The Current Status, Models, and Future of Outpatient Palliative Care

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The Challenge

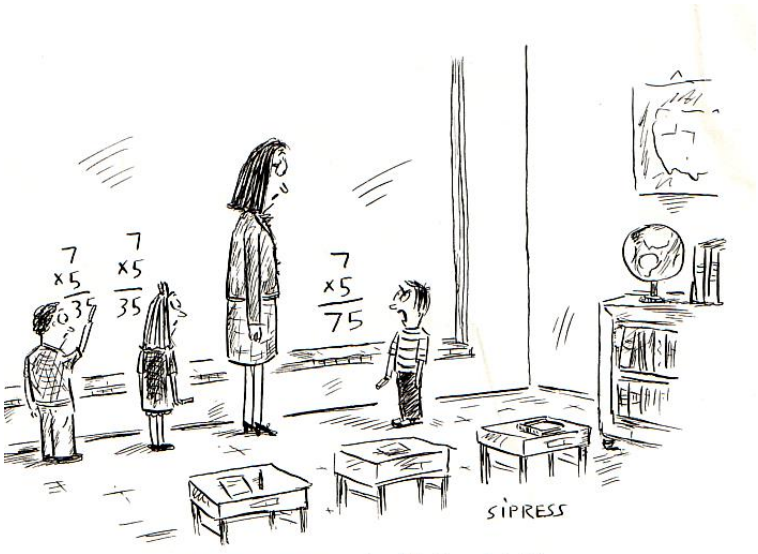
- Outpatient palliative care as the **Wild West**
- Massive, unregulated growth within palliative care AND in the health care system at large
  - Many models/experiments/pilots
  - Few with scale sufficient to manage growing expectations
- Business case is dependent on local variables

The Opportunity

- *Most* patients spend *most* of their time outside of hospitals
- Outpatient Palliative Care offers *value*
  - Improves **quality** patient care
  - Potentially **decreases** mortality
  - Increases **efficiency** in health care systems & ACOs
- The **frontier is an opportunity**

Main Points

- **Definition**
- Need
- Benefit
- Current Models
- Availability
- Future



"It may be wrong, but it's how I feel."

"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**.*

"Outpatient"

- Not inpatient
  - "Ambulatory," "Clinic," "Community-based"
- Across the continuum
  - Everywhere in our system: inpatient & non-inpatient
- What people/patients think of as "life"
  - Time & Space

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Carrots and Sticks

- Patients and families suffer with serious illness and at the end of life. Palliative care helps, so we should provide it.
- People with sticks say we have to
  - Commission on Caner
  - JC
  - ASCO
  - SB1004

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Proven Benefits

- Improved patient and family **satisfaction**
- Reduction in **symptom burden**
- **Prolonged life** (hospice, outpatient)
- Improved efficiency/Reduced **costs**

Morrison, Annals Intern Med, 2008; Teno et al, JAMA, 2004; Christakis & Iwashyna, Soc Sci Med, 2003; Miller et al, JPSM, 2003; Connor et al, JPSM, 2007. Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002, Zimmerrman, JAMA 2008; Follwell, J Clin Onc, 2008; Rabow, Arch Intern Med, 2004; Temel, NEJM, 2010; Rabow, J Palliative Med, 2013.

1. Improved Satisfaction

- Patients
- Family
- Clinicians

Rabow, JPM, 2014

2. Improved Symptoms

- Improved outcomes pre/post (mostly cancer pts)
  - Pain, Fatigue, Nausea, Depression, Anxiety, Drowsiness, Appetite, Dyspnea, Insomnia, Constipation, and Satisfaction
- Improved outcomes in controlled trials
  - e.g. The CCT Trial at UCSF: outpatient palliative care team working with primary care physicians
    - Dyspnea, Anxiety, Sleep, Spiritual Well-being improved compared to routine primary care

Rabow, Arch Intern Med, 2004
Follwell, J Clin Onc, 2008
Yennurajalingam, JPSM, 2011
Kim, J Palliat Med, 2012
Bischoff, Supp Care Cancer, 2013

