Disclosure Information

Promoting palliative care for patients with ESRD: Why, When and How
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I will not discuss off label use/or investigational use in my presentation.

PROMOTING PALLIATIVE CARE FOR PATIENTS WITH ESRD: WHY, WHEN AND HOW

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Outline

- Palliative care needs among patients with ESRD
- Facilitators
- Barriers
- Approaches to improve palliative care

One third of Medicare spending is attributed to patients with chronic illness in the last 2 years of life

ICU days during the last six months of life

Patients seeing 10 or more doctors during the last six months of life

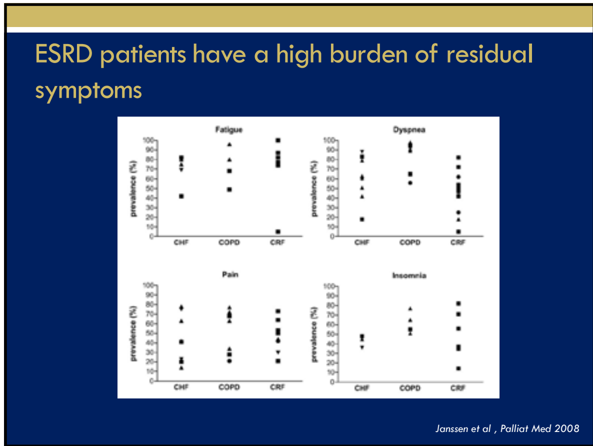
Goodman DC, Dartmouth Atlas

The value crisis is encapsulated in the Medicare ESRD program

USRDS Annual Data Report

The cost of dialysis care increases with comorbidity

USRDS Annual Data Report



Potential facilitators of palliative care

- Medicare is primary payor for >80% patients
- Two for-profit companies control 67% of the dialysis market share
- Between these entities, ~215,000 dialysis patients

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DaVita

Fresenius Medical Care

Potential facilitators of palliative care

- A value-based purchasing program, the ESRD QIP, was implemented by Medicare in 2012
- Quality measurement and reporting systems (CROWN Web and USRDS)
- Elements of multidisciplinary care teams exist in many centers

Barriers to palliative care in ESRD

- ACCESS TO CARE
- CAPACITY/WORKFORCE
- EVIDENCE BASE

5 policies to promote palliative care in ESRD:

1. Universal screening for palliative care needs
(ACCESS)

Geographic variations in dialysis withdrawal and hospice utilization

6.20 Patients withdrawing from dialysis (percent) 2005–2006 ESRD patients

6.21 Patients who withdrew from dialysis (%) & used hospice (2005–06) ESRD pts

USRDS ADR 2008

Regional intensity of care and dialysis discontinuation

Error bars represent 95% confidence intervals.
*The first is the lowest end-of-life expenditure index quintile and the fifth is the highest quintile.

O'Hare AM, JAMA 2010

Table. Intensity of Care During the Final Month of Life

Intensity of Care	Dialysis (Present Study)	Cancer[7]	Heart Failure[8,9]
	Medicare Beneficiaries		
Hospitalization, %	76.0	61.3	64.2
Days hospitalized, mean	9.8	5.1	NA
Intensive care unit admission, %	48.9	24.0	19.0
Days in an intensive care unit, mean	3.5	1.3	NA
Any intensive procedure, %	29.0	9.0	NA
Hospice use, %	20.0	55.0	39.1
Death in a hospital, %	44.8	29.0	35.2

Wong SP, Arch Int Med 2012

Policy #1: Universal screening for palliative care needs

Barrier addressed	Stakeholders	Examples of implementation
Access	Nephrologists Dialysis providers Insurers Clinical orgs	Screen patients with the SQ at transitions in care (dialysis initiation, hospital admission) Standardized symptom assessments and treatment algorithms for pain, depression, sleep disorders

Palliative care consultation after screening hospitalized patients with the surprise question – an RCT

Measure	Palliative care screening versus Usual care (N=512)
Index Hospitalization LOS	No difference
Median survival	No difference
Days to hospice	No difference
Hospice LOS	↑ 12 days (50% ↑)
Advance directives	↑ 13%
QOL	No difference
Satisfaction with care	↑ 8%
Total costs ($)	↓ $6700
ICU admissions	↓ 45%

