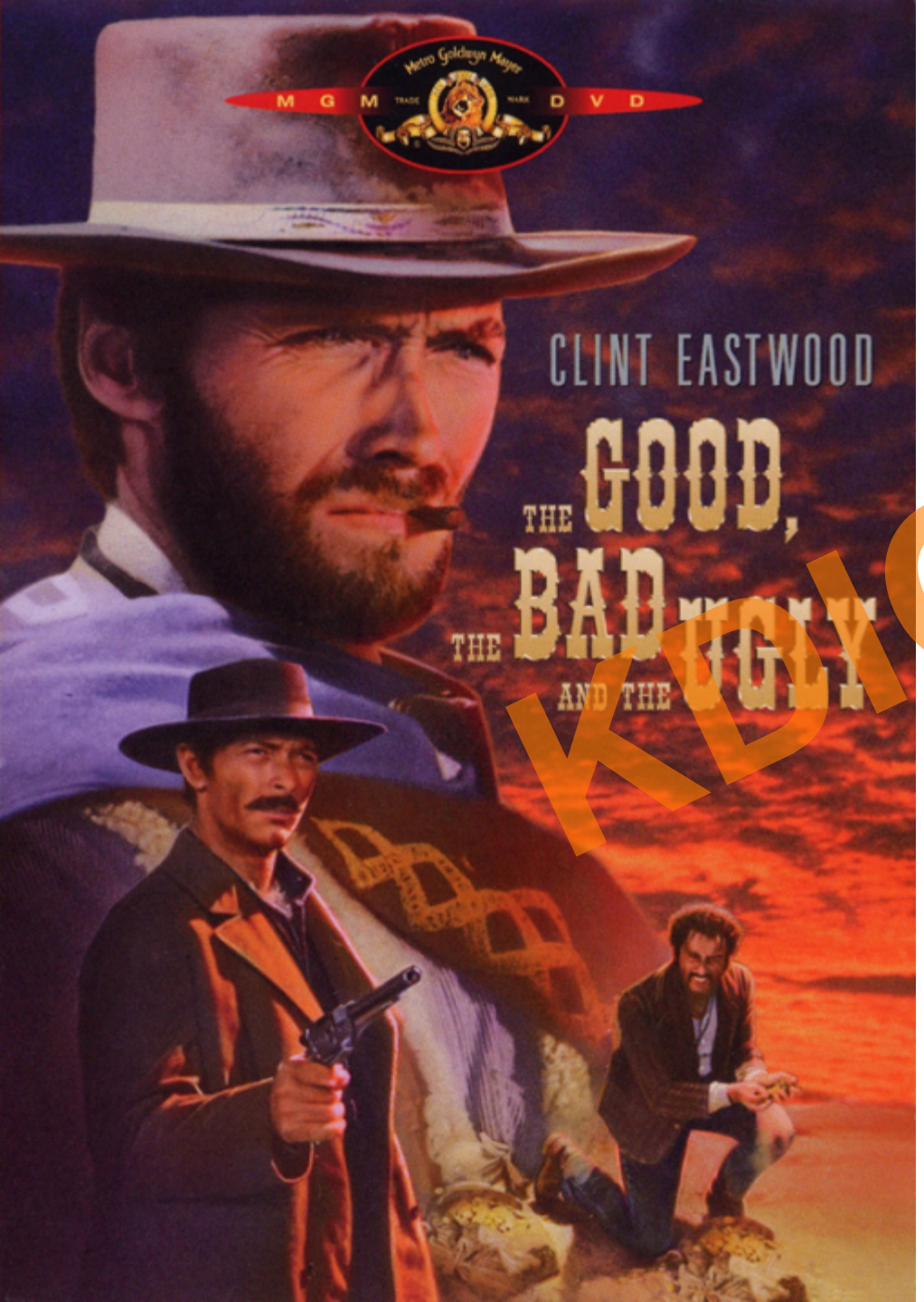


Integrated Renal Palliative Care: The North American Experience

Sara Davison

Integrated Palliative Care in Canada

- Publicly funded health care system (income taxes)
- Free at the point of use - supplemental insurance can be purchased
- Each province manages their own health care system – accountable for the quality of the care through federal standards
- Universal access
- All essential care is covered, includes dental and vision.

Canada Health Act

Public administration: on a non-profit basis, responsible to the provincial government and subject to audits.

- Reduces ability for private insurers to cover insured services

Comprehensiveness: insurance plans must cover "all insured health services provided by hospitals, medical practitioners or dentists“

Universality: All insured persons must be covered.

Portability: covering individuals who are in another province.

Accessibility: must provide for "reasonable access" to insured services

Canadian Senate Reports 2010 & 2011

The Senate of Canada

Le Sénat du Canada

Raising the Bar:

A Roadmap for the Future of Palliative Care in Canada

June 2010

The Honourable Sharon Carstairs, P.C.