3. Prolonged Survival in Hospice

[Connor, J Pain Sx Mgmt, 2007]

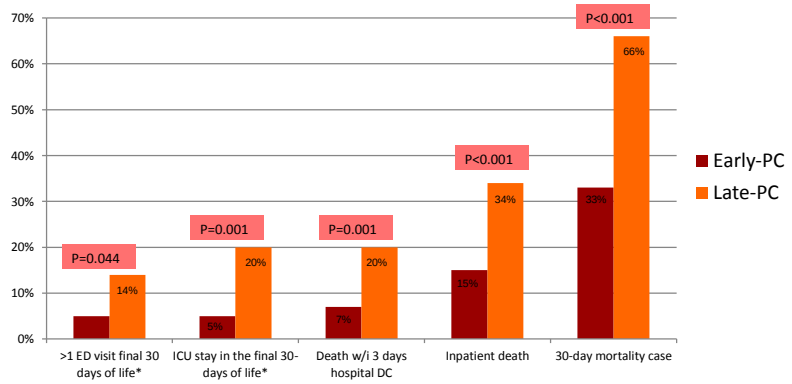
Matched cohort study: hospice use or not. 4493 Medicare patients, 2095 (47%) received hospice care for at least one day, 1999	
Disease	**Added survival**
CHF	+ 81 days, P = 0.0540
Lung cancer	+ 39 days, P < 0.0001
Pancreatic cancer	+ 21 days, P = 0.0102
Colon cancer	+ 33 days, P = 0.0792
Breast	+ 12 days, P = 0.6136
Prostate	+ 4 days, P = 0.8266

3. Prolonged Survival: BOTH / AND

- 151 patients with NSCLC at Mass General
- Immediate vs. delayed palliative care along with usual oncologic care
- Early pc patients with…
  - Improved QOL
  - Less depression
  - Less chemo in last 2 weeks
  - Fewer hospitalizations in last month
  - Nearly 3 months longer survival (11.6 mos. vs. 8.9 mos., p<0.02)

Temel, NEJM, 2010

4. Early-PC = Better Utilization & Quality

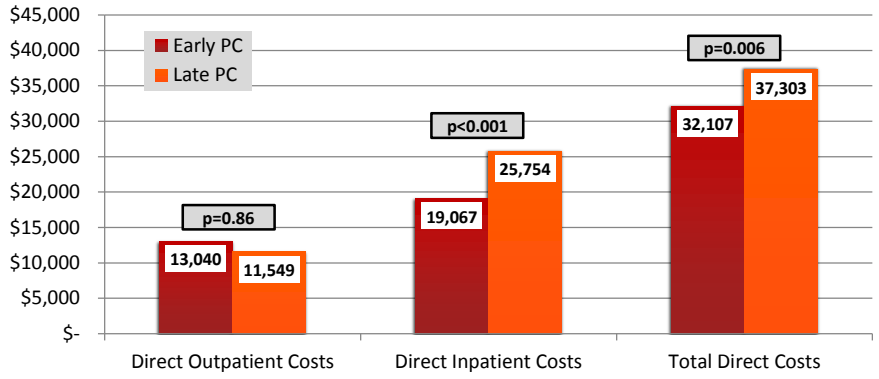


Early-PC associated with better performance on EOL quality measures

*NQF measures

Scibetta, Kerr, McGuire, Rabow, 2015

Early PC: $5000/patient lower total costs in final 6 mos



**Early PC = first contact with specialty service >90 days prior to death*

Scibetta C, Kerr K, Mcguire J, Rabow MW. *The Costs of Waiting: Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center*. J Palliat Med. 2016 Jan;19(1):69-75.

