

# Palliative Care

Something **Old**  
Something **New**  
Something **Borrowed**  
Something **Blue**

**Oklahoma Osteopathic Association**

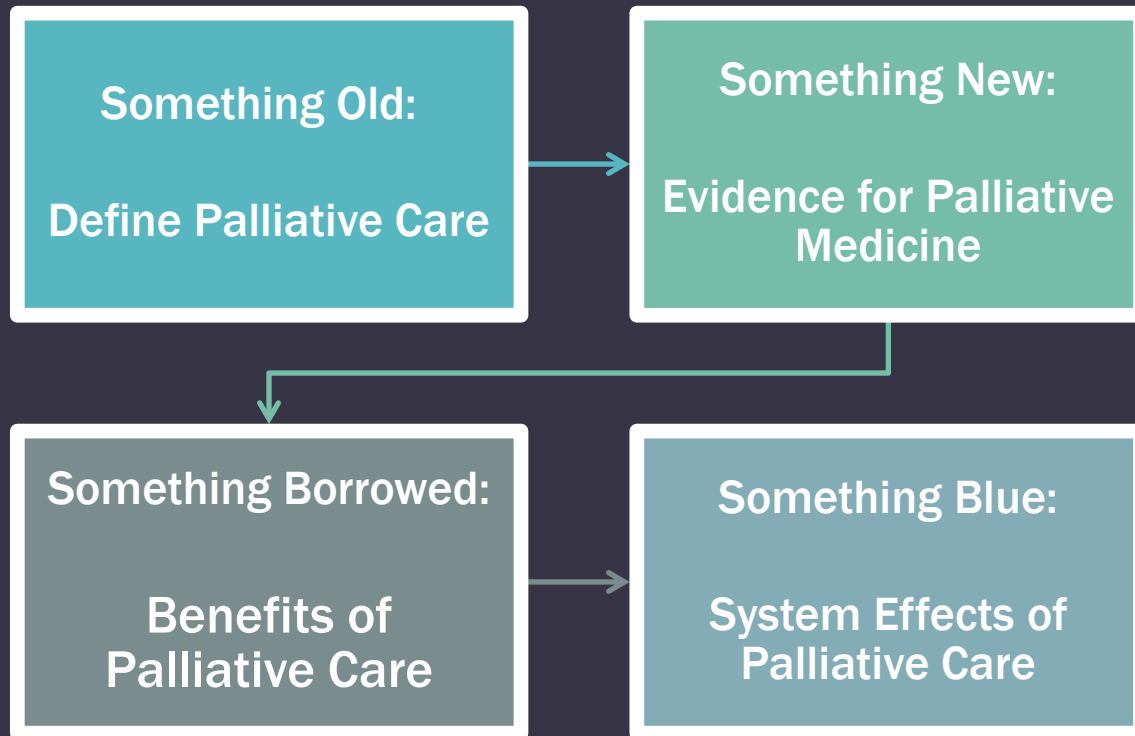
**2019 Summer CME Seminar**

**Jennifer K. Clark, MD**



# Disclosures

- Dr. Clark has no financial disclosures pertinent to today's topic.