The Senate of Canada

Parliamentary Committee on Palliative and Compassionate Care

Not to be Forgotten

Care of Vulnerable Canadians

Harold Albrecht MP Co chair

Joseph Comartin MP Co chair

Frank Valeriote MP Co chair

Kelly Block MP

Francis Scarpaleggia MP

Committee Co founders

November 2011

ALBERTA QUALITY MATRIX FOR HEALTH USER GUIDE

Dimensions of Quality	Acceptability	Accessibility	Appropriateness	Effectiveness	Efficiency	Safety
	Health services are respectful and responsive to user needs, preferences and expectations.	Health services are obtained in the most suitable setting in a reasonable time and distance.	Health services are relevant to user needs and are based on accepted or evidence-based practice.	Health services are provided based on scientific knowledge to achieve desired outcomes.	Resources are optimally used in achieving desired outcomes.	Mitigate risks to avoid unintended or harmful results.
Areas of Need						
Being Healthy Achieving health and preventing occurrence of injuries, illness, chronic conditions and resulting disabilities.						
Getting Better Care related to acute illness or injury.						
Living with Illness or Disability Care and support related to chronic or recurrent illness or disability.						
End of Life Care and support that						

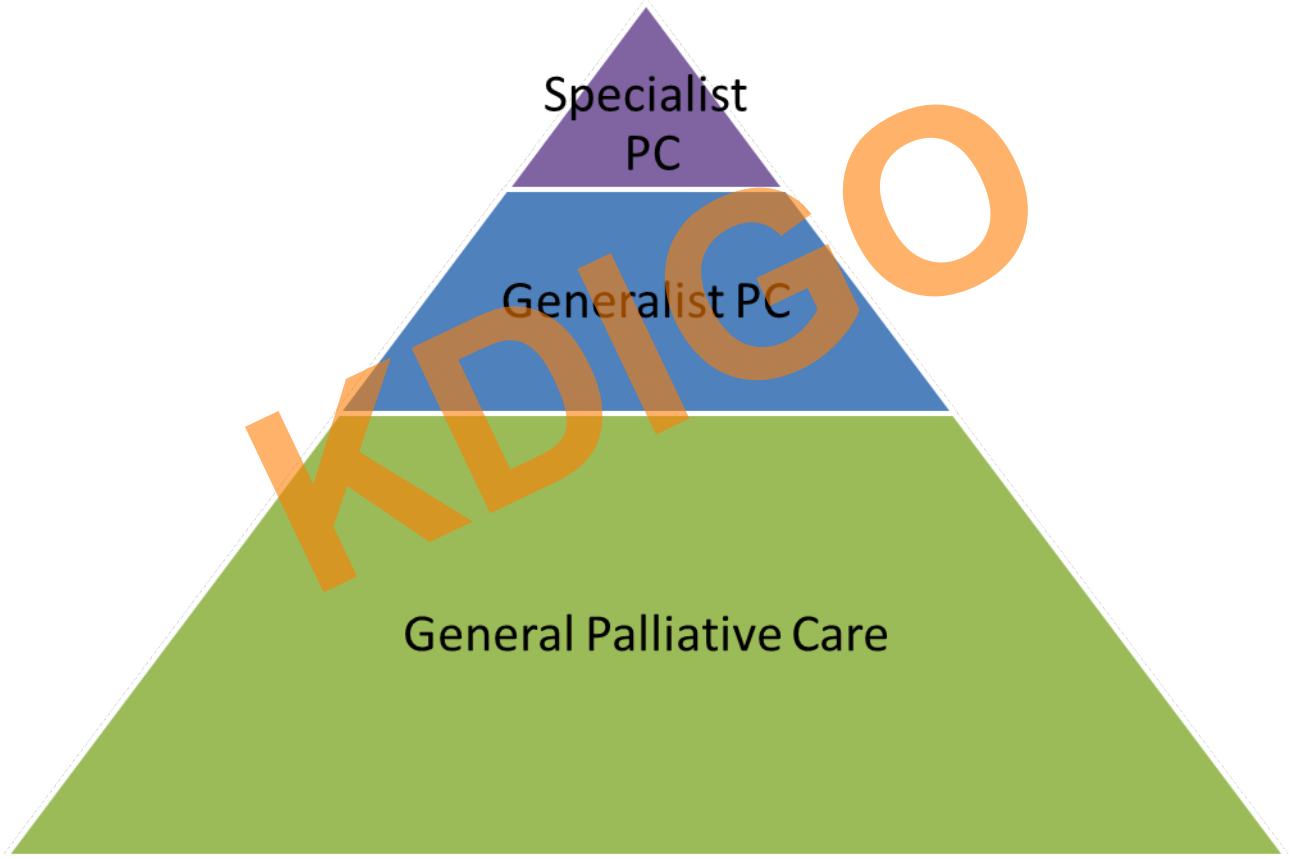
Burden of Chronic Disease (CKD)

- **62% of people in NA die with a chronic illness**
  - **The vast majority of these patients do not access specialist palliative care despite tremendous needs**
  - **Chronic disease programs have yet to successfully integrate appropriate and timely access to palliative care**
- 8 million individuals with GFR < 60 ml/min/1.73m^2 in the US
- Alberta, Canada: 45 Nephrologists serve ~ 2 million km^2; > 20,000 patients with > 1g/day of albuminuria & have never seen a nephrologist
- Current models of palliative care in NA are unable to meet the needs of patients with advanced CKD.

3 Levels of Palliative Care in Canada

- **General Palliative Care:** intended to integrate basic PC methods and procedures in general settings of care.
- **Generalist Palliative Care:** additional general PC training for clinicians frequently involved with PC patients or acting as a resource person for PC in their setting of care but for whom PC is not the main focus of their clinical practice.
- **Specialist Palliative Care:** consultant level PC for clinicians working solely in the field of PC and whose main activity is devoted to dealing with complex problems requiring specialized skills and competencies.

3 Levels of Palliative Care in Canada



Pallium Canada

working together to improve the quality of living and dying in Canada

Funded by Health Canada (2009): $3 million in 2013

To create curricula and etools (educational resources and clinical decision-support) for HCP to ensure capacity for timely general and generalist PC

Canadian Hospice Palliative Care Association

Speak Up

"Start the conversation about end-of-life care."

