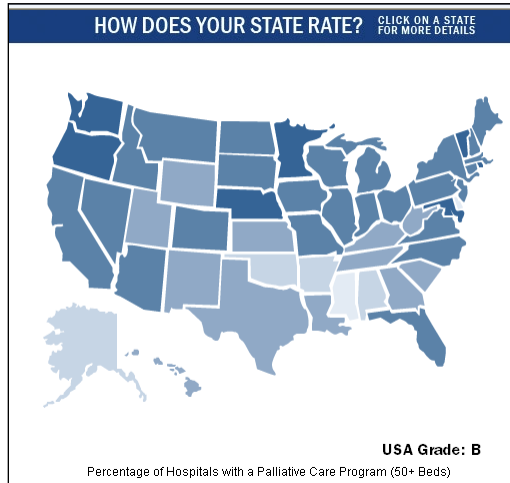
- Bakitas M et al. JAMA 2009;302(7):741-9



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Public Awareness and America's Care for Serious Illness

A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals



Source: Center to Advance Palliative Care, 2011 Slide 38

Grades

- The nation improved, receiving a grade of B, up from a C in 2008.
- Seven states plus the District of Columbia now receive a grade of A, with more than 80 percent of hospitals reporting palliative care services.
- More than half of the fifty states receive a grade of B.
- Fewer than 25 percent of states now need significant improvement (C).
- Approximately 12 percent receive non passing grades of D or F.

Top performers (programs in 83% to 100% of hospitals): States receiving an **A grade**

District of Columbia	100%
Maryland	90%
Minnesota	89%
Nebraska	93%
Oregon	88%
Rhode Island	88%
Vermont	100%
Washington	83%

On their way (programs in 61% to 80% of hospitals): States receiving a **B grade**

Arizona	69%
California	67%
Colorado	73%
Connecticut	72%
Florida	62%
Idaho	63%
Illinois	67%
Indiana	63%
Iowa	61%
Maine	71%
Massachusetts	67%
Michigan	76%
Missouri	75%
Montana	67%
Nevada	69%
New Hampshire	77%
New Jersey	80%
New York	75%
North Carolina	75%
North Dakota	67%

Ohio	80%
Pennsylvania	67%
South Dakota	78%
Virginia	78%
Wisconsin	74%

States in the middle (programs in 42% to 60% of hospitals): States receiving a **C grade**

Georgia	43%
Hawaii	58%
Kansas	47%
Kentucky	55%
Louisiana	43%
New Mexico	44%
South Carolina	51%
Tennessee	52%
Texas	42%
Utah	60%
West Virginia	55%
Wyoming	50%

States that need significant improvement (programs in 28% to 38% of hospitals): States receiving a **D grade**

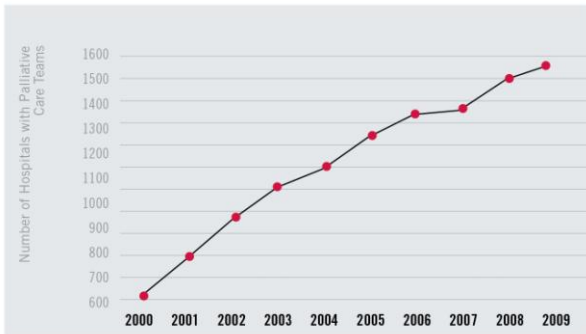
Alabama	28%
Alaska	29%
Arkansas	38%
Oklahoma	30%

States with little or no access (programs in 0% to 20% of hospitals): States receiving an **F grade**

Delaware	20%
Mississippi	20%

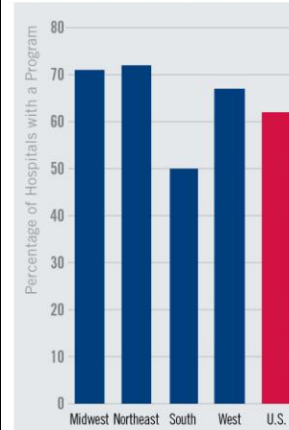
Geographic Variation in Palliative Care Team Growth

Prevalence of U.S. Hospital Palliative Care Teams 2000–2009



Source: Center to Advance Palliative Care, March 2011

Distribution of Palliative Care Programs by Region



Source: Center to Advance Palliative Care, ^{Slide 40} 2011

Variation in Access

PALLIATIVE CARE

DID YOUR STATE MAKE THE GRADE?

If you or someone you know suffers from a serious or chronic illness, getting palliative care is a bit easier in some states than others. So why does it matter? Because palliative care is one of the fastest growing trends in health care when it comes to improving quality of care while also reducing costs. And yet, 48% of the public is unfamiliar with the term. However, when informed about palliative care, 68% say they would likely consider it for a loved one with serious illness.

A State-by-State Report Card on how well America cares for the seriously ill, conducted by the Center to Advance Palliative Care and the National Palliative Care Research Center, gave the following states an ...

GRADE OF "A"

Maryland
Minnesota
Nebraska
Oregon
Rhode Island
Vermont
Washington

What is Palliative Care?

- Specialized medical care that focuses on relief from the symptoms, pain, and stress of a serious or chronic illness—whatever the diagnosis
- Improved quality of life for both patient and family
- Appropriate at any age and any stage in a serious illness
- Can be provided along with curative treatment
- Delivered by a team of physicians, nurses and other specialists who work together with a patient's new doctor to provide an extra layer of support
- Better coordinated care, fewer days in the ICU, and shorter hospital stays, resulting in substantial cost savings.

To find out how your state did or if your Congressional District made the **100% Club**, meaning every hospital in your district has a palliative care team, or just to learn more about palliative care and its benefits, visit CACP.org/reportcard.

*Data from a 2008 Optima Strategies national survey of low adults age 46, June 3-4, 2008

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Policy Priorities for Improving Access to Quality Palliative Care

- Workforce
- Research funding
- Access through regulatory, accreditation, and payment incentives.

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“Life is pleasant. Death is peaceful. *It's the transition that's troublesome.*”

– [Isaac Asimov](#)

US science fiction novelist & scholar (1920 - 1992)



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