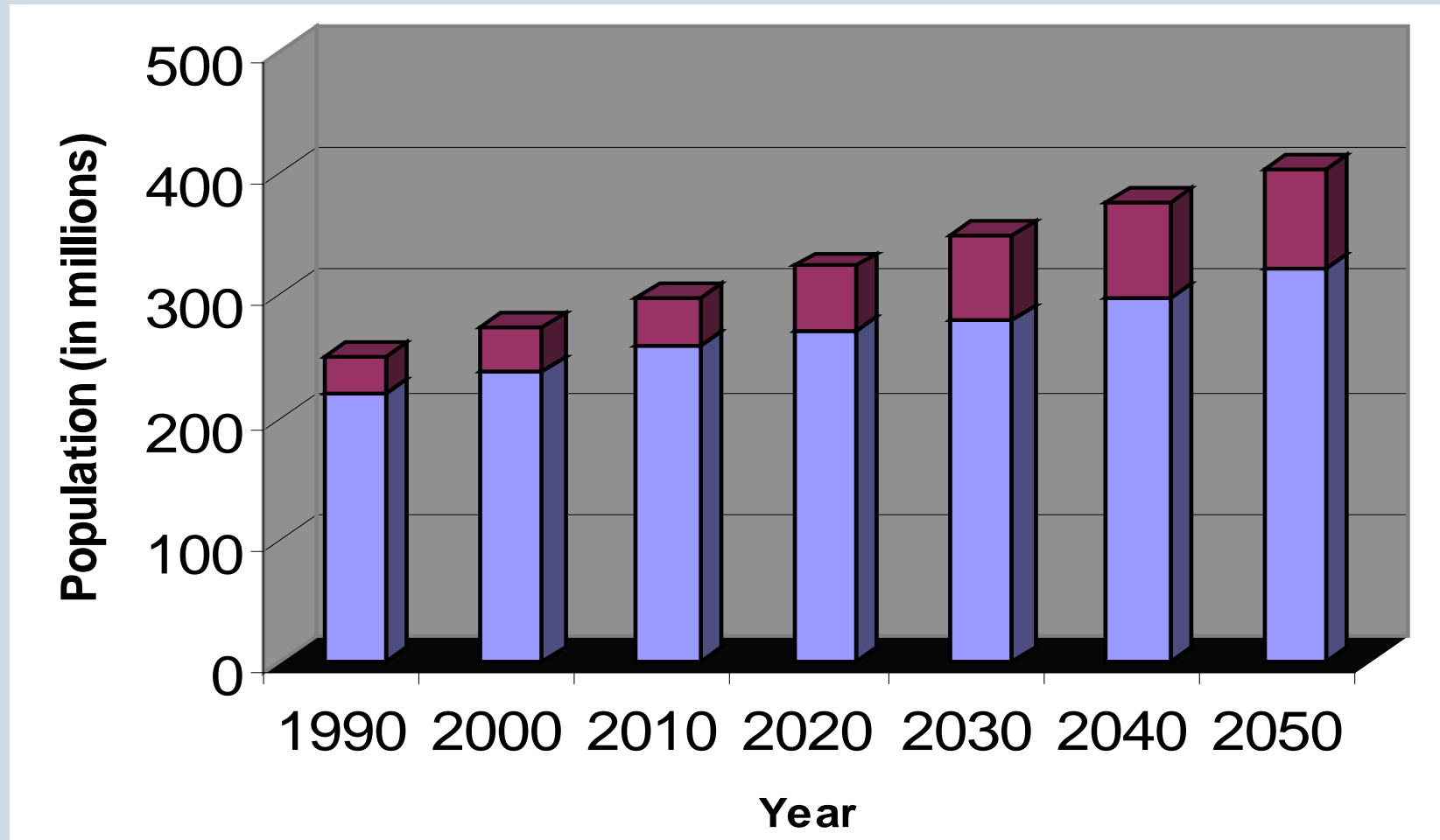


# Today's Objectives



**SOMETHING  
OLD...**

# Americans are Living Longer





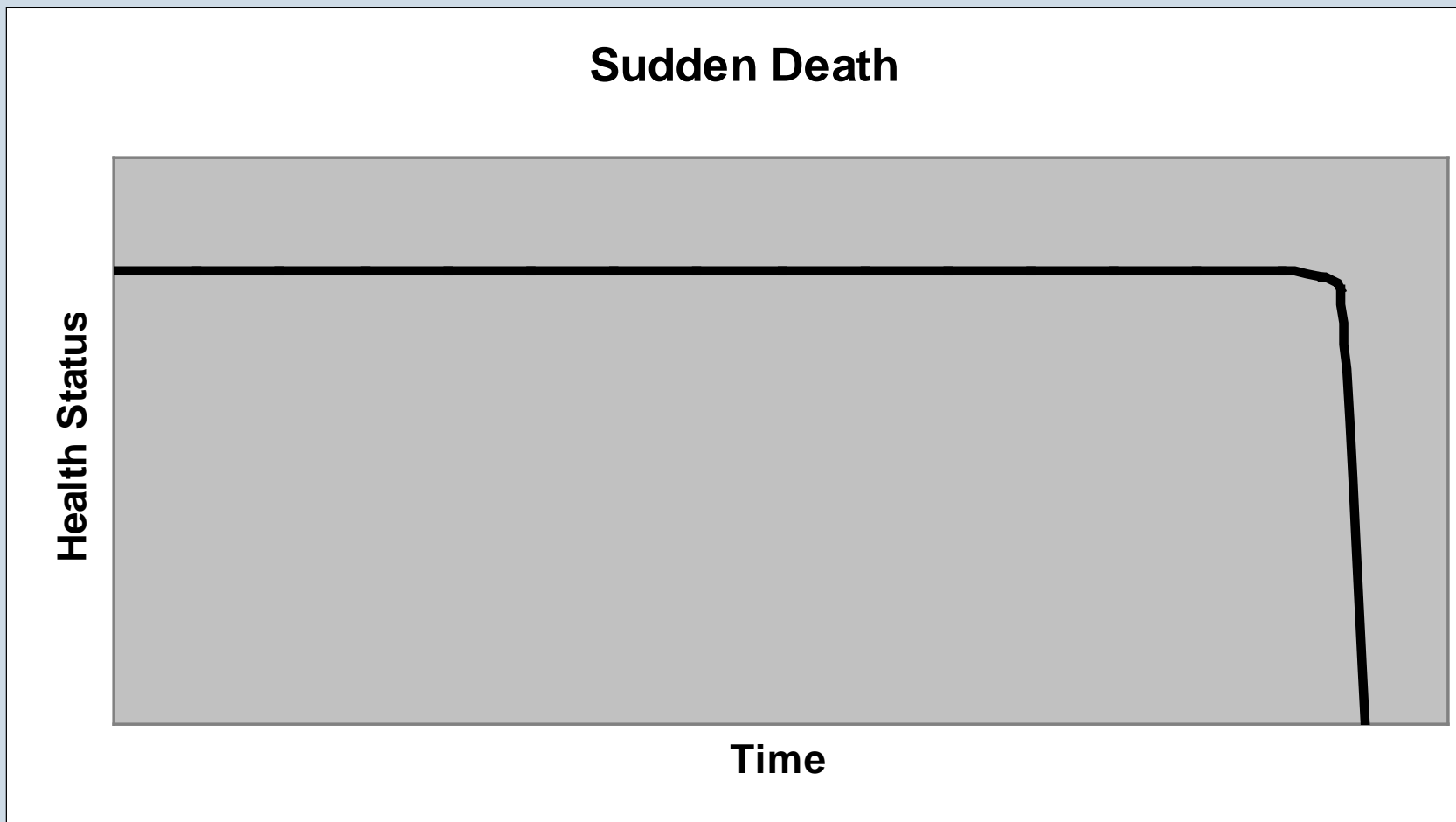
## Chronic Illness

There is a 90% chance patients will grow older with worsening medical problems

# The 'C' Diseases:

- *Cancer*
- *CHF*
- *CVA*
- *CAD*
- *COPD*
- *CKD*
- *Cirrhosis*
- *Cognitive Disorders*

# What Patients Want

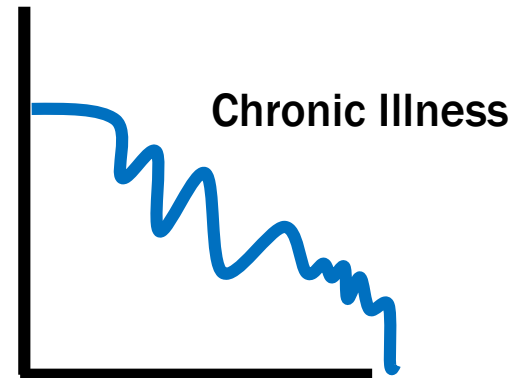
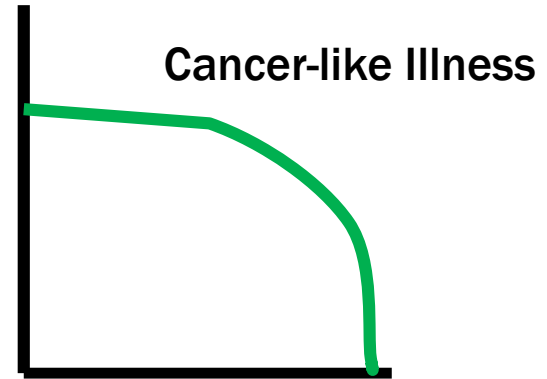
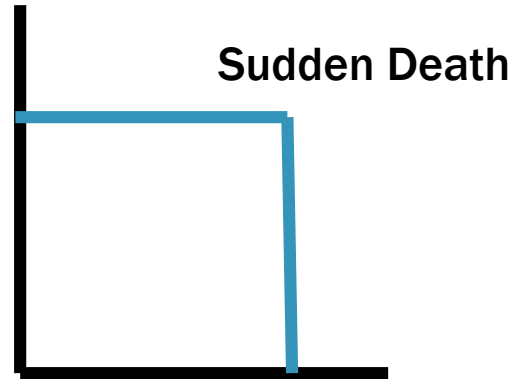




# What do Patients with Serious Illness Want?

- Pain and symptom control
- Avoid prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