Home | About Advance Care Planning | Make Your Plan | Blog | Contact Us | Français

Community Organizations | Health Care Professionals | Researchers | Personal Stories | News Room | CoP | Search

Imagine - one day, without warning, you find yourself in a hospital, unable to communicate. Who would speak for you and make health care decisions for you?

Learn more about Advance Care Planning.

Quick Links

- News
- Our Blog

Integrated Specialist Palliative Care in Canada?

Regional Palliative Care Programs: cost shifting

- AB, BC……ON is developing programs
- Each province (region) negotiates separately, no consistency in how PC is prioritized
- Still under-resources areas

Alberta: fully integrated specialist palliative care

- **Consult service**: MD, RN, home care RN – co-manage with GP
  - Acute care, LTC, home care
  - Contract out home care aids (private companies) and hospice
  - Minimal gate keeping (except for hospice)
  - Patients can make initial consult in some programs
- **In-patient care (units):** tertiary pc/ in-patient hospice
- **Out-patients services (clinics)**
  - 24 hr access to opioids

Nephrologists EOL Decision-Making

	Canada & United States	
	1990	2005
Prepared for EOL DM		39%
W/D dialysis: permanently unconscious	83%	90%
W/D dialysis: severely demented	39%	53%
HD units: written resuscitation policy	31%	86%
HD units: written W/D policy	15%	30%
Honour patient's DNR	66%	83%

Canadian nephrologists: more likely to withdraw dialysis in keeping with current RPA guideline

Integrated Renal Palliative Care?

- Depends upon the priority of PC within any renal program and linkages with their PC programs/colleagues

AB: Provincial RPC Program

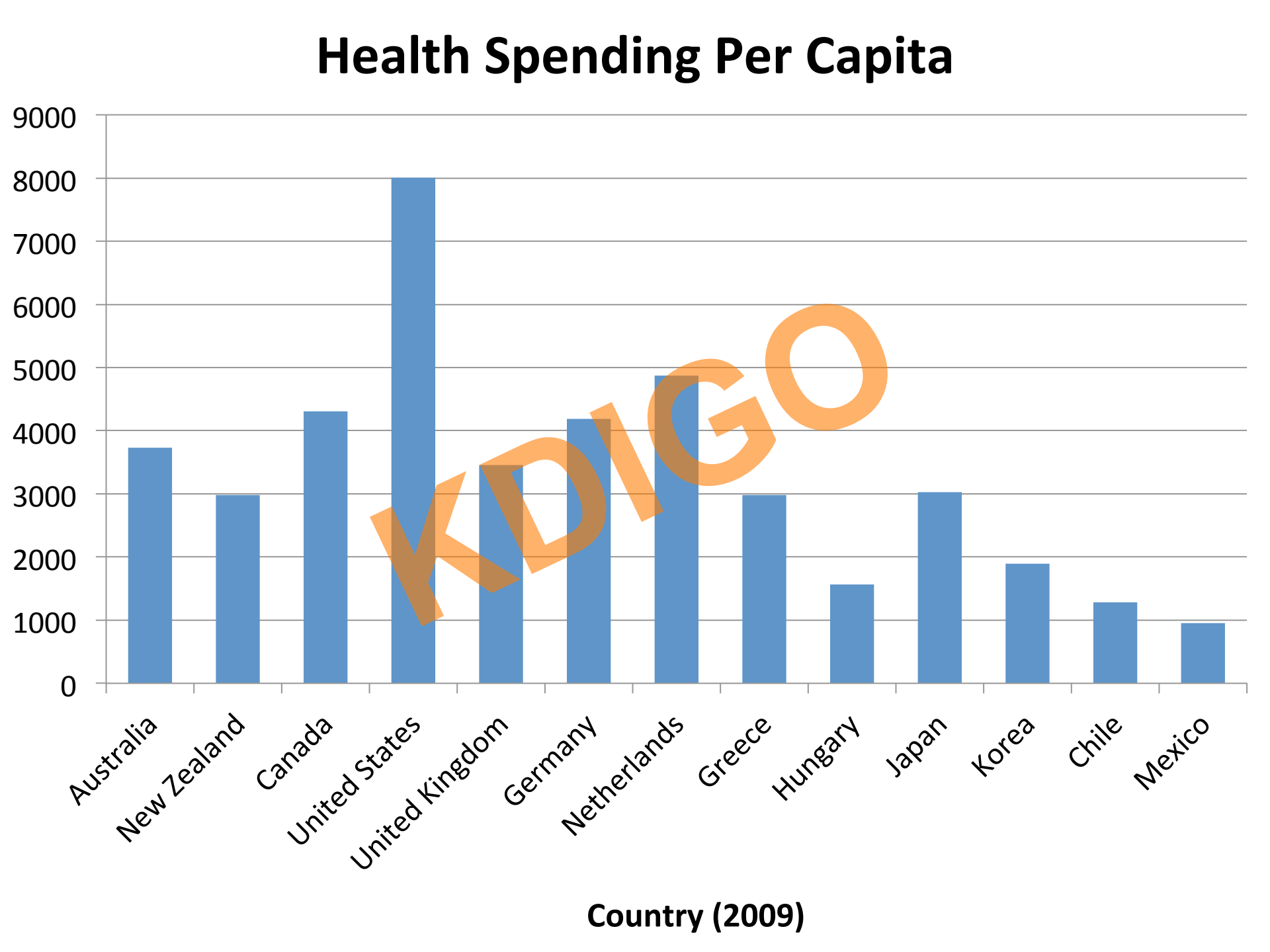
- Routine identification of patients with high PC needs: prognostication, spiritual and symptom assessments, fct status, QOL
- Facilitated ACP
- Chronic pain assessments and management algorithms
- Primarily out-patient focused

