Palliative Care Improves Quality, Reduces Cost

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Objectives

1. What is palliative care?
2. How does it differ from hospice?
3. Impact of palliative care on quality and costs
4. Policy priorities

New CMS Definition of Palliative Care *Does Not Mention Prognosis*

Palliative care *means patient and family-centered care that optimizes quality of life* by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

73 FR 32204, June 5, 2008

Medicare Hospice Conditions of Participation – Final Rule

How Does Palliative Care Differ from Hospice?

- Hospice care provides palliative care for those in the last weeks-months of life under a Federal Medicare Benefit.

- Non-hospice palliative care is appropriate at any point in a serious illness. It can be provided at the same time as life-prolonging treatment.

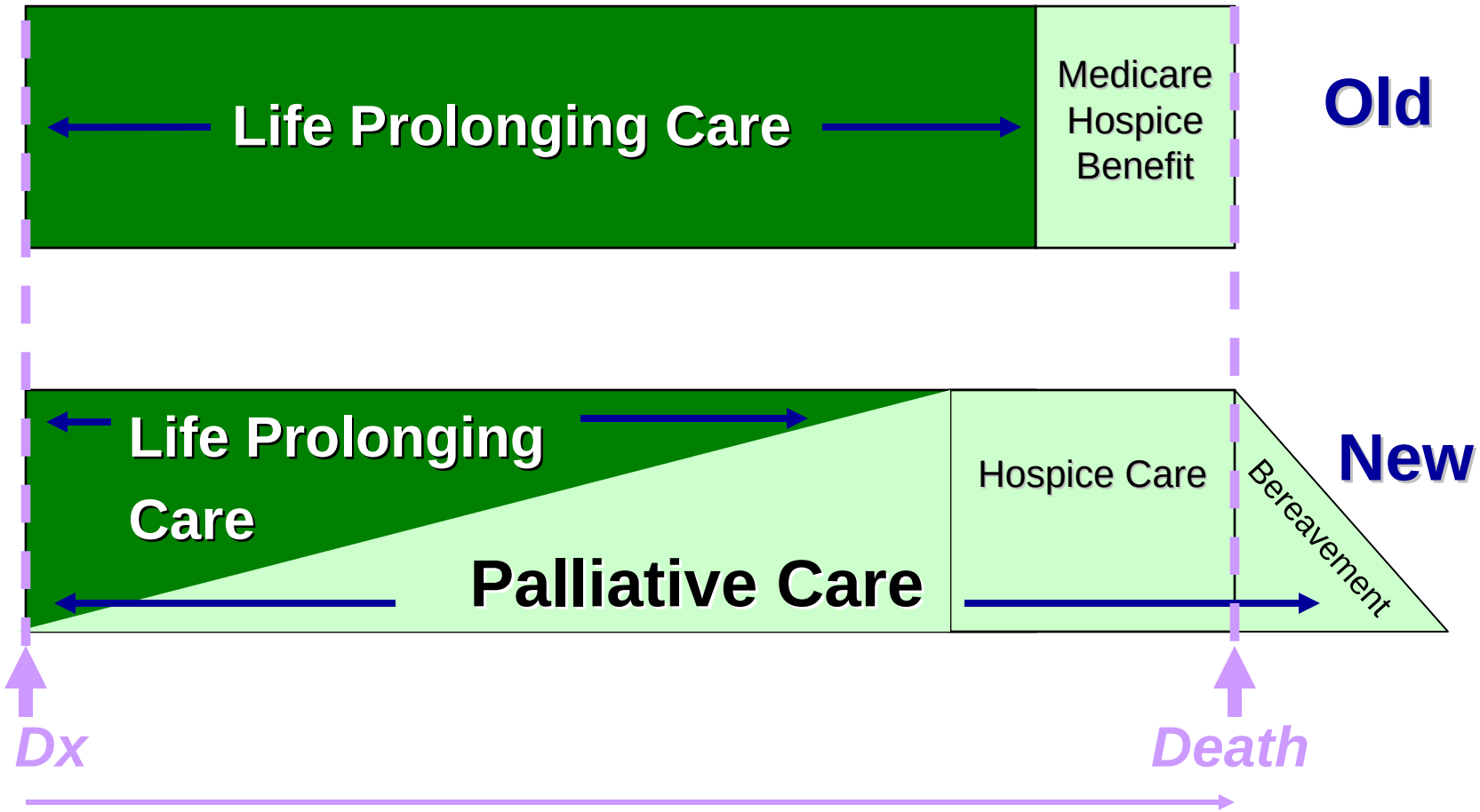
Why is non hospice palliative care necessary?

