



Article from

Health Watch

October 2016

Issue 81

An Introduction to Palliative Care for Patients With Serious Illness

By Diane Meier, Torrie Fields, Randall Krakauer and Bruce Smith

Palliative care is a relatively new medical specialty focused on the complex needs of people with serious illness and/or multiple chronic conditions. With today's focus on patient-centered and value-based care, it is beneficial for professionals working in health care to understand what palliative care is and how it can contribute to the dual aims of higher quality and lower cost.

The Center to Advance Palliative Care (CAPC) is a national organization whose mission is to increase the availability of quality palliative care services. To this end, CAPC operates a Health Payer Initiative both to collect and disseminate best practices and also to educate specific audiences within payers about palliative care, including actuaries. Given its impact on health care services, the net incremental impact of palliative care services may be a useful component of actuarial models. This article seeks to explain palliative care, share the research on its impact, and solicit feedback and suggestions from readers on what types of future research may be beneficial for actuaries and others.

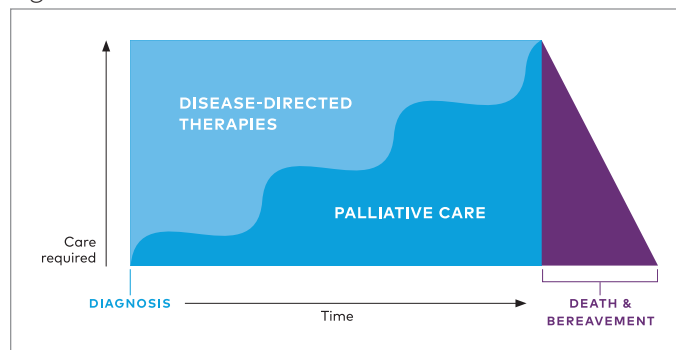
WHAT IS PALLIATIVE CARE?

Palliative care focuses on relieving the pain, symptoms and stress of a serious illness, regardless of diagnosis or prognosis, with the goal of improving quality of life for both the patient and family. It is delivered by an interdisciplinary team of specially trained doctors, nurses and social workers who work with a patient's treating doctors to provide an extra layer of management and support. Palliative care also focuses on clarifying all care options and soliciting goals and preferences.

Palliative care can be appropriate at any age and any stage of a serious illness and is provided together with curative and life-prolonging treatment (see Figure 1). Hospice is a form of palliative care focused on the end of life. In the United States, most hospice care is provided through the Medicare hospice benefit, which requires two physicians to certify that life expectancy is six months or less and patients must agree to forgo curative care.

Because palliative care focuses on the relief of pain, symptoms and stresses of serious illness, patients under the care of a palliative care team tend to experience fewer crises and exacerbations of illness. Common diagnoses for which palliative care has proven helpful and effective include cancer, heart failure, chronic lung disease, dementia, end-stage renal disease, amyotrophic lateral sclerosis (ALS) and HIV/AIDS.

Figure 1



AVAILABILITY OF PALLIATIVE CARE IN THE UNITED STATES

Palliative care is provided in many acute care hospitals. At least 20 percent of hospitals in every U.S. state report a palliative care program; while patients in 18 states can access palliative care services in more than 80 percent of hospitals.¹ There are also many palliative care programs outside the hospital setting; for example, 87 percent of the National Cancer Institute's comprehensive centers incorporate palliative care into their office-based treatment, and many home health agencies are deploying specialized palliative care teams.

The availability of specialized palliative care professionals is still small, but is growing. There are now more than 13,000 nurses certified in palliative care, up 19 percent since 2010, and more than 6,500 physicians have received board certification in palliative medicine since the American Board of Internal Medicine introduced it in 2008. Health plans and other risk-bearing entities have launched specialized care management programs, expanded benefits, and created serious illness network tiers that include certified palliative care providers. Some early adopters include Aetna, Highmark, Cambia Health Solutions, Kaiser Permanente and Blue Cross Blue Shield of Massachusetts, along with Sutter Health, Banner Health and WestMed Medical Group's accountable care organizations.

PALLIATIVE CARE'S IMPACT ON QUALITY

Palliative care teams bring expertise in the care of complex, high-risk patients to all settings, including hospitals, nursing homes, home care, physician offices, dialysis centers and cancer centers. This is important because although patients with serious illnesses, multiple co-morbidities, and significant pain and symptoms typically represent only 5 to 10 percent of patients, they are scattered throughout the health system and disproportionately account for adverse events such as multiple ambulance calls, medication errors and rapid-cycle readmissions.