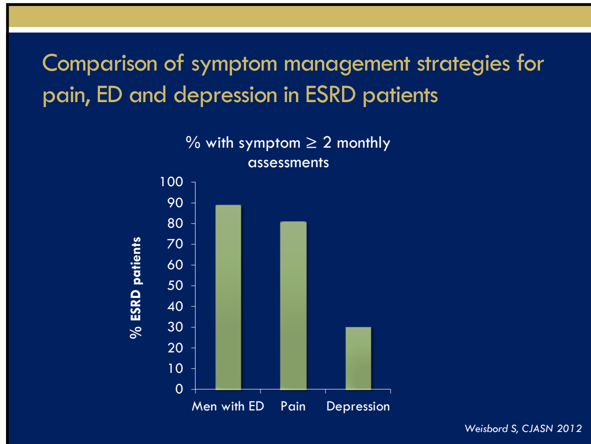
2% had ESRD

Gade G, J Pall Med 2008

A Controlled Trial of Outpatient Palliative Medicine Consultation

Measure	Palliative care consult vs. usual care (N=90)
Dyspnea	↓ 20%
Sleep	↑ 13%
Pain	No difference
Depression	No difference
QOL	No difference
Satisfaction with care	No difference
Clinic visits	↓30%
Hospitalizations	No difference
Charges	No difference

Rabow M, Arch Int Med 2004



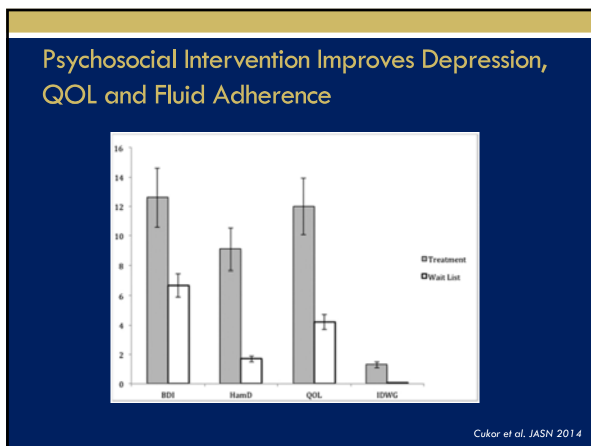
Treatments implemented

	Pain	ED	Depression
RN mgmt	25%	11%	21%
Feedback	42%	5%	29%

Effect on symptoms

	Pain	ED	Depression
RN mgmt vs. obs	NS	↓ 5%	↓ 8%
Feedback vs. obs	↓ 7%	↓ 7%	↓ 12%
RN mgmt vs. feedback	NS	NS	NS

Weisbord S, CJASN 2012



5 policies to promote palliative care in ESRD :

1. Universal screening for palliative care needs during transitions in care (ACCESS)
2. Incorporate palliative care measures in the ESRD Quality Incentive Program (ACCESS)

Policy #2: Incorporate palliative care measures in ESRD QIP

Barrier addressed	Stakeholders	Examples of implementation
Access	Nephrologists Dialysis providers CMS/other Insurers	Incorporate NQF endorsed palliative care metrics

Palliative care measures endorsed by NQF

Domain	Example Data Collection Tools
Symptom Assessment	Edmonton Symptom Assessment Scale Palliative Care Outcome Scale Dialysis Symptom Index McGill Pain Questionnaire Patient Health Questionnaire 9
Goals of care	Physician Orders for Life Sustaining Treatment (POLST) Appointment of health care agent Documentation of advance care planning
Support to patients and caregivers	Consumer Assessments and Reports of End of Life Care (CARE) Bereaved Family Survey (PROMISE)
Transition management	Care Transitions Measure

adapted from Weissman et al.

Why measure goals of care documentation?

- 15-35% of ESRD patients complete an AD
- 43% of deaths are preceded by a treatment decision
- Of these, 70% of patients lacked decision-making capacity

Silveira MJ, NEJM 2010

www.Geripal.org

CMS Disease Management Demonstration

Figure 6.1: Percentage of Patients with an Advanced Care Plan by Month, DMO B, 2006-2008*

5 policies to promote palliative care in ESRD:

1. Universal screening for palliative care needs during transitions in care (ACCESS)
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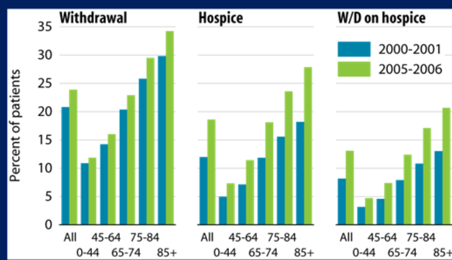
3. Payment reforms (ACCESS/CAPACITY)

Medicare Hospice Benefit for ESRD

- **50.6.1.4 – Coverage Under the Hospice Benefit**
- *If the patient's terminal condition is not related to ESRD, the patient may receive covered services under both the ESRD benefit and the hospice benefit. A patient does not need to stop dialysis treatment to receive care under the hospice benefit. Consequently, hospice agencies can provide hospice services to patients who wish to continue dialysis treatment.*

Hospice utilization in the US ESRD program



USRDS ADR 2008

Costs and length of hospice stay among ESRD decedents

Measure	Mean days in hospice	Costs last week of life ($)
All deaths	2	4827
All hospice patients	14	1883
All non-hospice patients	0	5428
All dialysis withdrawals	4	3502
Hospice patients	10	1858
Non-hospice patients	0	4878