The abiding desire not to be dead…

I don’t want to achieve immortality through my work. I’d rather achieve it by not dying.

Woody Allen

Conceptual Shift for Palliative Care



Kaila

- 24 year old recent college graduate
- Uninsured
- Several month gradual onset headache, fatigue, bone pain, shortness of breath
- Delayed care because of $
- Collapsed at home, brought to Emergency Department
- Diagnosis: acute leukemia
- Severe bone pain, short of breath, depression, worry
- Emergency Medicaid
- Chemo, bone marrow transplant. Rx > 1 year, mostly in hospital, 3 month stay in ICU- simultaneous care from palliative care service and oncologists.
- Died after 2 months at home on hospice

Palliative Care Improves Care in 3 Domains

1. Relieves physical and emotional suffering
2. Improves patient-professional communication and decision-making
3. Coordinates continuity of care across settings

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

Palliative Care Improves Patient Care

- Mortality follow back survey palliative care vs. usual care
- N=524 family survivors
- Overall **satisfaction markedly superior** in palliative care group, p<.001
- Palliative care superior for:
  - emotional/spiritual support
  - information/communication
  - care at time of death
  - access to services in community
  - well-being/dignity
  - care + setting concordant with patient preference
  - pain
  - PTSD symptoms

arett et al. J Am Geriatr Soc 2008;56:593-99.
Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003; Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.

Palliative Care Reduces Costs

- Data demonstrate cost avoidance impact across settings, region, institutional and delivery model.
- How?
  - Talking with patients and families and treating physicians about what is happening and their realistic options leads to more conservative choices.
  - Allows provision of higher quality care in appropriate, often less costly, settings.

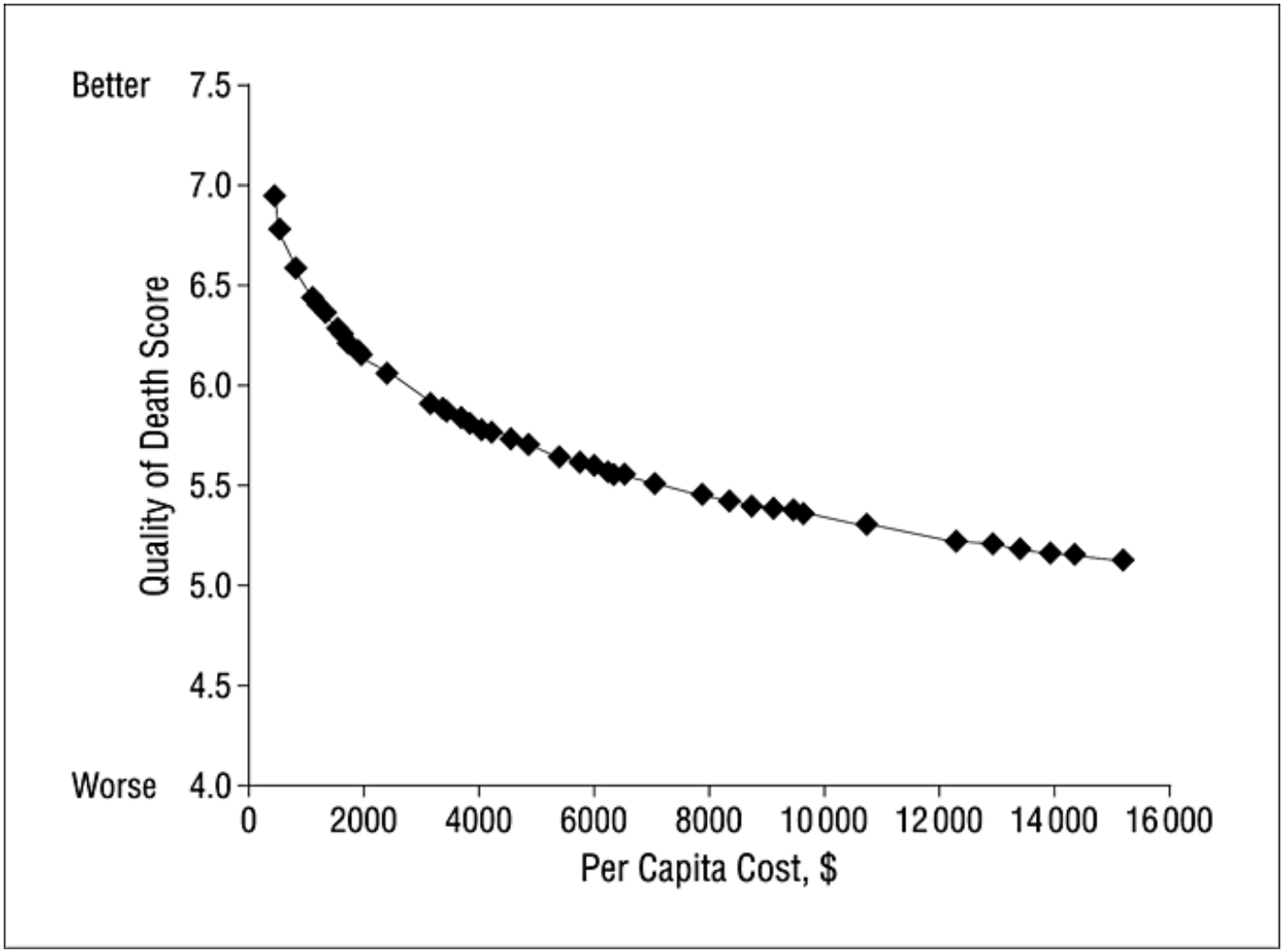
End of life conversations demonstrably improve quality, reduce costs