# What they get...

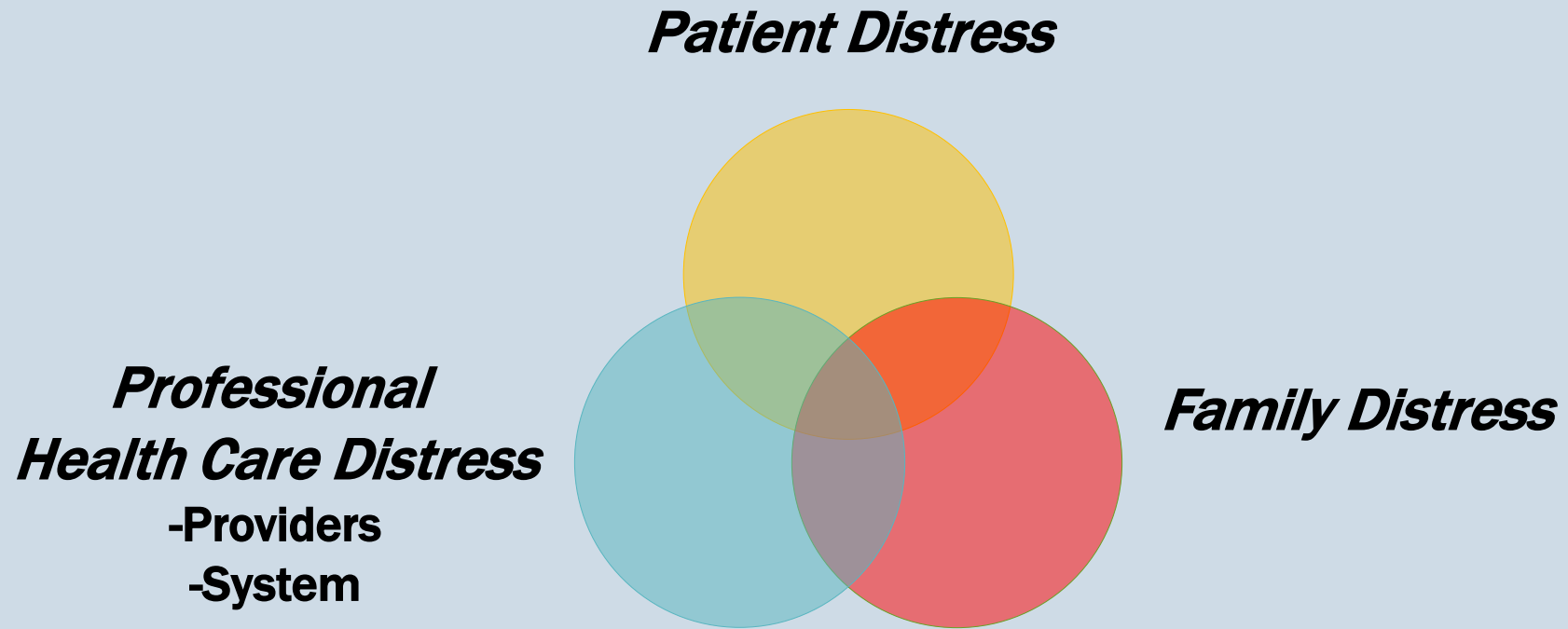


Adapted from Lunney, 2003

# What do Hospitalized Patients Get?

- Physical suffering
- Poor communication regarding goals of medical care
- Care discordant with patient and family preferences
- Financial, physical, and emotional burdens on family

# Suffering...



# Defining Palliative Care

**Palliative care is specialized medical care for people with serious illnesses.**

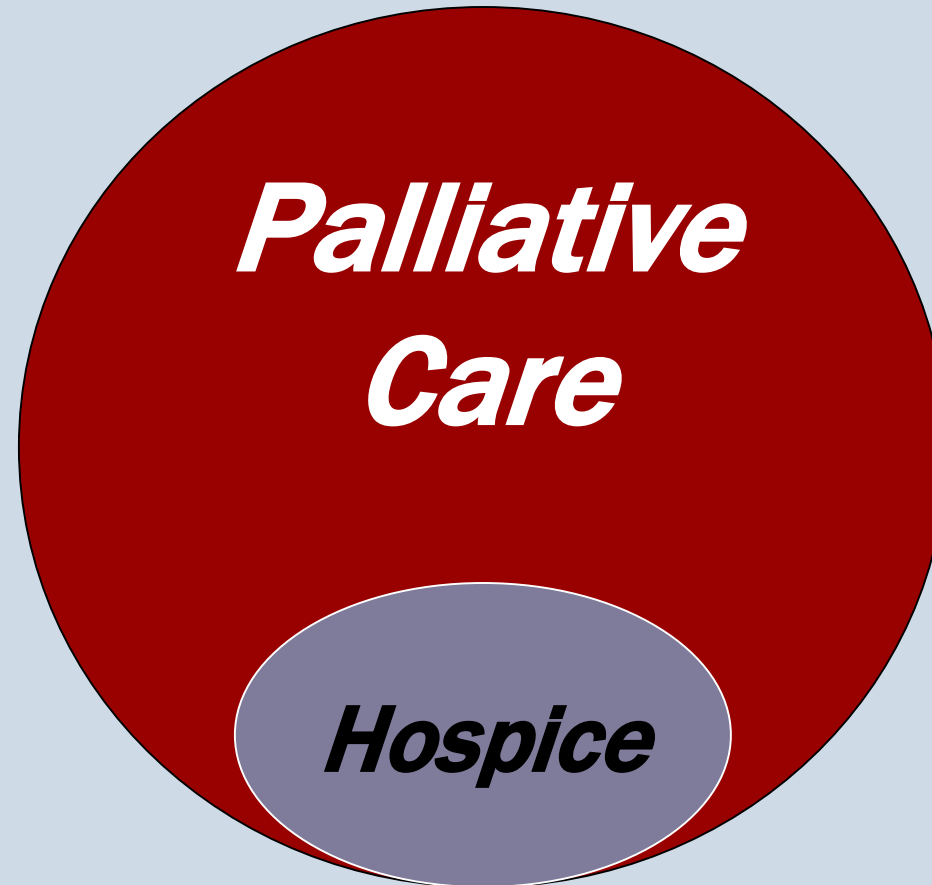
- Palliative care is focused on providing patients with **relief from the symptoms, pain, and stress of a serious illness** - whatever the diagnosis.
- The goal is to **improve quality of life** for both the patient and the family.
- Palliative care is **provided by a team** of doctors, nurses, and other 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.**

# Pornography?!

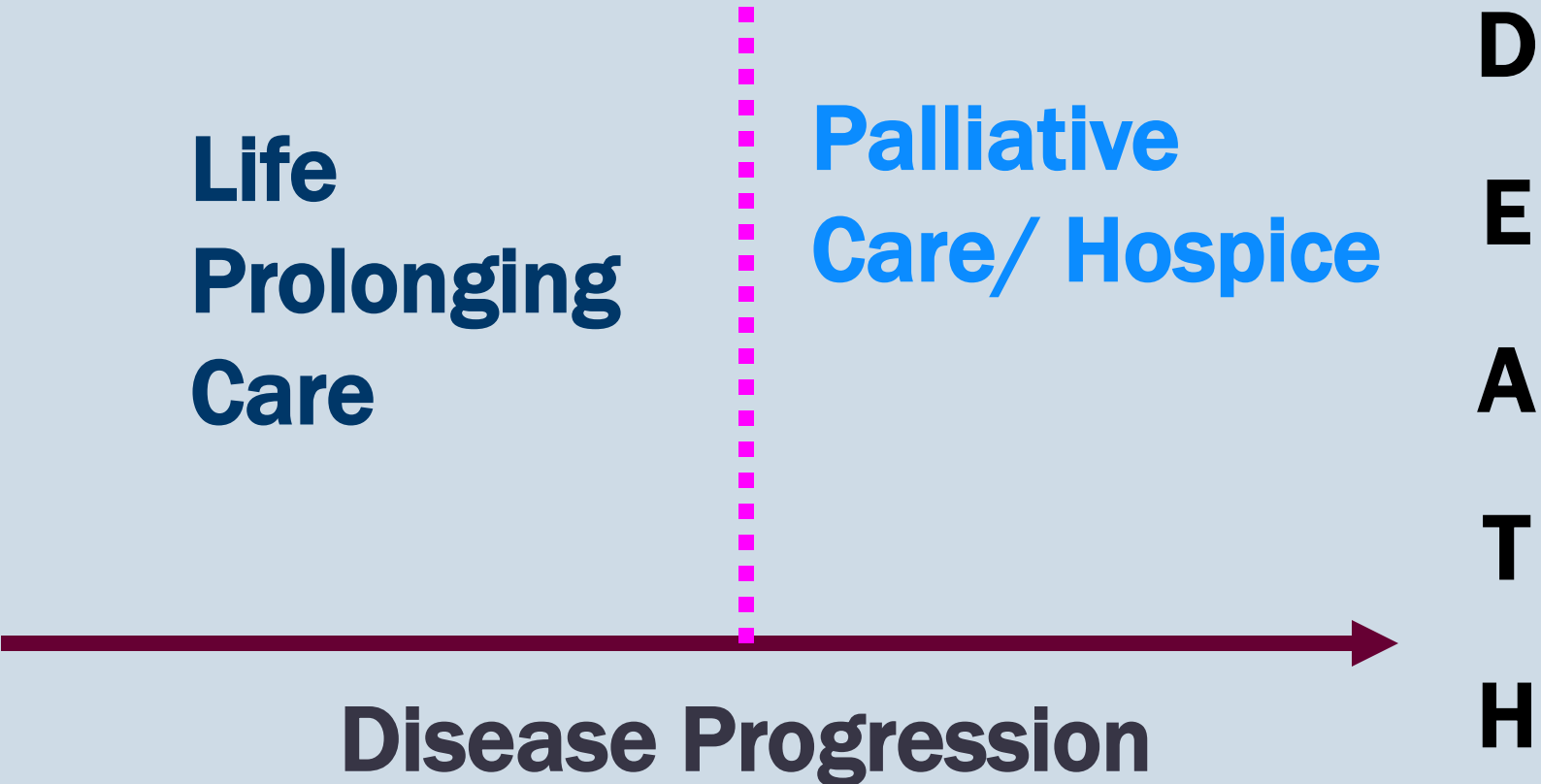
- Consultant delivery model...inpatient, outpatient, home
- Addressing the domains of Palliative Care:
  - **Advance decision making and prognostication**
  - **Complex symptom management**
  - **Psycho-social assessments and interventions**
  - **Spiritual/existential**

