Taking Palliative Care Mainstream: A Glimpse of the Future

10th Annual Summit: Better Together
California Coalition for Compassionate Care
April 10, 2018

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Vice President, Medical Affairs, Hospice and Palliative Care
Case 1: PC from Diagnosis: Frank

- 58 yo man
- Fever, cough
- Emergency Department
- Pneumonia
Case: Frank

- Metastatic Lung Cancer
- Post obstructive pneumonia
‘Excellent’ Quality of Care

Teno et al JAMA 2004;291:88-93
Outcomes in Last Place of Care

Teno et al JAMA 2004;291:88-93

n = 1578

percent

Home care  Hospice  NH  Hospital

Want pain relief  Want Physician contact  Got no respect
Cost

• Significant Savings with Hospice Care as compared with no hospice care.
  
  1-7 days; $2,650
  8-14 days: $5,040
  15-30 days: $6,340
  53-105 days: $2,561

Kelley AS et al Health Affairs 2013;552:561.
Case 2: Peppy Chernoff

- Moved to Columbus from New York City
- Diagnosed with Breast Cancer
  - Stage IV (spread to bones, liver, lungs)
- Primary Care doc asked for palliative medicine help with pain
  - Medical Oncologist agreed
Rebecca and John Moores
UCSD Cancer Center

An NCI-Designated Comprehensive Cancer Center
Drivers for Palliative Care

• Medical Oncologist turnover
  50% per year
  Difference between ‘clinical oncologists’ and ‘research oncologists’ (80% laboratory)
Doris A. Howell Service
Inpatient Referrals from Hematology/Oncology Physicians

n = 310 patients

n = 131 patients

BMT

26 bed unit

n = 131 patients
Type I vs Type II Oncologists

• Type I: biomedical and psychosocial. Clear communication strategies. Positive impact on patient and family

• Type II: biomedical only. Distant patient / family relationships. Sense of failure.

OhioHealth

Not-for-profit, faith-based health system
West Ohio Conference of United Methodist Church

23,000 staff
3,600 physicians
5,000 volunteers
11 hospitals
2000 active beds
ALOS 2.1 – 5.3 days

60+ sites
169,000+ effective occupancy cases
(inpatient admissions and observation stays)
510,000 ED visits
2.6 million outpatient visits
(excluding Emergency Department)
7.2% operating margin
447 days cash on hand
OhioHealth Locations

Coverage

40 county market area serving 3.5M people

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Journey from ‘Volume’ to ‘Value’

• Predominant payment method in the US is fee-for-service
  – More service, more money
• 30% of Medicare Spending in last year of life ($151B)
• Ohio is a high intensity, high volume, high expense State in the last 2 years of life.
• System needs coordinated hospice and palliative care program if change to ‘value’
Facts & Assumptions

• Hospice care is proven to be the best care at the end of life
  – Key issue: reach all eligible patients
  – Improves quality and lowers cost
  – Treat as a quality measure


• Palliative Care improves quality while reducing cost

• Having one Program, with one leadership and one standard improves quality while reducing cost
OHHC: OhioHealth Home Care
> 10,000 patients under service at all times

- Home Health
- Hospice
- Palliative
- Home Medical Equip.
- Home Infusion
- SNF network
- Employed Medical Group Practice
- Orthotics
OHHC
OhioHealth Home Care

- Over 840 FTEs and 900+ associates

- Provides services in 31 counties. Service area covers 37% of the population of Ohio
Clinical Hospice & Palliative Care

- Hospital Consultation Services
- Specialty Inpt Unit Kobacker House
- Ambulatory Outpatient
- ECF
- Home Palliative Care
- Home Hospice
Kobacker House
32 GIP beds
Highs and Lows

- Siblings (biological): 25
- Creatinine (Cr): 1.9
- CRP: 146.5
- Bili: 1.8
- Platelet: 1
- PSA: 5.6
- INR: 2.8
- pro-BNP: 88,695
- Primary Cancers: 5
- Alcohol: 2 cases per day
- Total bilirubin: 1.4
- BMI: 15.9
- LDH: >8800
- WBC: 25,170
- Hgb: 2.1
- Sodium: 175/103
- Albumin: 0.9
- HbAC: 16.8
- F: 30
- B: 143, 944 CD4: 43
Highs and Lows

- Pack Years 228
- Start Smoking Age 6
- Quit Smoking Age 97
- Alcohol 2 case beer / d
- Siblings (biological) 25
- Drug Allergies 83
- Deaths / Day 9
- BMI 13.9
- BP 215 / 27
- PSA 5,646
- CA19-9: 910,410

- Sodium 175
- Potassium 2.0
- BUN 299
- Blood Sugar 1,790
- Albumin 0.9
- LDH > 8,800
- TSH 280
- Ammonia 252
- Total Bilirubin 47
- BNP 88,695
- Alk Phos 2,090
- WBC 251.7
- Platelets 1
Impact of Effective Palliative Care

**Historical Model**
- Improved Quality of Care
  - Improved Pain & Symptoms
  - Better End of Life / Quality of Life
- Lower Overall Cost of Care
  - Fewer Redundant, Unnecessary Tests
  - Shorter ICU / Hospital Length of Stay
- Improved Patient/Family Satisfaction & Patient Engagement
- Efficient Coordination of Care
  - Management of Aging Population
- Physician Support
  - Improved Productivity
- Physician Satisfier

