Quality Corner Call
July 17, 2019
Noon - 1 p.m.

Palliative Medicine in the Rural Setting

For Audio, please call the following:
U.S. and Canada Toll Free: (866) 740-1260
Required Participant Passcode: 2337436

Palliative Medicine in the Rural Setting

Brandy Ficek, MD, MBA
Medical Director
Palliative Medicine & Supportive Care
Stormont Vail Health, Topeka, KS
July 17th, 2019
Disclosures

I have no relevant financial relationships or commercial interests to disclosure.
Objectives

- Recognize the differences between palliative medicine and hospice services in the care of patients.

- Explain the benefits of palliative medicine for patients, families, and healthcare systems.

- Understand the unique challenges faced in the provision of palliative care in the rural setting.

- Describe the concept of primary palliative medicine.

- Discuss strategies being utilized to improve rural access to palliative medicine.

The only certainty is that every one of us will die. Nothing else in healthcare applies to 100% of patients.
Comprehensive, specialized, interdisciplinary care aimed at improving symptoms and quality of life for patients and families living with advanced or serious illness.

History of Palliative Medicine

- 1950s: Modern day hospice begins
- 1960s: Term “Palliative Medicine” is coined
- 1974: “On Death and Dying” is published
- 1974: Focus expanded to include life-limiting illness
- 2004: Palliative Medicine becomes ABMS recognized subspecialty
# Palliative Medicine ≠ Hospice Care

## Palliative Medicine
- Starts at time of diagnosis
- Not an insurance entity
- Concurrent with curative care
- Hospitalization
- Assist with defining goals
- Symptom focused
- Care for patient and family

## Hospice
- Prognosis of 6 months or less
- Medicare/insurance benefit
- Exclusive from curative care
- Limited Hospitalization
- Goals often defined
- Symptom focused
- Care for patient and family

---

### Palliative Medicine ≠ Pre-Hospice

![Cartoon Image](https://example.com/cartoon.png)

*Image courtesy of Stormont Vail Health, © 2010 cantervisions.com*
Traditional Medical Model

- Medical care for patients with advanced illness is characterized by:
  - Inadequately treated physical distress
  - Fragmented care systems
  - Poor communication between doctors, patients, and families
  - Strains on family caregiver and support systems
5% of Medicare beneficiaries account for > 50% of the cost.

80% of Americans want to die at home.

60% of patients die in a hospital.

<20% of patients actually die at home.

20% of patients die in a nursing home.
Coordinated Medical Model

• Improved:
  – Quality of Life
  – Caregiver Burden and Depression
  – Symptom Distress
  – Patient Satisfaction
  – E.R. and Hospital Readmission Rates
  – Healthcare Costs
Cost Savings

PALLIATIVE CARE REDUCES AVOIDABLE SPENDING AND UTILIZATION IN ALL SETTINGS

- **48%** readmissions
- **50%** admissions
- **43%** hospital/ED transfers
- **36%** total costs

*Source: Center to Advance Palliative Care*

---

Reduction in Hospital Readmissions and Overall Costs...

*Without Shortened Life Expectancy!!!!*
Survival Benefits

Retrospective cohort study of 4493 Medicare patients between 1998-2002

- Increased length of survival for NSCLC by 2.7 months
Timing of Palliative Care

- ENABLE III Trial
- Reaffirmed survival benefits of early palliative care
- Significant improvement in family caregiver depression
- Attempted to define “early”

What about other diseases?
COPD versus NSCLC

More:
- Dyspnea
- Anxiety
- Depression
- Prognosis uncertainty

Less:
- Referrals to palliative medicine (30%)
- Interventions to treat dyspnea
- Independence with ADLs

Growth of Palliative Medicine
PALLIATIVE MEDICINE SHORTAGE

APPROXIMATELY
10% OF ALL PATIENTS SEEN IN A PRIMARY CARE CLINIC HAVE PALLIATIVE CARE NEEDS

NEED TO FILL THE GAP

students graduating from medical, nursing and other health professions typically have very little to no formalized training in basic tenets of palliative medicine such as communication skills, pain and symptom management, advance care planning, care coordination

327 PALLIATIVE MEDICINE PHYSICIANS TRAINED ANNUALLY

APPARXIMATELY TWENTY SIX THOUSAND IS THE NUMBER OF PATIENTS PER ONE PALLIATIVE MEDICINE PHYSICIAN EXPECTED

Rural Access to Palliative Medicine

Decreasing Coverage

840
860
880
900
920
940
960

Rural Hospices

2007 2017

stormontvail.org
Why?

• Financial issues
  – Reimbursement < Operating Costs
  – Rural factors
    • Population change
    • Culture
    • Geography
  – Federal Regulations
  – Workforce Issues
  – Technology issues
Primary palliative medicine refers to the basic skills and competencies required of all primary care physicians.
Basic Competencies

• Primary care physicians should be able to:
  – Assess and manage physical symptoms
  – Assess and manage psychosocial concerns
  – Ensure adequate understanding of illness
  – Establish goals of care
  – Help patients complete advance directives

Foundations of Palliative Medicine
INCREASED PRIMARY CARE VISITS PRECEDEING THE LAST 6 - 12 MONTHS OF LIFE RESULTS IN:
FEWER HOSPITAL DAYS, LOWER COSTS, AND LOWER RATES OF IN-HOSPITAL DEATH

But Wait...
Training

https://www.capc.org/training/
Training Programs

The two new CPT advance care planning codes (99497 and 99498) are used to report the face-to-face counseling and discussing advance directives.
Telemedicine

- MUSC awarded $1.27 million dollar grant
- Establishing statewide network
- Works in conjunction with local team members

Legislation

- Rural Access to Hospice Act
  - Introduced May 2019
- Palliative Medicine Advisory Councils
  - 28 states have passed legislature
  - Kansas
    - Senate Sub for HB 2031
      - Led to establishment of Interdisciplinary Advisory Council & State Palliative Care Consumer and Professional Information and Education Program
Tactics to Improve Access

• Medicaid Reimbursement
  – Arizona, California
• Practice Standards for Facilities
  – Maryland, Colorado
• Leverage Continuing Education Requirements
  – Vermont, Rhode Island

let’s DISCUSS
Upcoming Webinars

- 2019 SHIP Informational Webinars
  - September 20 and December 20
- Quality Corner Calls
  - August 14

Upcoming In-Person Education

- CART Abstraction Training
  - July 23 – Wichita
- Quality 101
  - August 1 & 2 – Topeka
Turning Data into Improvement

• Topics:
  – Refresher of MBQIP measures
  – Discussion of reported quality data
  – Group breakout
  – PDSA development
  – Quality improvement strategies

• Dates offered:
  – May 29 – Garden City
  – June 19 – Emporia
  – August 15 – Belleville

Contact Us

Jennifer Findley
jfinitely@kha-net.org
785.233.7436

Susan Runyan
srunnyan@kha-net.org
620.222.8366

Susan Cunningham
scunningham@kha-net.org
785.276.3119
This project was federally funded through KDHE-BCHS-FLEX Program. The FLEX program is managed by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services.