# What it is NOT.....

- Palliative Care is not limited to:
  - *End-of-Life Care*
  - *Hospice*
  - *“Death & Dying”*
- Palliative Care is not dependent on prognosis
- Palliative Care is not just for the elderly, it is for patients of all ages

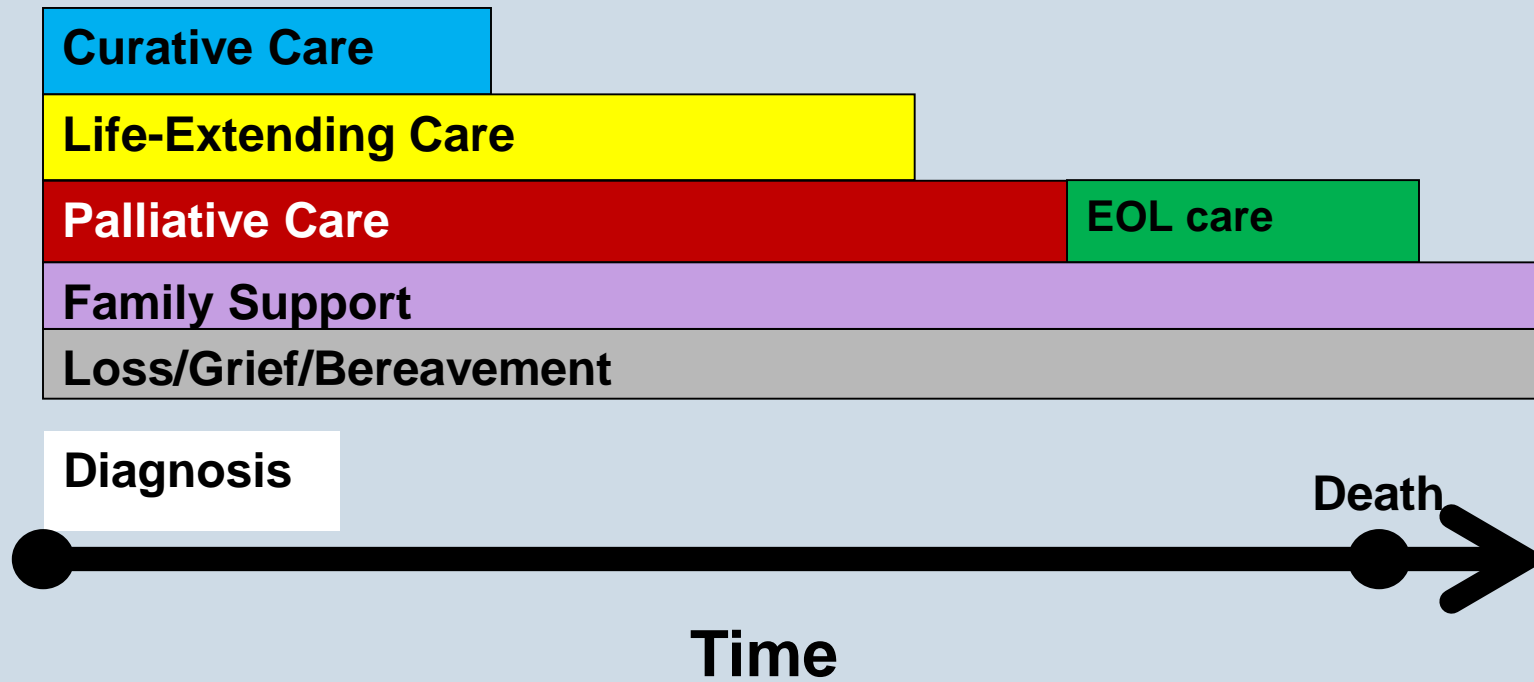


# The Either/Or Paradigm





# Both/&



Adapted from Feudtner et al, BMC Medicine 2003

# When to Consult Palliative Care

- Unrelieved suffering
- 7+ days in the hospital without clear goals
- 3+ days in the ICU without clear goals
- Multiple readmissions for same diagnosis
- DNR/AD uncertainties
- Patient-Family vs. Provider discord



*"There's no easy way I can tell you this, so I'm sending you to someone who can."*