BC: a priority at the regional renal program level

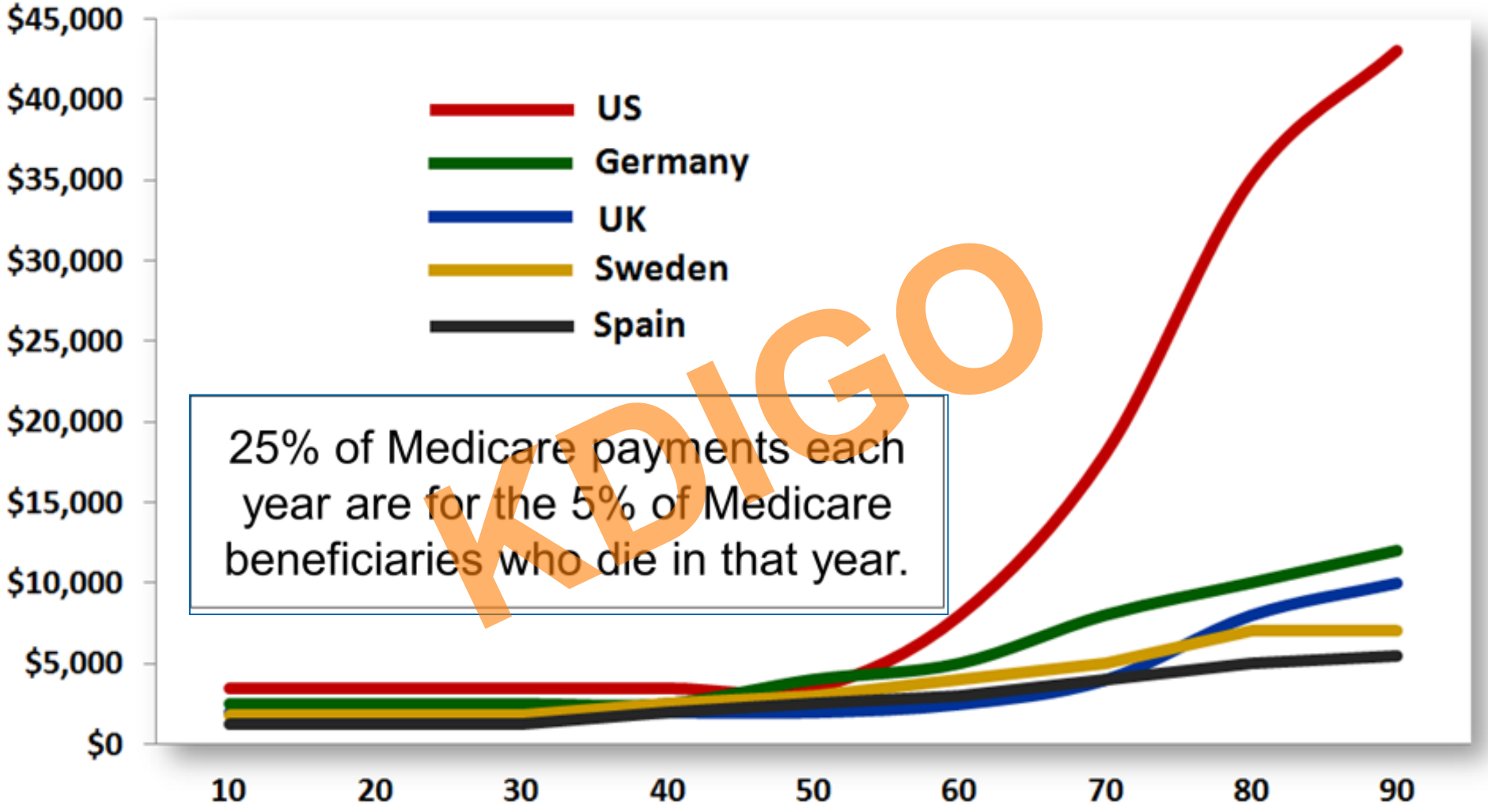
- sporadic integration of several of the above elements with intentions to continue developing the program