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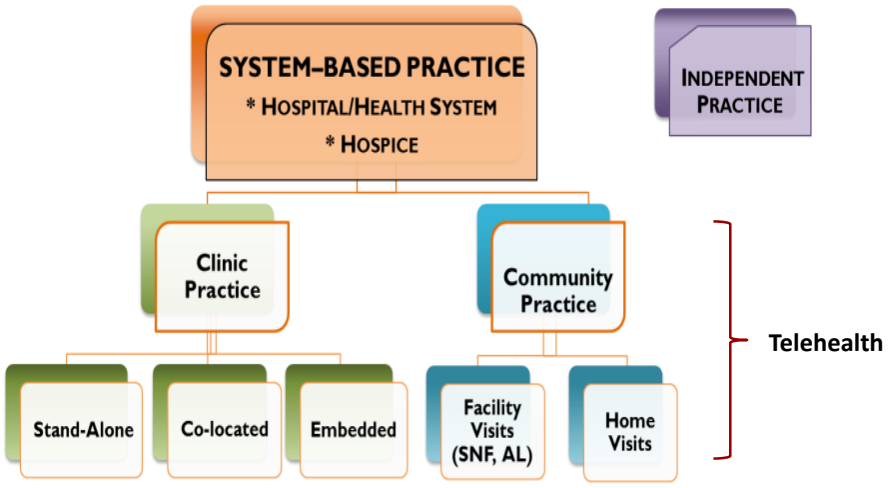
Conceptual Model of Outpatient PC



Program Development: What We've Learned

- Often good people start offering services before figuring out how to sustain or scale them
- **Health systems want outpatient palliative care**, but often have not established real business models to sustain change in delivery model (and may not pay enough)
- Starting with the basics & setting limits is wise
- Workforce limitations should lead to creative solutions, partnering, and training

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Outpatient PC in Cancer Centers

- 142 cancer centers (Hui et al. JAMA. 2010)

	NCI site	Non-NCI site
Palliative care program	98%	78%
Inpatient palliative care consult team	92%	56%
Outpatient palliative care	59%	22%

PC in NCCN Cancer Centers

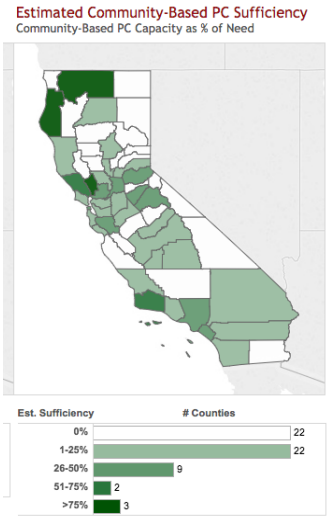
- 22/26 response(85%)
- 91% clinic-based PC (3/4 in the last 10 years)
  - 469 consults/year (GI, Breast, Thoracic)
  - 3.3 FTEs
  - **17-day wait time**
- 80% w/ **insufficient** PC capacity

Calton, JNCCN, 2016

Outpatient PC Mapping in California

- Programs in 36/58 CA counties (62%)
- Serving more than 53,500/yr
- ***2015 capacity between 24-37% of need***

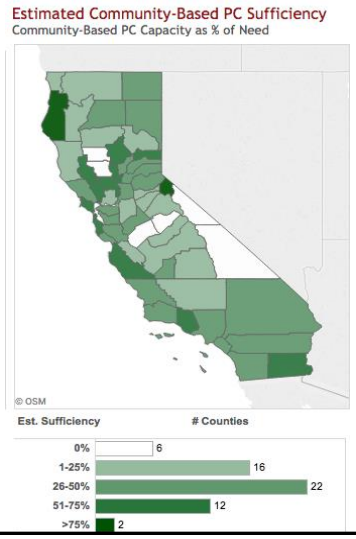
Kerr, Cassell, Rabow at CHCF.org
http://www.chcf.org/publications/2015/02/palliative-care-data



Uptdated Outpatient PC Mapping in California

- No programs in in only 6 counties
- ***Current capacity between 33-51% of need***

Kerr at CHCF.org
https://www.chcf.org/publication/palliative-care-california-narrowing-gap/



The Gap: Workforce Shortage

- 1 cardiologist for every 71 heart attacks
- 1 PC doc for every 1300 patients with serious illness

= 6,000-18,000 projected gap in pc physicians

- Just for hospitals and hospices (Lupu, J Pain Sx Mgmt, 2010)
- Most outpt clinics with staffing shortages (Smith, JPM, 2013)
- Similar/worse gaps for Nursing, Chaplains, Social Work