Murray AM, CJASN 2006

Policy #3: Payment reforms for palliative care services

Barrier addressed	Stakeholders	Examples of implementation
Capacity	CMS	Concurrent care models (i.e. dialysis + hospice care) Shared savings model (i.e. including non-ESRD services in the "bundle") Compensation for time-intensive cognitive services (could be supported by MIPAA)

5 policies to promote palliative care in ESRD:

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3. Payment reforms (ACCESS/CAPACITY)
4. Palliative care training for ESRD providers (WORKFORCE)

The palliative care workforce shortage

- Board certification in 2006
- 78 fellowship training programs
- Shortfall of 3000-7500 MD FTEs to meet current demand
- 40% of hospitals lack palliative care services, most are community hospitals

Meier D. Millbank Q 2011

What do nephrologists say?

- Survey of 121 medical directors from 3 dialysis organizations (64% response rate)
- Themes:
  - Nephrologists feel prepared to discuss end-of-life issues and provide prognostic estimates if asked
  - Main barrier to discussing end-of-life issues is patient resistance; other important barriers are fear of taking away hope, poor care continuity, unclear delegation of responsibility, and lack of confidence in prognostic models

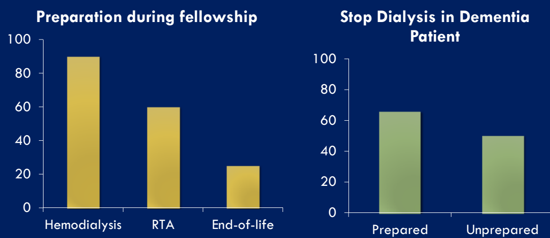
Schiller B, unpublished

What do patients say?

- From a Canadian study of 584 stage 4-5 CKD patients
  - Poor knowledge of palliative care options
  - 61% regretted decision to start dialysis
  - 65% were comfortable discussing end-of-life issues
  - but 90% had not discussed prognosis with their nephrologist

Davison SN, CJASN 2010

Training matters



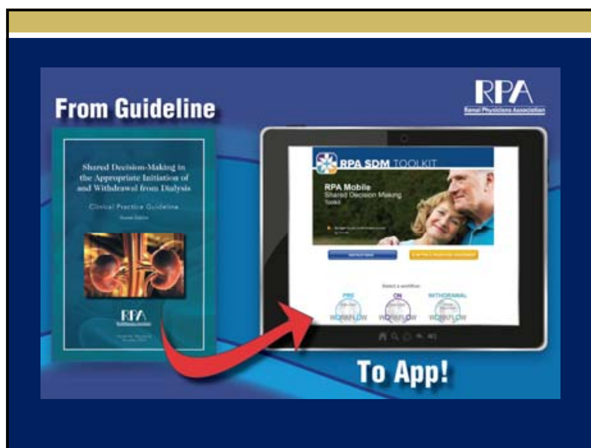
Holley JL, AJKD 2003; Davison SN, CJASN 2006

Policy #4: Train the nephrology workforce to deliver palliative care

Barrier addressed	Stakeholders	Examples of implementation
Capacity	Fellowship programs Accreditation orgs Professional societies	Enhance palliative care content in nephrology fellowship curriculum Assess competency in palliative care during fellowship Emphasize training for dialysis RNs, social workers, pharmacists

Training the Nephrology workforce in palliative care

- RPA Guidelines on Shared Decision Making
- ASN Geriatric Nephrology Training Curriculum & Travel Grant
- Dimitrios G. Oreopoulos Visiting Professor Program in End-of-life Care
- Coalition for Supportive Care of Kidney Patients
- Nephrotalk



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4. Palliative care training for ESRD providers (WORKFORCE)
5. Fund palliative care research (EVIDENCE BASE)

www.ClinicalTrials.gov

- 'ESRD' – 1161 studies
- 'ESRD' and 'symptom' – 152 studies
- 'ESRD' and 'quality of life' – 132 studies
- 'ESRD' and 'pain' – 32 studies
- 'ESRD' and 'palliative' or 'hospice' – 3 studies
- 'Cancer' and 'palliative' – 420 studies

NIH funded palliative care research 2006-2010

Institute	N, (%)
All NIH	391
NIA	71 (18)
NCI	125 (32)
NHLBI	5 (1)
NIDDK	1 (0.3)

Gelfman L, J Palliat Med, 2012

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2. Incorporate palliative care measures in the ESRD quality incentive program
3. Payment reforms
4. Palliative care training for ESRD providers
5. Fund palliative care trials

Palliative care vs. Hospice care

Nat'l consensus project for palliative care, 2004