Healthcare in the United States

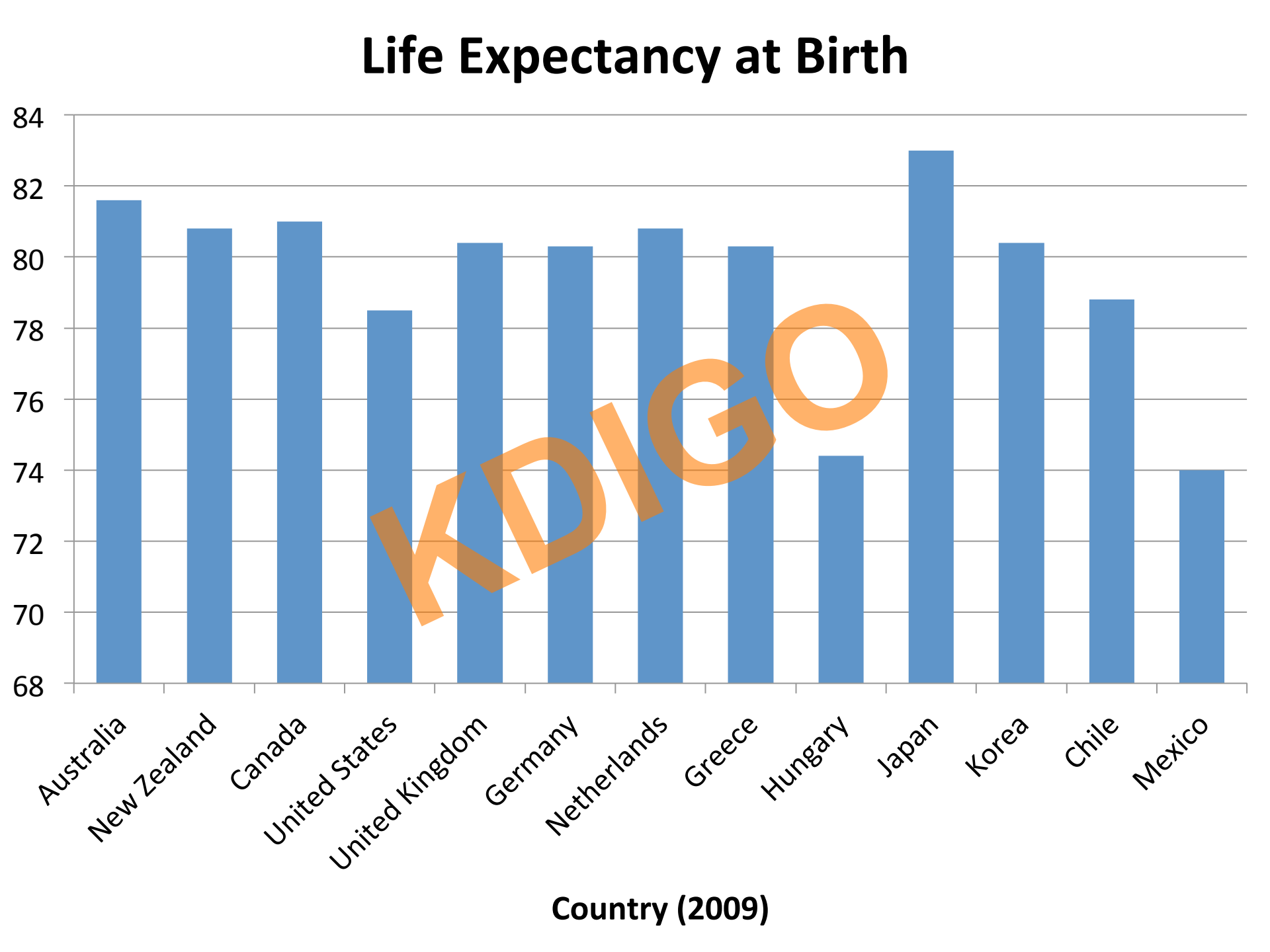
- Healthcare in the US is largely owned and operated by private sector businesses.
- > 60% of healthcare funding comes from programs such as Medicare, Medicaid, and the Veterans Health Admin.
- Most under 65-67 are insured by an employer
  - Some buy health insurance on their own
  - **49.9 million residents, 16.3% of the population, were uninsured** in 2010 (up from 49.0 million residents, 16.1% of the population, in 2009). U.S. Census Bureau
  - **The US** is among the few industrialized nations in the world that **does not guarantee access to healthcare** for its population. (others = Mexico & Turkey)
  - all other OECD countries achieved near-universal (>98% insured) coverage by 1990


Health Spending Per Capita
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Australia
New Zealand
Canada
United States
United Kingdom
Germany
Netherlands
Greece
Hungary
Japan
Korea
Chile
Mexico
Country (2009)
KDIGO

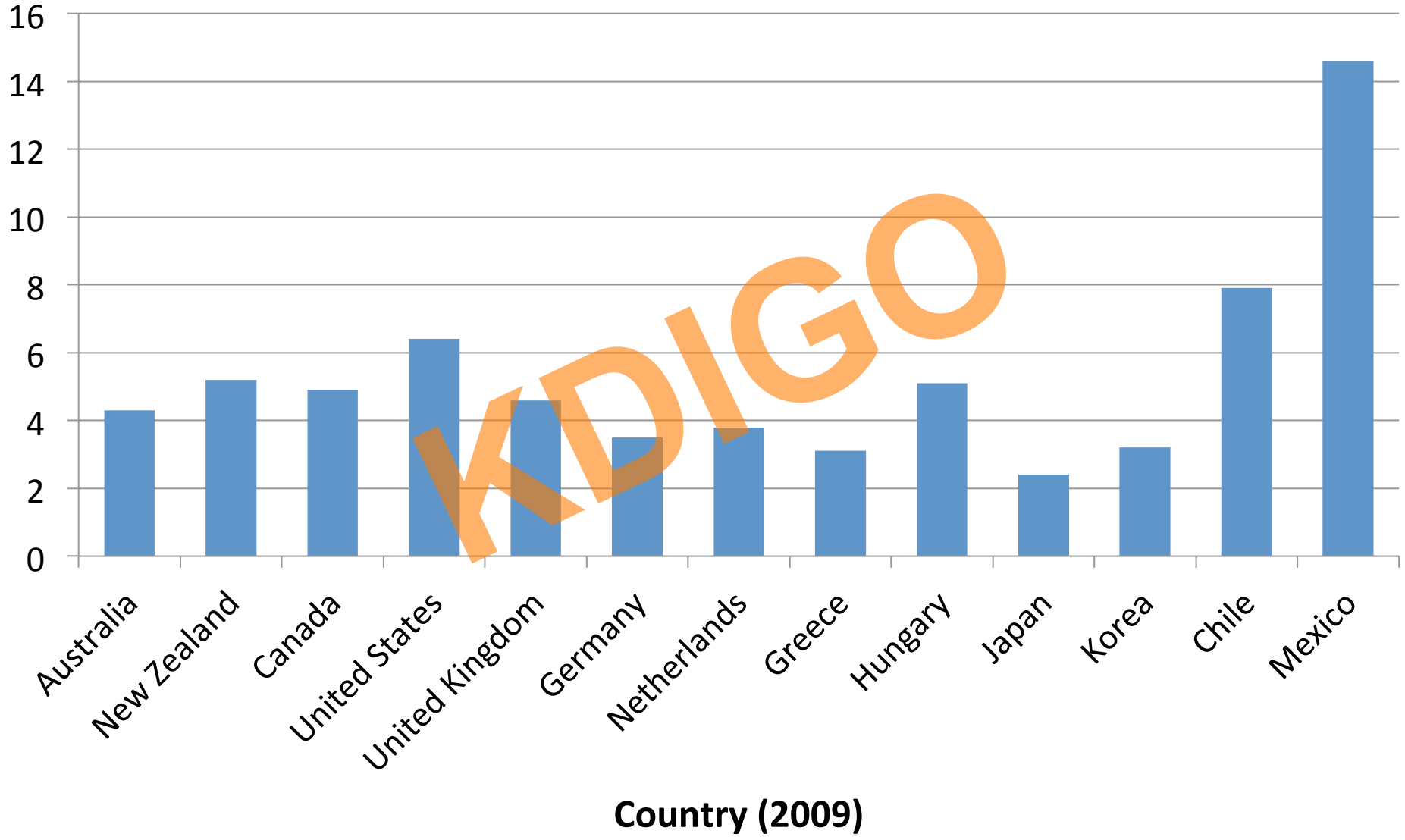
Annual Per Capita Healthcare Costs by Age