Through focus on the patient and his/her function rather than the disease, palliative care can enable further quality gains than curative treatment alone. A recent comparative effectiveness review conducted by the federal Agency for Healthcare Research and Quality on home-based primary care for high-need individuals—a key mechanism for delivering palliative care in the community—has found solid evidence for reduction in symptoms, reduction in emergency room visits, increases in quality of life, and increases in satisfaction scores.² In addition, a new study has shown that patients' functional ability in activities of daily living improves—sometimes to the level of the year prior—after admission to hospice.³

PALLIATIVE CARE'S IMPACT ON COST

As noted, palliative care teams work to improve the management of pain and other symptoms—which can reduce emergency room visits and hospitalizations. Several studies demonstrate statistically significant reductions in hospitalizations, days in the hospital, and emergency department visits for patients receiving home-based palliative care services compared to their matched peers in usual care.⁴

Not only does the effective control of pain and symptoms reduce emergency room visits, but well-trained palliative care teams can also help patients and families to weigh the pros and cons of realistic treatment options in the context of patient-centered goals and values. Fully informed patients and families frequently (but not always) choose to receive further care in lower-intensity settings. This usually leads to higher-quality care, most often at lower expense.

Two high-quality comparative analyses—one at Kaiser Permanente⁵ and one at Sutter Health⁶—have calculated the net cost savings from home-based palliative care in the last three months of life. Kaiser Permanente found a net mean savings of \$7,552 per patient—a 33 percent reduction—while the Sutter Health program experienced a \$5,975 mean per-patient savings in the last three months of life.

Health plans have reported similar savings. Aetna's Compassionate Care Program—a specialized care management program for members with serious illness incorporating palliative care

principles and partnership with specialist palliative care providers—has resulted in an 81 percent decrease in acute care days, an 86 percent decrease in ICU days, and a total cost reduction of more than \$12,000 per member.⁷

The patients eligible for palliative care programs are those who are the costliest 5 percent of patients and account for 50 percent of health care spending, according to the Institute of Medicine's 2014 report "Dying in America." Control groups in "usual care" have spending in the last three months of life of more than \$26,000.⁸

PALLIATIVE CARE STRATEGIES ADOPTED BY PAYERS AND OTHER RISK-BEARING ORGANIZATIONS

Since the early adopters, other payers are integrating palliative care principles and practices into their member services, products and programs. Current programs can be broadly categorized as shown in Table 1.

Table 1
Categories of Palliative Care Programs

Program Design Types	Definition
Targeting	Targeting uses claims algorithms, often combined with data from the clinical records, to identify patients and members who can benefit most from palliative care interventions.
Care/case management	Specially trained care management resources made available to members with serious illness. These can be delivered telephonically or in person, either through a dedicated team or across all case managers. Both models have shown favorable results.*
Coverage and benefits	Specific coverage policies to provide access to home-based palliative care, along with practical services such as transportation or stress reduction. Payers may also use existing benefits creatively to incorporate palliative care professionals into the patient's care team.
Payment models and reimbursement	Payment policies, incentive programs for provider training in palliative care, and alternative reimbursement models designed to encourage palliative care consultation and ensure adequate payment for both inpatient and outpatient palliative care and other services.
Provider network	Provider network designs, such as tiers, can help direct members to specialty palliative care and/or hospice when needed. Credentialing requirements can also include palliative care designations for hospitals, home health agencies and selected specialists.
Member palliative care and advance care planning awareness	Using existing member support tools to build awareness of palliative care and its benefits, along with ensuring good documentation of wishes and preferences.

* Randall Krakauer, Claire M. Spettell, Lonny Reisman and Marcia J. Wade. 2009. "Opportunities to Improve the Quality of Care for Advanced Illness." *Health Affairs* 28(5):1357–1359.

FUTURE RESEARCH FOR HEALTH ACTUARIES AND OTHER PROFESSIONALS: WE WANT TO HEAR FROM YOU!