In a prospective multicenter study of 332 seriously ill cancer patients, recall of occurrence of an end of life care conversation was associated with:

- Better quality of dying and death
- Lower risk of complicated grief + bereavement
- Lower costs of care
- Less ‘aggressive’ care

Zhang et al. Arch Int Med 2009;169:480-8.
Wright et al. JAMA 2008;300:1665-73.

Association between cost and quality of death in the final week of life (adjusted P = .006)



Zhang, B. et al. Arch Intern Med 2009;169:480-488.

ARCHIVES OF INTERNAL MEDICINE

Medical Care Received in the Last Week of Life by End-of-Life Discussion

Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion

	No. (%)			Adjusted OR (95% Confidence Interval)[a]	*P* Value
	Total (N=332)	End-of-Life Discussion			
		Yes	No		
Medical care received in the last week	332	123 (37.0)	209 (63.0)		
ICU admission	31 (9.3)	5 (4.1)	26 (12.4)	0.35 (0.14-0.90)	.02
Ventilator use	25 (7.5)	2 (1.6)	23 (11.0)	0.26 (0.08-0.83)	.02
Resuscitation	15 (4.5)	1 (0.8)	14 (6.7)	0.16 (0.03-0.80)	.02
Chemotherapy	19 (5.7)	5 (4.1)	14 (6.7)	0.36 (0.13-1.03)	.08
Feeding tube	26 (7.9)	11 (8.9)	15 (7.3)	1.30 (0.55-3.10)	.52
Outpatient hospice used	213 (64.4)	93 (76.2)	120 (57.4)	1.50 (0.91-2.48)	.10
Outpatient hospice ≥1 wk	173 (52.3)	80 (65.6)	93 (44.5)	1.65 (1.04-2.63)	.03

Abbreviation: ICU, intensive care unit; OR, odds ratio.