Fischbeck et al, Health Services Research 2010;45:565-576.


Life Expectancy at Birth
84
82
80
78
76
74
72
70
68
Australia
New Zealand
Canada
United States
United Kingdom
Germany
Netherlands
Greece
Hungary
Japan
Korea
Chile
Mexico
Country (2009)
KDIGO

Infant Mortality (deaths/1000 live births)



Palliative Care in the US: The Ugly

- **Opposition to palliative care, "Death Panels"**
- **No systemic integrated/community PC**
  - Out-patient PC is almost non-existent
  - 85% of hospitals (> 300 beds) have access to a PC program
- **Medicare funds hospice**
  - Substantial gatekeeping: < 6 months prognosis
  - Medicare hospice benefit & Medicare ESRD benefit can be used simultaneously for a patient with a terminal illness from a non-kidney related disease (cancer, CHF COPD etc.)
  - Max $/day: not supposed to fund other services or many meds e.g. EPO
  - Hospice would have to pay for the dialysis therefore reluctant to take dialysis patients (driven by profit-corporate model).
- **Local PC programs**: services depend upon how "rich" they are and how willing they are to supplement through endowments

Palliative Care in the US: The Ugly

- Medicare and Social Security Programs are estimated to run up to a $90 trillion deficit over the next 75 years!

- Dialysis is funded by Medicare benefits (after 90 days) – patients has to have paid into it for at least 2.5 years.
  - Dialysis costs the HC system but generates substantial revenue for corporations
  - Cuts to dialysis reimbursement: 12% cut in payments for injectable drugs
  - Readmission costs are huge (highest among ESRD patients – 35%)
  - Hospitals are being penalized for these readmissions
  - Hospitals are also being penalized for high mortality rates

The Coming Fiscal Crisis: Nephrology in the Line of Fire

- The uncertain course of "Obamacare" The Patient Protection and Affordable Care Act
- Cost containment: Accountable Care Organizations (ACOs) – ESCOs for ESRD patients on dialysis.
- Concerns: rationing of care:
  - Restricting access to dialysis – elderly: higher mortality rates, higher ICER (incremental cost effectiveness ratios) and QALY
  - Delaying dialysis as a financial Imperative
  - Mandating dialysis modality
  - Compensating kidney donors

Andersen, Friedman, CJASN July 2013

Renal Palliative Care in the US: The Bad

DOPPS data: US has highest withdrawal from dialysis rates

Patients with poor prognosis (elderly, frail, demented) receive dialysis due to perverse financial incentives

- The culture of "do everything"