**SOMETHING  
NEW...**



The NEW ENGLAND  
JOURNAL of MEDICINE

# Early Palliative Care for Patients with Metastatic Small Cell Lung Cancer

**Jennifer Temmel, MD, et al**

# Letting Go

*What should  
medicine do when it  
can't save your life?*



By Atul Gawande

July 26, 2010

#1 NEW YORK TIMES BESTSELLER

Atul Gawande



Being Mortal

Medicine and What Matters in the End

READ BY ROBERT PETKOFF  
INCLUDES A BONUS INTERVIEW WITH THE AUTHOR

FORWARD BY ABRAHAM VERGHESE  
WHEN  
BREATH  
BECOMES



air

PAUL KALANITHI

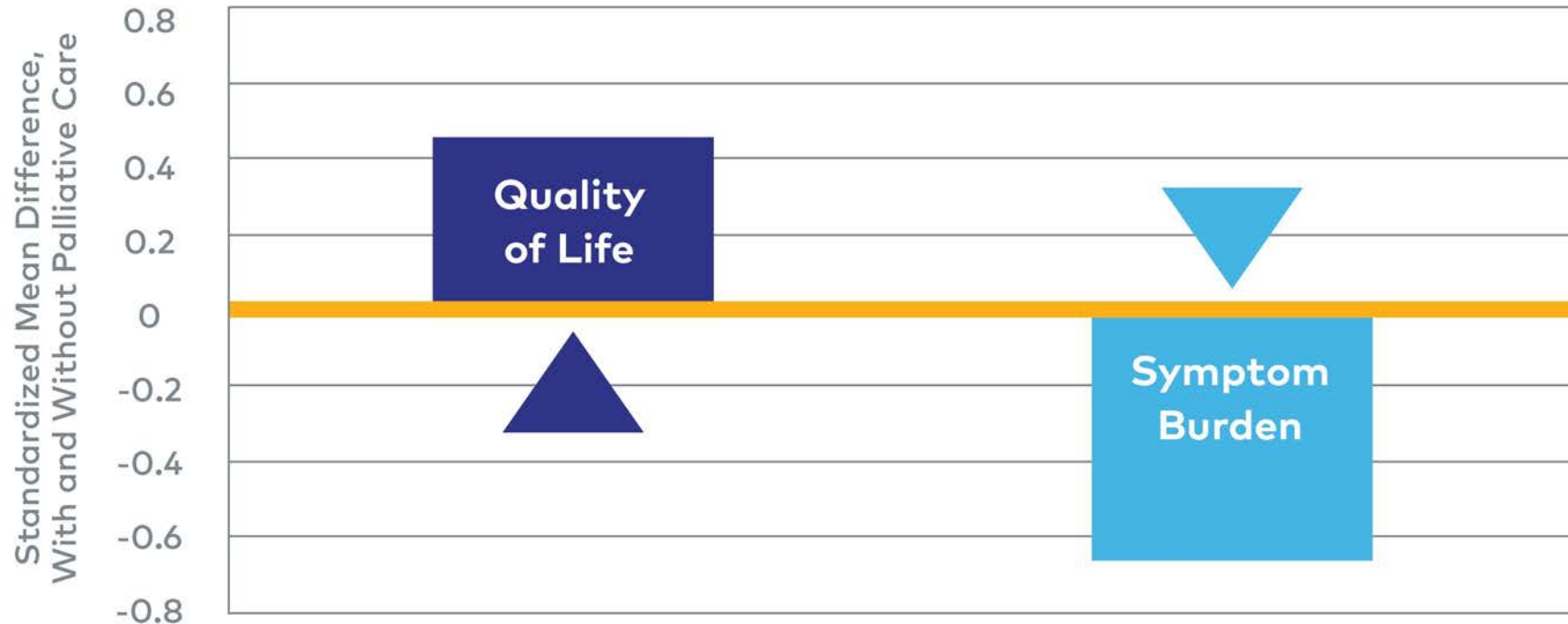
READ BY SUNIL MALHOTRA  
AND CASSANDRA CAMPBELL

AN UNABRIDGED PRODUCTION

Physician led discussion about dying in America

# Palliative care is a standard

## Meta-Analysis Highlights Improvements in Quality of Life and Reduced Symptom Burden through Palliative Care



Kavalieratos, D, J Corbelli, and D Zhang. "Associations Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis." **JAMA, (2016): 316(20).**



**SOMETHING  
BORROWED...**





# Meeting Hospital System Needs

- Improved patient, family and provider experience
- Efficient use of hospital resources
- Increase capacity, reduce costs
- Identifying and eliminating medically invalid options, thus reducing unnecessary and expensive care
- Reduce unnecessary readmissions
- Retain Staff

# The New Normal





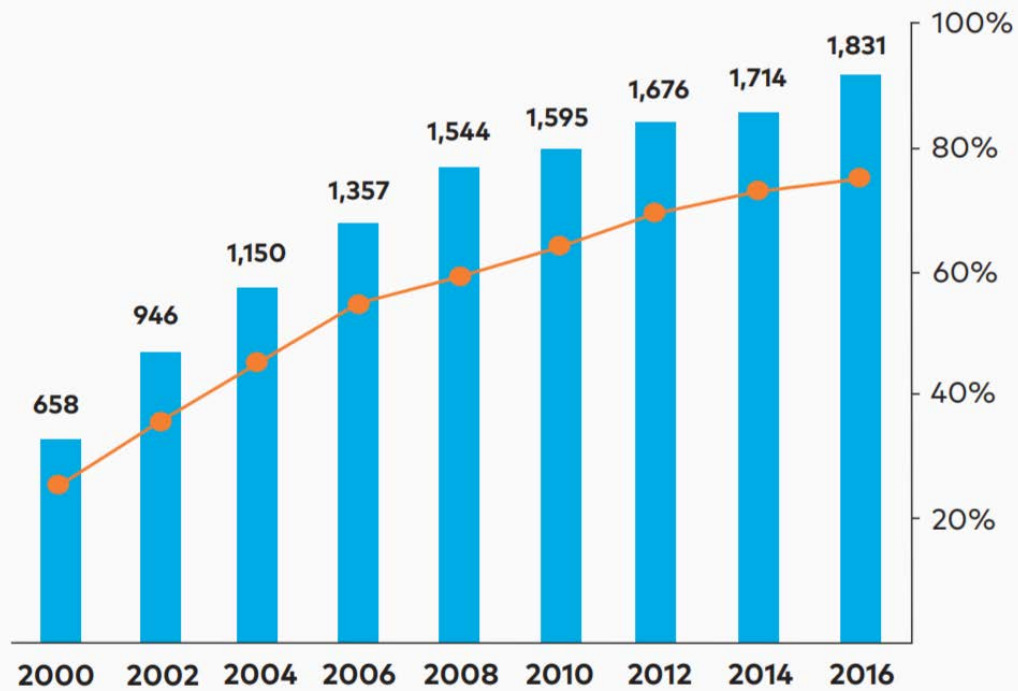
## Palliative Care Programs in U.S. Hospitals with 50 or more beds, 2000-2016\*



Count of Hospitals with Palliative Care Program



Percent of Hospitals with Palliative Care Program

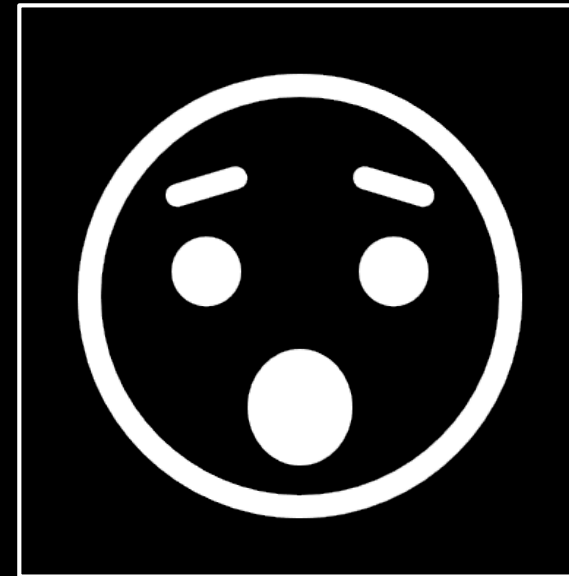
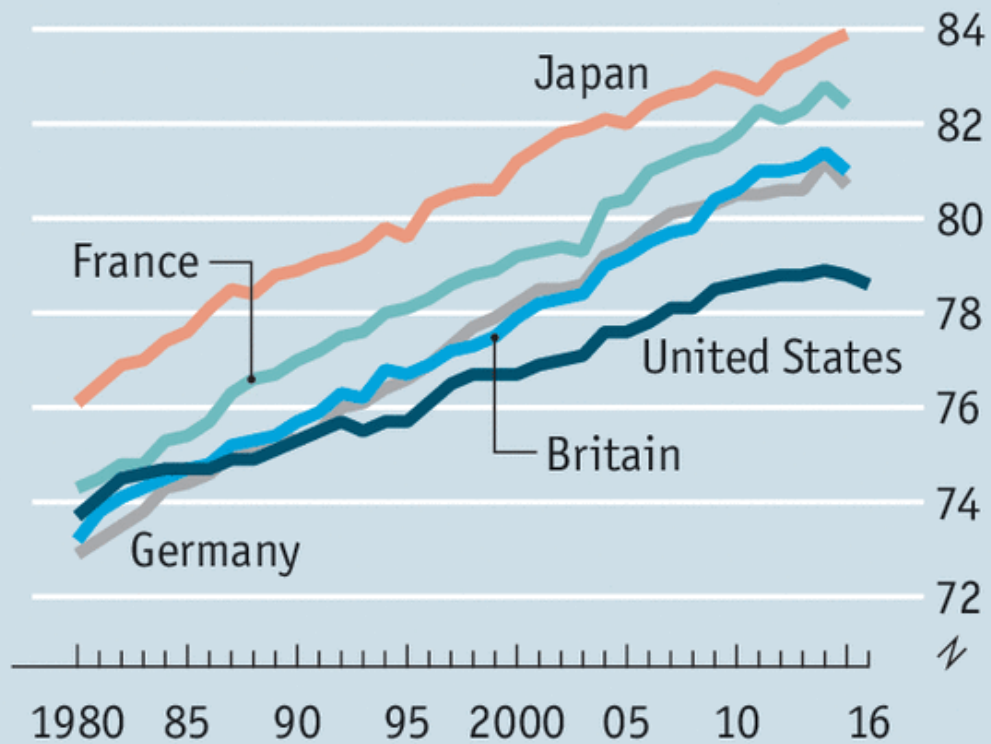