In light of the growing trend for palliative care services, the authors and SOA research staff are greatly interested in suggestions for further work in this area that would be beneficial for actuaries and other health professionals. For example, future research in this area may include how to best incorporate the impact of palliative care into actuarial pricing and predictive models. We would love to hear from you with ideas and suggestions! Please contact Steven Siegel, SOA research actuary, at ssiegel@soa.org with your thoughts and feedback for further consideration. ■



Diane Meier, M.D., FACP, is director of Center to Advance Palliative Care. She can be reached at diane.meier@mssm.edu.



Torrie Fields, MPH, is senior program manager for palliative care at Blue Cross Blue Shield of California. She can be reached at torrie.fields@blueshieldca.com.



Randall Krakauer is a retired chief medical officer for Medicare at Aetna. He can be reached at rmkrakauer@comcast.net.



Bruce Smith, M.D., MACP, is executive medical director at Regence BlueShield. He can be reached at bruce.smith@regence.com.

RESOURCES

Christine Chang, Susan S. Jackson, Tim A. Bullman and Elizabeth L. Cobbs. 2009. "Impact of a Home-Based Primary Care Program in an Urban Veterans Affairs Medical Center." *Journal of the American Medical Directors Association* 10(2):133-137.

Steven R. Counsell, Christopher M. Callahan, Daniel O. Clark, et al. 2007. "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial." *Journal of the American Medical Association* 298(22):2623-2633.

Eric De Jonge and George Taler. 2002. "Is There a Doctor in the House?" *Caring* 21(8):26-29.

Thomas Edes, Bruce Kinosian, Nancy H. Vuckovic, Linda Olivia Nichols, Margaret Mary Becke and Monir Hossain. 2014. "Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care." *Journal of the American Geriatrics Society* 62(10):1954-1961.

R. Sean Morrison, Joan D. Penrod, J. Brian Cassel, Melissa Caust-Ellenbogen, Ann Litke, Lynn Spragens and Diane E. Meier. 2008. "Cost Savings Associated with US Hospital Palliative Care Consultation Programs." *Archives of Internal Medicine* 168(16):1783-1790.

Samantha Smith, Aoife Brick, Sinead O'Hara, and Charles Normand. 2014. "Evidence on the Cost and Cost-Effectiveness of Palliative Care: A Literature Review." *Palliative Medicine* 28(2) 13-150.

Claire M. Spettell, Wayne S. Rawlins, Randall Krakauer, Joaquim Fernandes, Mary E.S. Breton, Wayne Gowdy, Sharon Brodeur, Maureen MacCoy and Troyen A. Brennan. 2009. "A Comprehensive Case Management Program to Improve Palliative Care." *Journal of Palliative Medicine* 12(9): 827-832. doi:10.1089/jpm.2009.0089.

Jennifer S. Temel, Joseph A. Greer, Alona Muzikansky, Emily R. Gallagher, Sonal Admane, Vicki A. Jackson, Constance M. Dahlin, Craig D. Blinderman, Juliet Jacobsen, William F. Pirl, J. Andrew Billings and Thomas J. Lynch. 2010. "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer." *New England Journal of Medicine* 363(8):733-742.

ENDNOTES

- ¹ "America's Care of Serious Illness." 2015. Center to Advance Palliative Care.
- ² "AHRQ Comparative Effectiveness Review No. 164, Home-Based Primary Care Interventions." AHRQ Publication No. 15(16)-EHC036-EF, February 2016.
- ³ Shayam Cheraghlou, et. al. 2016. "Restricting Symptoms Before and After Admission to Hospice." *American Journal of Medicine*. March 8.
- ⁴ See "Resources": Counsell (2007); Chang (2009); De Jonge (2002); Edes (2014).
- ⁵ Richard Brumley, Susan Enguidanos, Paula Jamison, Rae Seitz, Nora Morgenstern, Sherry Saito, Jan McIlwane, Kristine Hillary and Jorge Gonzalez. 2007. "Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care." *Journal of the American Geriatrics Society* 55(7):993-1000.
- ⁶ Harris Meyer. 2011. "Innovation Profile: Changing the Conversation in California About Care Near the End of Life." *Health Affairs* 30(3):390-393.
- ⁷ "Improving Care for People with Serious Illness Through Innovative Payer-Provider Partnerships." 2014. Center to Advance Palliative Care.
- ⁸ "MedPAC Spending in the Last Year of Life and the Impact of Hospice on Medicare Outlays." 2015. Institute of Medicine.