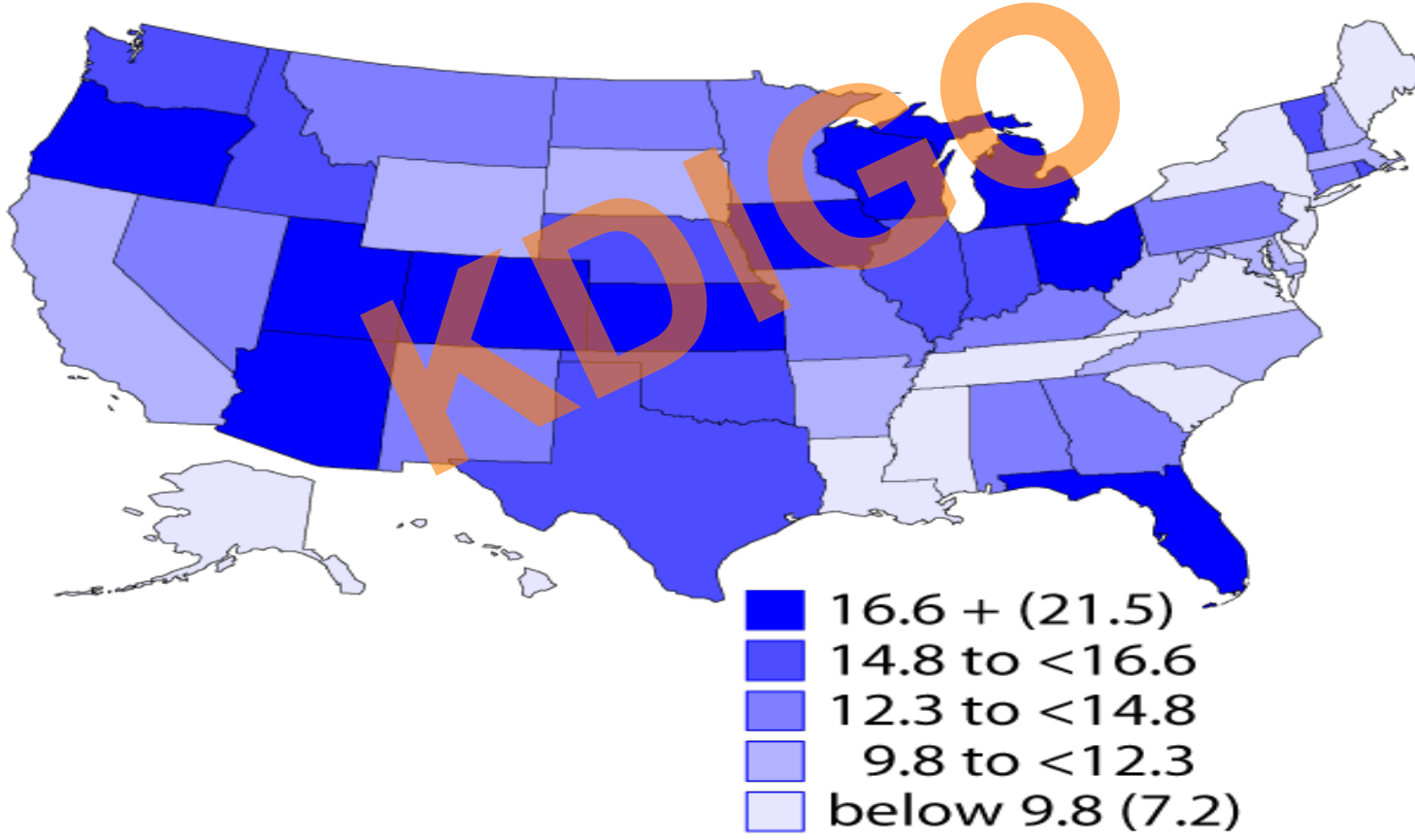
No conservative care programs (financial disincentives)

Declining interest in nephrology training; workforce shortages

- Poor preparation of trainees in palliative care skills

Geographic Variations in the % of Patients Using Hospice by State

Incident & prevalent ESRD patients dying in 2001–2002.



Geographic Variations in the % of Patients who Withdraw by State

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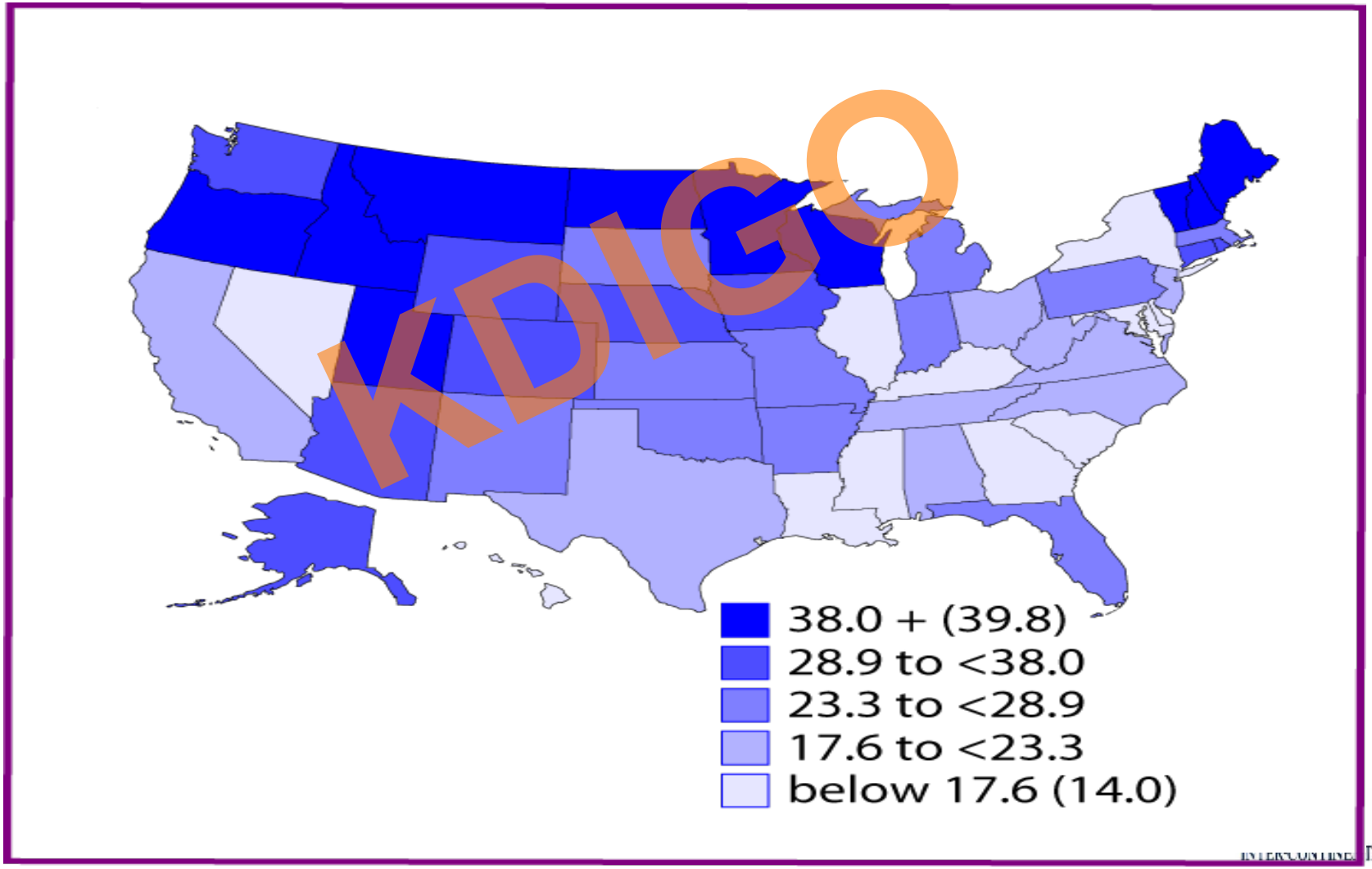