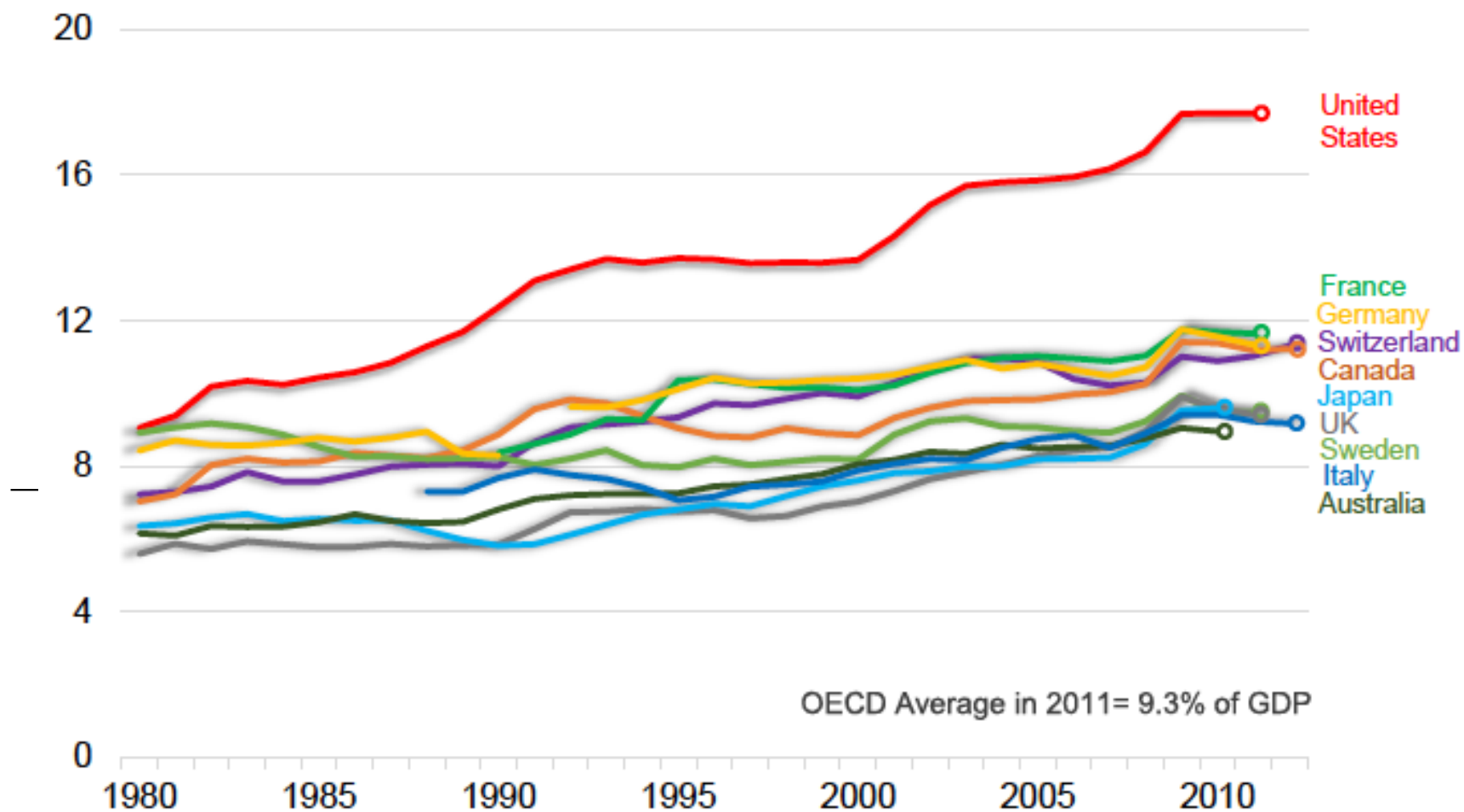
**SOMETHING  
BLUE...**

## Wrong turn

Average life expectancy at birth, years



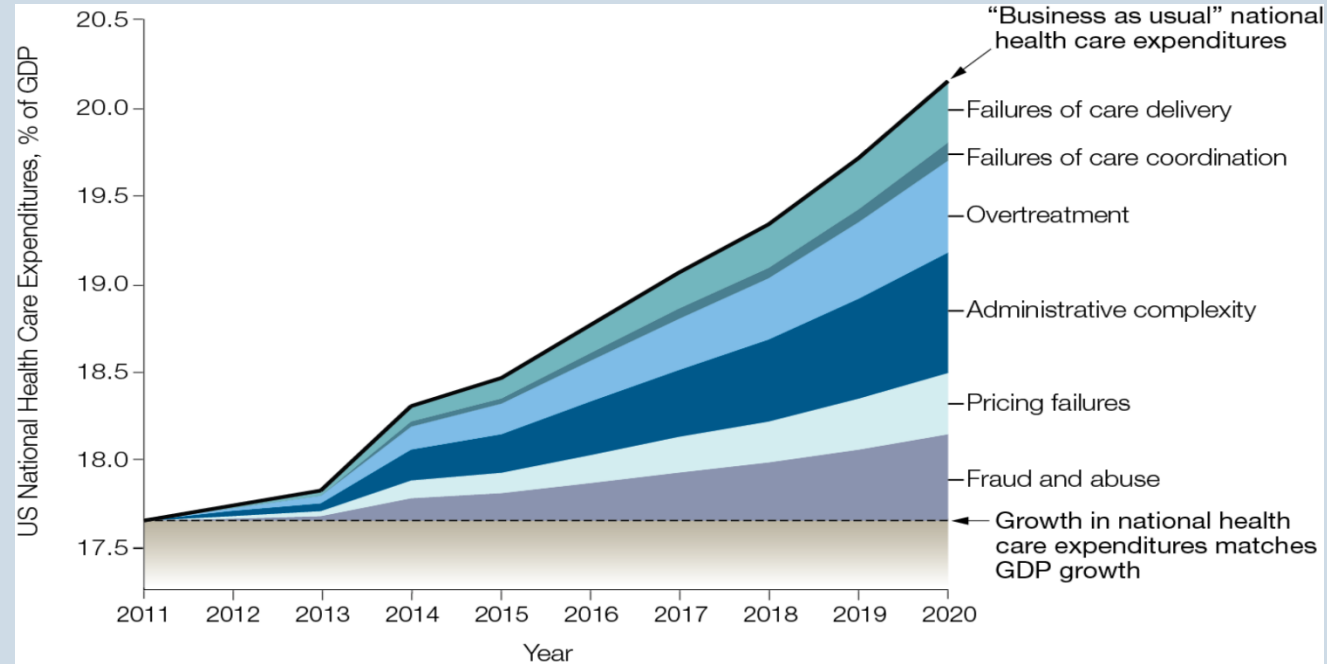
# Health Care Spending as Percentage of GDP



OECD Average in 2011= 9.3% of GDP

Source: OECD Health Data 2013.  
Produced by Veronique de Rugy, Mercatus Center at George Mason University.