**Emerging Model**

Cost of delivering palliative care ($-\text{)} + \text{benefits of getting palliative care (+)} = \text{net value}
### Specialist Palliative Care is a Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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| **Physician**             | • Leader of IDT and principal interface between referring physicians and Palliative service; education for unit providers  
                            • Treatment and management of symptoms  
                            • Assistance in goals of care discussions |
| **Advanced Practice Provider** | • Treatment and management of symptoms  
                               • Assistance in goals of care discussions  
                               • Interface between unit nursing and Palliative service; education for unit providers |
| **Social Work**           | • Provides assessment of social, cultural, community, and familial needs  
                            • Assists the family, unit Social Work staff in discharge plans and identification of resources appropriate with family needs and goals |
| **Chaplain**              | • Spiritual counseling and support for patients/families that request it  
                            • Support to unit staff in end of life cases  
                            • Support for IDT in issues of self-care and resiliency |
| **Pharmacist**            | • Medication reconciliation  
                            • Resource for complex pain cases  
                            • Significant opportunity to impact hospital cost and pain scores |
Case 3: Kevin

- Neuroendocrine cancer of pancreas
- Divorcing for 4 years
- Lived in Naples, Florida
- Cancer Care at Moffitt Cancer Center in Tampa
- Interview after 4 months in hospice care
  - Moved to Columbus to be near wife, kids
  - Living with mother-in-law
  - Hospitalized at Kobacker House for Hyperactive Delirium
- Interviewed in front of 50 physicians
Watch for

• How he describes role of hospice & palliative medicine physician
• Compare and contrast understanding of hospice care
• Relationship with his wife
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• What is most valuable to him about being enrolled in hospice care?
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Watch for

• What about this patient would drive hospice staff crazy?
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How do we have to change?

• All patients
  – ‘Both / And’ not ‘either / or’
  – Best medical care, not ‘choice’
  – Accept or Reject medical advice

• We can tolerate ambivalence and wishing for something different

• We can be confident in our skills
  – Transfusions, Ventilators, Dobutamine, VAD

• We can enjoy being an essential part of standard health care
Case 2: Peppy Chernoff
4 years after diagnosis
Initial prognosis < 6 months with standard cancer care
FY 18 System Palliative Care Consults

Annualized Total: 6,000 consults
20% growth year over year
System Hospice (21 counties)

3,000 Hospice Deaths / Year

Average Length of Service Increased to 60 days

Median Length of Service Increased from 10 to 15 days
Charles, There’s a workforce shortage

It’s impossible
## Finding Staff for Palliative Care and Hospice Medical staff (including APP)

<table>
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<tr>
<th>Full Time Staff</th>
<th>Start 2013</th>
<th>Now 2018</th>
<th>Future 2023</th>
</tr>
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<tbody>
<tr>
<td>Physicians (Board Certified)</td>
<td>4</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Advanced Practice Providers</td>
<td>7</td>
<td>23</td>
<td>43</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Chaplains</td>
<td>0</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>75</strong></td>
<td><strong>135</strong></td>
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Current Cost (FY 2017-2018)

- Hospital-Based Palliative Care $8M
  - Overhead $1M
- Hospice Addition of Physicians $2M
- Total Annual New Cost = $11M
- Billing Income $2M
- Cost Savings $29M

Net Impact $20M
$1 M Overhead

- Physician Vice President, Medical Affairs
- System Director, Palliative Care
- 2 System Managers
- 1 Finance
- 1 Quality Measurement
- 6 FTE in overhead
“Overall, I am satisfied with hospice services”
3,600 physicians surveyed, n = 1,800

Strongly Agree

Agree

Neutral
Medical Oncologists refer ‘late’

- Make money from chemotherapy
- Don’t tell the truth / Don’t tell prognosis
- Are cold, heartless and don’t care
- Are anti-palliative care and anti-hospice
Median Length of Service with Hospice Care referred from OhioHealth Medical Oncologist's Offices 1/2014 - 10/13/2014

National Cancer LOS 43.8 days

OhioHealth Cancer LOS 21 days
Hospice LOS Doubled for Cancer Patients Referred from Oncologist Offices

- 2014: N = 176
- 2015: N = 133 (10 months)

- Hospice LOS for Cancer Patients

- Comparison of hospice length of stay (LOS) for cancer patients referred from oncologist offices in 2014 and 2015.
Clinical Guidance Councils

• Primary Care
• Hospitalist
• Critical Care
• Oncology
• Cardiovascular
• Neurosciences
• Pulmonary
Median Hospice Length of Stay

N = 1,888 physicians who referred at least one patient for hospice care

2015: 16
2016: 15
2017: 27
Conclusions about Physicians

• Value Palliative Care Highly
• Want long lengths of stay for their patients
• More than 25% want Palliative Care Specialists to ‘do it’
• When given their own, personal data by their own specialty, they improve
Case 2: Maryn

- **Stage III C Ovarian Cancer**
  - Diagnosed 2014
  - Died Christmas 2016
- **Dr. Paul Been, emergency medicine physician and husband**
  - Interviewed in front of new class of fellows, July 2017
  - Kobacker House, inpatient hospice unit
  - Dr. Hudak, Maryn’s Hospice Doctor, on R
Case 4 : Maryn

- Stage IIIb Ovarian Ca, 2 boys age 3 and 5
- Emergency Medicine Physician Husband
- Standard ‘Best’ Oncology at NCI-designated JAMES Cancer Center at OSU
- Inoperable Bowel Obstruction
  - Intractable nausea and vomiting
  - Decided ‘no more chemo’, admit inpatient hospice for symptom control and expected end of life care
- ‘Miraculous’ resurrection with octreotide
- 3 months of great quality of life
- ‘Active’ Dying over 3 days ‘as predicted’
What did you notice?