By R. Sean Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

THE CARE SPAN

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

ORIGINAL INVESTIGATION

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

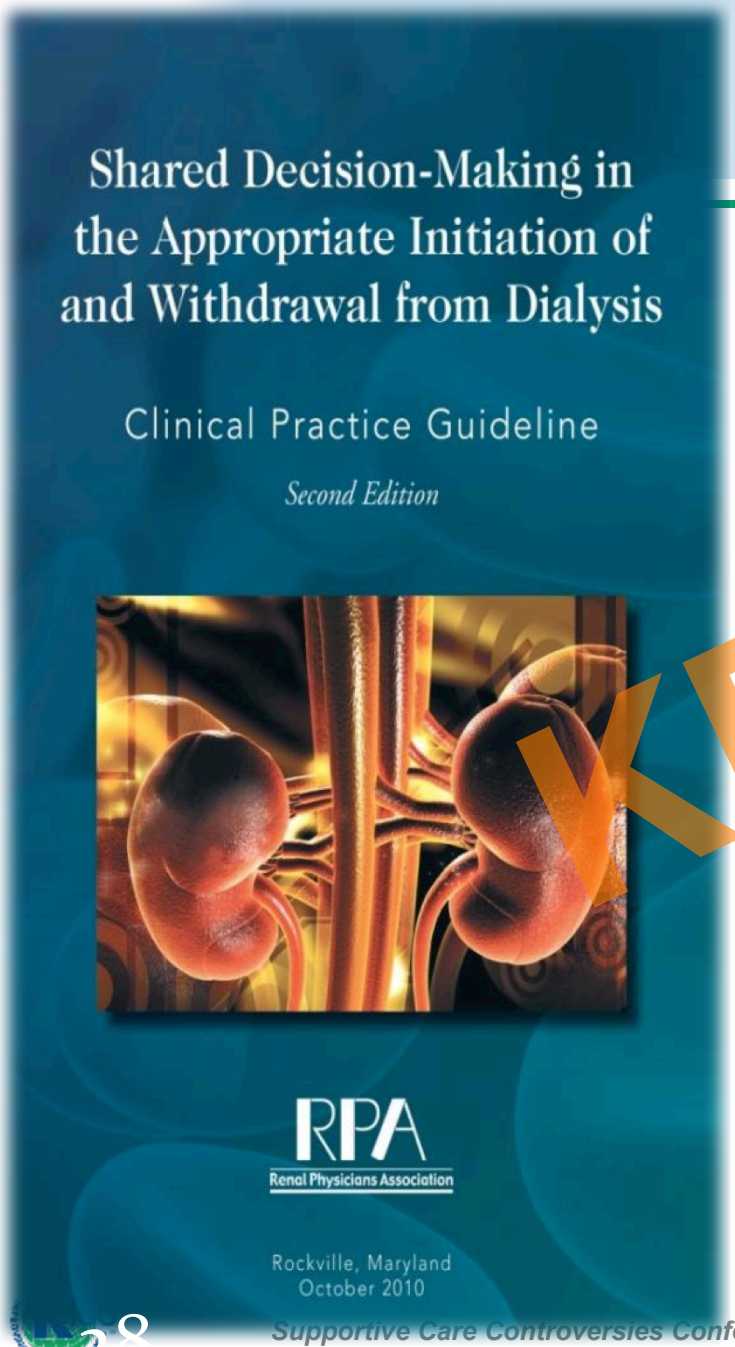
R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Arch Intern Med. 2008;168(16):1783-1790

Renal Supportive Care in the USA: The Good

Many resources available now to support development of programs at the local level

- **NephroTalk** is a program that trains nephrologists in better communication skills
- **National guideline** endorsing supportive care has been updated and is a national and international standard
- **Studies informing what our patients think and want**
- Use of **POLST/MOLST/POST** is growing nationally
- Coalition for Supportive Care of Kidney Patients kidneysupportivecare.org



Evidence-Based Clinical Practice Guideline

10 recommendations

Practical strategies

Available at RPA online store
www.renalmd.org

KDIGO

Renal Supportive Care Initiatives

Tools to implement RPA SDM guideline:

- mobile and EMR decision support tools/apps

LDO recognition of value of supportive care in the era of global payment.

Integration of supportive care into ACOs and ESCOs

Training nephrologists and fellows in supportive care

Leveraging of international guidelines as quality standards for providing comprehensive care

- **International peer pressure**

Choosing Wisely®

An initiative of the ABIM Foundation

ConsumerReports Health

ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

ABIM FOUNDATION

Chronic kidney disease

Making hard choices

Acknowledgements

- Dr. Alvin Moss
- Dr. Michael Germain