# Wedges & WASTE



 The **JAMA** Network

JAMA. 2012;307(14):1513-1516. doi:10.1001/jama.2012.362

Date of download: 9/3/2016

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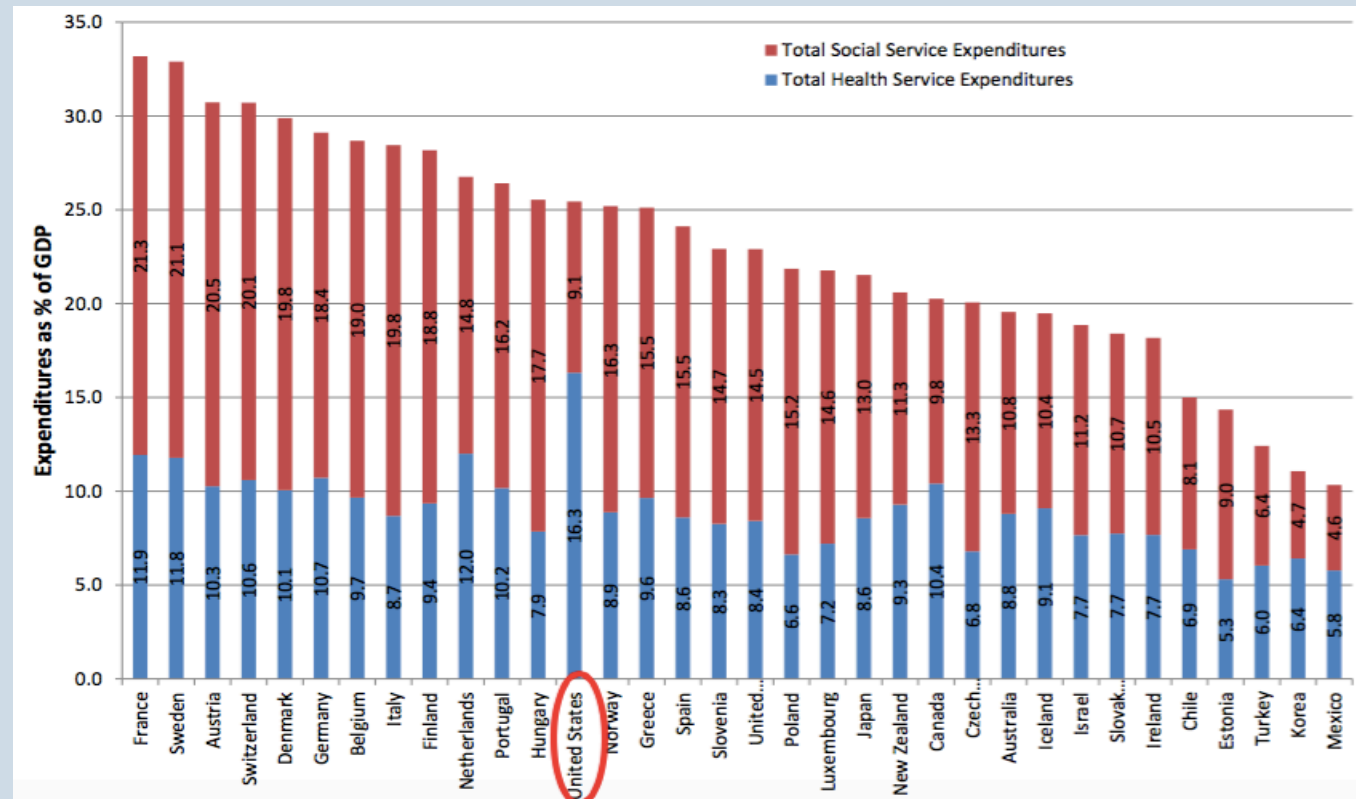
# The Costs of Health Care

- 67% of all Health Care spending goes to the sickest 5% - 10% of enrollees <sup>1</sup>
- Medical Debt contributes to 25% of personal (and corporate) bankruptcy <sup>2</sup>
- When a death occurs, 30% of American Families enter Poverty <sup>3</sup>

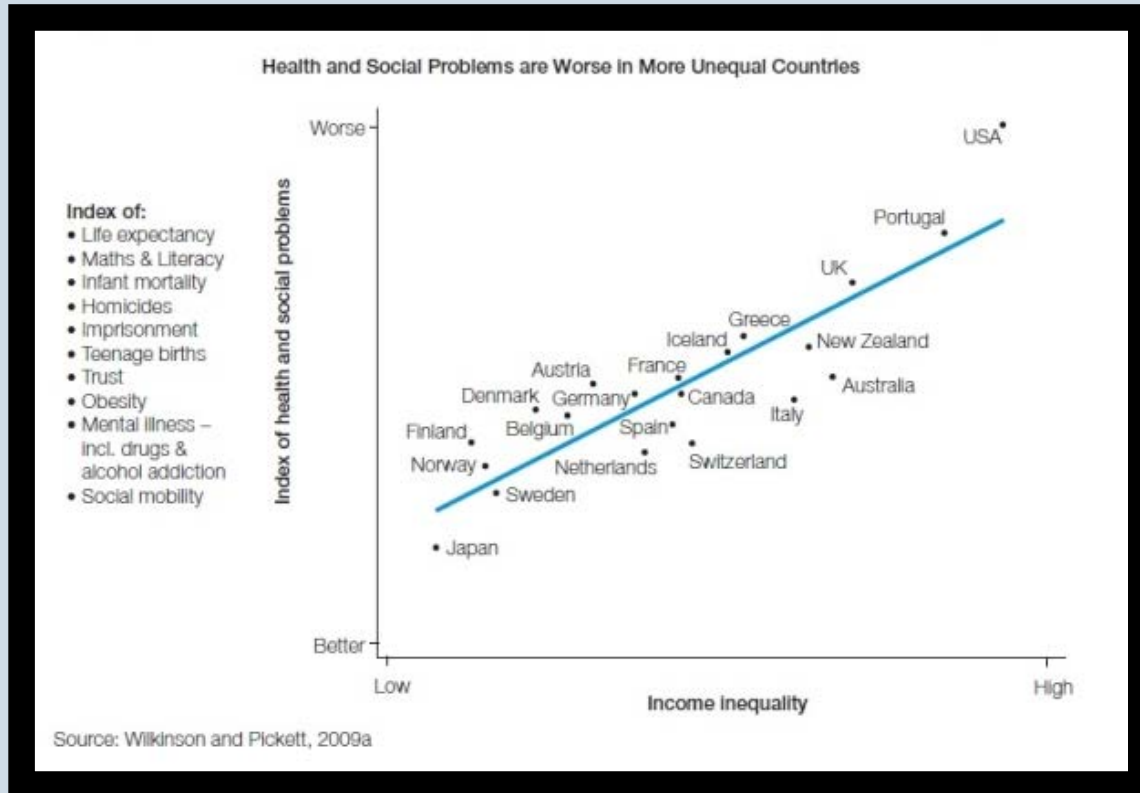
1. Agency for Healthcare Research and Quality (AHRQ)
2. Himmelstein, et al. Health Affairs, Feb 2005,
3. Covinsky, et al. JAMA 1994; 272:1839-44



## Per Capita Health Care and Social Service Spending – 34 OECD Countries

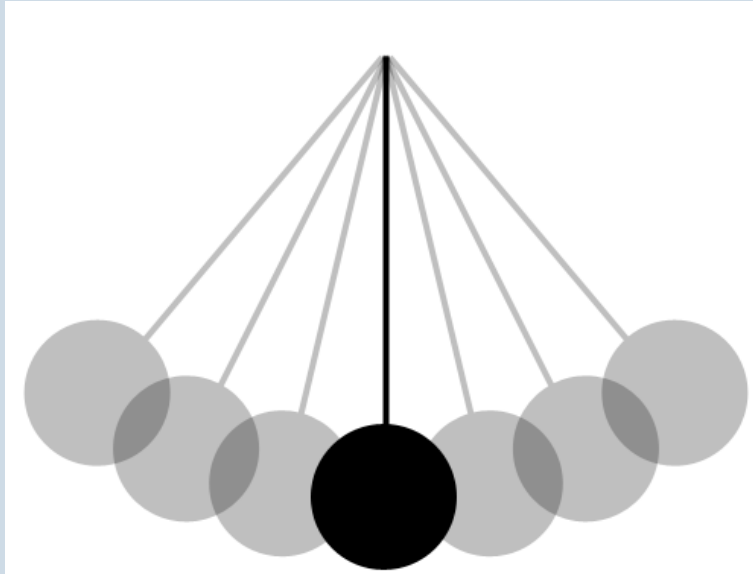


Bradley, E. The American Health Care Paradox, 2013



**INCOME  
INEQUALITY IS  
BAD FOR YOUR  
HEALTH**

# How did we get here?



- Social
  - *WWII & GI Bill*
  - *60's-70's assertion of autonomy*
  - *80's greed culture*
  
- Medical
  - *Biggest growth of medical technology in human history was in the last 100 years*
  - *Paradigm shift:*
    - Paternalism
    - Patient Autonomy
    - Shared Decision making

# Shared decision-making...



- 90% of health has nothing to do with healthcare
- Just because we can doesn't mean we should...
- More doesn't equal better...

