Palliative Care and Avoidable Readmissions

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Health Care Challenge: Illness Burden and Excessive Cost

- The 90% of Americans who die from incurable illnesses have high illness burden
  - Poorly controlled symptoms
  - Psychiatric disorders and psychosocial and spiritual distress
  - Concrete needs in the home
  - Challenges in care coordination, communication, decision making, goal setting
  - Caregiver burden and financial stress
  - Fear about managing the period of active dying
Cost of the Chronically and Terminally Ill

- $2.5 trillion spend annually
  - $1 trillion government
  - $500 billion Medicare
- 95% of Medicare is for the chronically ill
- About one-third of health care costs accrue during the last 6 months of life

Medical Expenditure Panel Survey, HHS, 2006
Excessive and Unnecessary Costs

- Of >$2.5 trillion spend, >$750 billion is wasted
  - $210 billion in unnecessary services;
  - $130 billion in services delivered inefficiently;
  - $190 billion in excess administrative expenses;
  - $105 billion in excessive prices;
  - $75 billion in fraud;
  - $55 billion in missed opportunities for prevention

(2012 IOM report, based on 2009 data)
Part of the Problem:
Avoidable Readmissions

- Avoidable readmission is part of this excess cost
  - Almost 20% Medicare discharges are readmitted within 30 days
  - MedPAC estimates 75% may be avoidable (about $12 billion/yr)
Seeking Solutions: What is Palliative Care?

- An interdisciplinary therapeutic model appropriate for all populations with serious or life-threatening illnesses, the goal of which is to prevent and manage suffering and illness burden for both patient and family from the time of diagnosis onward.
Palliative Care: Key Objectives

- Palliative care promotes:
  - Comfort through symptom control
  - Management of psychosocial and spiritual distress
  - Communication that supports goal setting, shared decision making and advance care planning
  - Availability of practical help in the home
  - Expert management of active dying and its aftermath
  - Family support while caregiving and when bereaved
Palliative Care and Health Care Cost

- Cost control is not an **objective** of palliative care
- But, core precepts may lead to less costly care
Palliative Care: Key Concept

Palliative care can be:

- **Generalist-level care**
  - Best practices during the routine care

- **Specialist-level care**:
  - Interdisciplinary team with special competencies
    - Hospice agencies
    - Palliative care services
      - Institution-based
      - Community-based
Hospice: High Satisfaction and Potentially Favorable Financials

- Interdisciplinary care management
  - Across sites of care
  - High patient and family satisfaction

- Hospital financial considerations
  - Conversion to hospice is a discharge that yields new per diem revenue
  - Admission or readmission of a hospice patient for a problem related to the terminal diagnosis is not a hospital admission
Specialist Palliative Programs

- Hospital-based programs are rapidly growing
  - 2011: 63% of hospitals with >50 beds and 85% of hospitals with >300 beds
- Other specialist models of palliative care are emerging but experience is very limited
Hospital-Based Palliative Care Programs

- Reduce cost of hospitalization
  - Largest study
    - Data from 8 hospitals 2002-2004
    - Palliative care consult saved $1696 per admission if discharged alive ($P = .004$) and $4908$ if death in the hospital ($P = .003$)

Morrison et al, Arch Int Med, 2008
Hospital-Based Palliative Care Programs

- May reduce readmission
  - Retrospective Kaiser Permanente Study
    - 200 patients referred to PCS 11/06 – 2/10
      - First 100 patients seen solely by a palliative care RN
      - Second 100 patients seen by an interdisciplinary team
    - Readmissions per patient during next six months
      - 1.15 for RN consultation (probability 73%)
      - 0.7 for team consultation (probability 33%)
        (p=0.025)

Other Palliative Care Models: Reducing Readmission

- Many other models evolving
  - ED-based models
  - Integrated palliative care/hospice inpatient model
  - Nursing home early intervention model
  - Numerous types of community-based models

- All have the potential to reduce readmission but no evidence as yet
Other Palliative Care Models: Reducing Readmission

- ED-based models
  - NP-led (O’Mahony et al. J Urban Health 2008;85:443-51)
  - Trained home care planner with access to inpatient/outpatient hospice services
Other Palliative Care Models: Reducing Readmission

- Integrated palliative care/hospice inpatient model
  - May improve rate of appropriate inpatient conversion to hospice and community hand-off to a palliative care team
Other Palliative Care Models: Reducing Readmission

- Nursing home early intervention model
  - Repeated review of advance care planning
  - Improved management of distress on transition to NH
  - Improved access to hospice service
Other Palliative Care Models: Reducing Readmission

- Community-based models
  - Many types
    - Telephonic/telehealth
    - Single clinician in varied disciplines
  - Interdisciplinary team with individualized care planning may be ‘gold standard’
    - Requires financial structure other than fee-for-service
Palliative Care and Avoidable Readmissions

- Improved access to specialist palliative care holds promise as an element in a multifaceted strategy to reduce avoidable readmission
- Studies are needed