The Big Question…

- Big need, limited capacity, workforce shortage…
- **How will palliative care grow/transform to meet the need?**

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The Future

Opportunities for the Post-Temel Universe

1. **The Historic Alignment: Managing populations**
2. **Primary palliative care**
3. **PC Everywhere**

1. The Historic Alignment: Managing Populations

- Palliative Care is positioned to serve a key role in health care reform: caring for seriously ill patients
  - The 10% cost 63% (Kaiser Family Foundation, 2011)
  - Systems of Shared Cost/Risk need PC
- It's not just mission anymore… it's margin too
  - Value = benefit/cost

"The Big But" of PC Finances

- If you provide outpatient clinic with long appointment times and IDT care, and cover support staff costs and overhead – you will lose money unless you have revenue in addition to CPT Billing
  - Billing = <50% of expenses (Rabow, Arch Intern Med, 2010)

BUT other benefits sufficient to justify funding (value)

- Clinical (paying for quality)
- Financial (decreased global costs)

Value and The Triple Aim

Historic alignment:

Everyone now wants the same thing (i.e. value):

Quality, Quantity, and Cost Savings

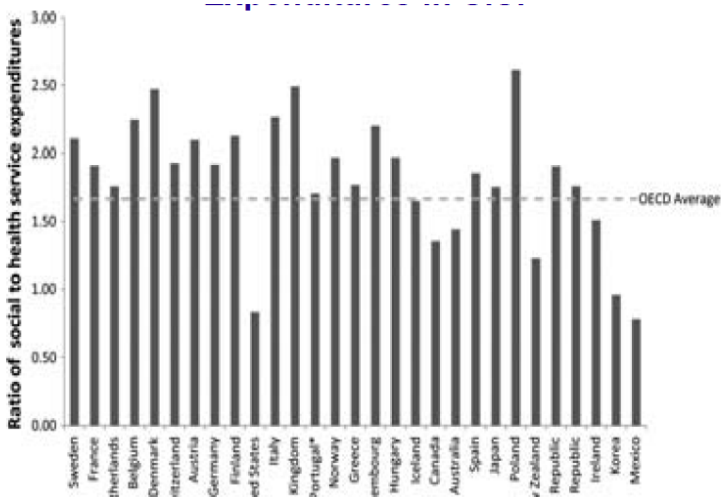
2. Primary Palliative Care

The Workforce/Capacity Issue

- Be clear about what *we* do
  - Train & certify new and mid-career clinicians to do it
- Teach everyone else to do the basics
  - Primary care physicians, NPs
  - Specialists
  - Assistants, Home health aides
- Requires regulation, education, and technology

Quill & Abernethy, NEJM, 2013

It's Not Just Medical Care…



The Inverted Pyramid

- Social support is key to health (not just medical care)
  - Food (Health Affairs, 2013)
  - Housing (Larimer, JAMA, 2009)
- Community services and health workers
  - Everyone practicing at the top of their specialty

3. Patients at the Center = **PC Everywhere**

- To impact care, we need to have patients at the center
  - Be there (when it's happening, at their house)
  - From the beginning
  - **Without gaps**
    - "Timely access," Continuously
    - **Any hole** in the system makes it easy to slip back to bad (and expensive) habits
      - just send 'em to the ER, code them, etc.

Historic Alignment: Defining "Everywhere"

- ✓ <u>From health systems' perspective…</u>

  Traditionally: The providers and sites of care involved in delivery of medical services owned by the system

- ✓ <u>From patients' perspective…</u>

  All the places & providers that assist with their journey and the gaps in-between them, all time and everywhere, **life**

- ✓ **These two perspectives are aligning**
  - ✓ Payment reform is changing what systems care about
  - ✓ EVERYONE has skin in the game *the whole time*

Back to the Future

- After years of work to establish an identity…Will or should palliative care *disappear*?
  - Become part of the routine (not an “extra” layer)
  - Done by all clinicians and staff
  - Be built into the fabric of systems of care