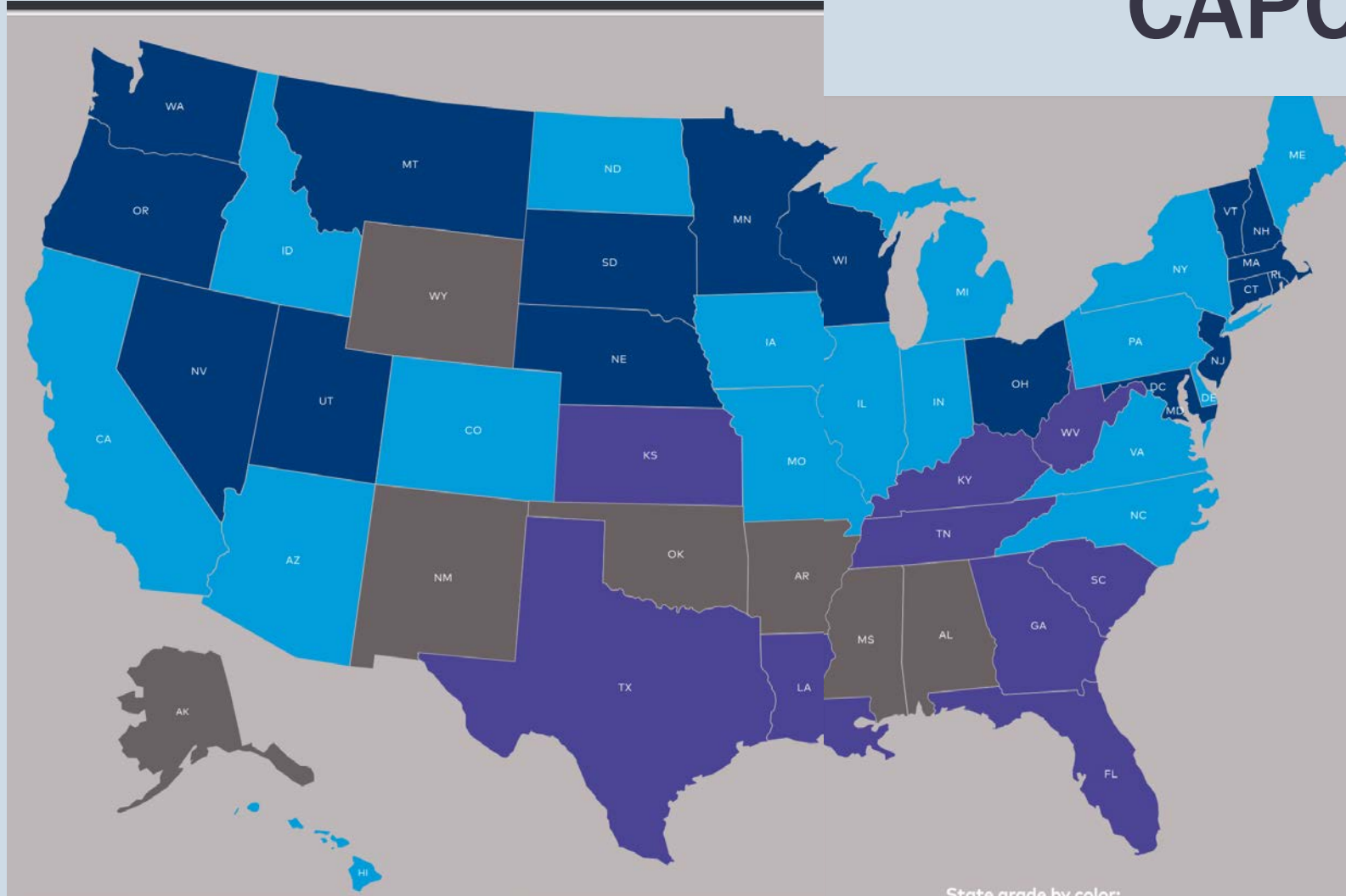
# Estimated National Economic Impact

Estimated savings based on palliative care services at 50% of U.S. hospitals, seeing 1.5% of all admissions:

Direct cost savings = \$1.2 billion/year

Estimates conservative, based on 2007 levels of penetration; relatively high % of live hospital discharges (savings much greater for hospital deaths), payer mix 40% Medicare. Estimates based on Morrison et al, *Arch Intern Med*, 2008; Siu et al, *Health Affairs*, 2009; Berenson et al, RWJF and Urban Institute, 2009. Assumes relatively high % of live hospital discharges (savings much greater for hospital deaths) & payer mix 40% Medicare

# CAPC



State grade by color:

|   |      |   |         |   |         |   |         |
|---|------|---|---------|---|---------|---|---------|
| A | >80% | B | 61%-80% | C | 41%-60% | D | 21%-40% |
|---|------|---|---------|---|---------|---|---------|

## Does your state make the grade?\*

\*As reported in 2013 AHA Annual Survey.

If we are to provide high-quality care for our sickest and most vulnerable patients, access to palliative care services must improve in our hospitals and in our communities.

The availability of palliative care services in U.S. hospitals varies widely by region. For example, in the south-central U.S., no state gained an A or B grade and less than one-third of hospitals in Arkansas, Mississippi and Alabama reported a palliative care team. These south-central regions are most in need of improvement.

In contrast, persons in the northeast and mountain regions have almost universal access to hospital palliative care. All hospitals in New Hampshire and Vermont report palliative care programs, as do 89 percent in Rhode Island and 88 percent in Massachusetts. Farther west, Montana, Nevada and Utah earned A grades with hospital palliative care rates of 100 percent, 92 percent and 85 percent, respectively.

Appendix **Table 1** presents detailed results by state, including hospital palliative care prevalence by hospital type (nonprofit, for-profit, and public), sole community providers and larger hospitals (300 beds or more). These data are limited to hospitals with fifty or more beds. **Table 1** also presents prevalence of palliative care programs among small hospitals (fewer than fifty beds) from the 2013 AHA Annual Survey Database™.

# Summary

- Palliative Care is standard of care for those patients with serious illness...of any age and at any stage
- Palliative Care offers: Prognostication, advance care planning, complex symptom management, psychosocial intervention, and spiritual support

# Summary

- Palliative Care promotes quality of life and shares honest information among patients, family members, physicians, friends, counselors, clergy and attorneys may prevent unnecessary, unwanted, burdensome care in patients with complex illness.



# Summary

- Palliative Care may improve QOL and Survival in Patients with Serious Illness
- At the same time, Palliative Care might reduce our nation's runaway health care spending...



# With Gratitude...

Jennifer K. Clark, MD

[jkclarkmd@outlook.com](mailto:jkclarkmd@outlook.com)

[www.TheGiftofChoosing.com](http://www.TheGiftofChoosing.com)