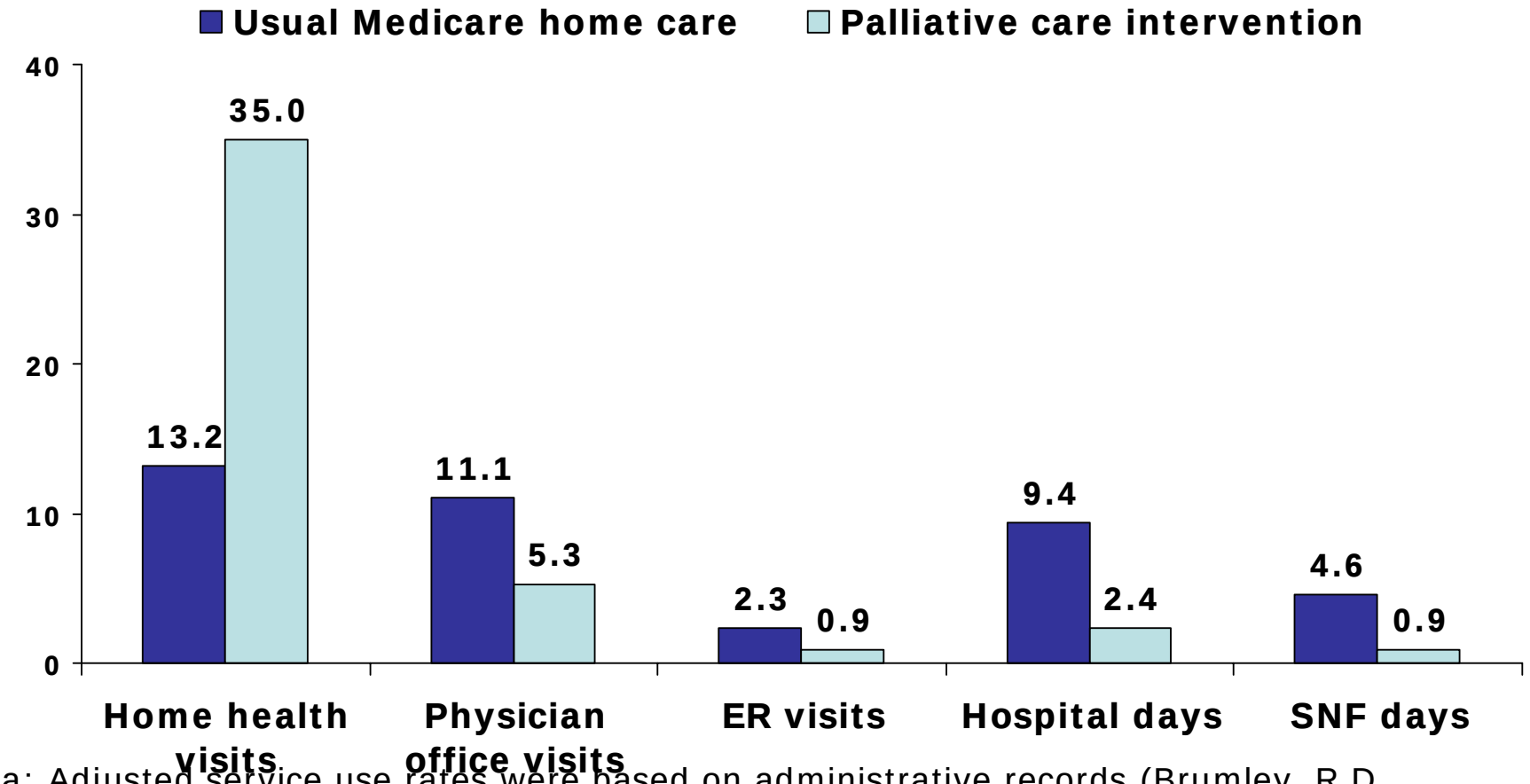
[a] The propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients' treatment preferences, desire for prognostic information, and acceptance of terminal illness.

Wright, A. A. et al. JAMA 2008;300:1665-1673.

JAMA

Palliative Care at Home for the Chronically Ill Markedly Reduces Utilization

Service Use Among Patients Who Died from Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer While Enrolled in a Palliative Care Intervention or Receiving Usual Care, 1999–2000



Data: Adjusted service use rates were based on administrative records (Brumley, R.D. et al. 2003. *The Permanente Journal* 7(2):7–12). Adapted and used by permission of the publisher, The Permanente Medical Group. SNF = skilled nursing facility.

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

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2030 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $1696 in direct costs per admission ($P=.004$) and $279 in direct costs per day ($P<.001$) including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4908 in direct costs per admission ($P=.003$) and $374 in direct costs per day ($P<.001$) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients. Two confirmatory analyses were performed. Including mean costs per day before palliative care and before a comparable reference day for usual care patients in the propensity score models resulted in similar results. Estimating costs for palliative care patients assuming that they did not receive palliative care resulted in projected costs that were not significantly different from usual care costs.

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

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

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Group Information: The Palliative Care Leadership Centers' Outcomes Group is listed at the end of this article.

ADVANCES IN DISEASE PREVENTION, disease-modifying therapies, and medical technology in combination with the aging of the population have resulted in a dramatic growth in the number of adults living with serious illness.[1] Despite enormous expenditures, patients with serious illness receive poor quality medical care, characterized by untreated symptoms, unmet personal care needs, high caregiver burden, and low patient and family satisfaction.[2]

Palliative care is the interdisciplinary specialty that focuses on improving quality of life for patients with advanced illness and for their families through pain and symptom management, communication and support for medical decisions concordant with goals of care, and assurance of safe transitions between care settings.[3] Until a decade ago, palliative care in the United States was typically available only to patients living at home and enrolled in hospice. Now, palliative care programs targeting acutely ill patients are found increasingly in hospitals. As of 2005, 30% of US hospitals and 70% of hospitals with more than 250 beds reported the presence of a palliative care program—an increase of 96% from 2000.[4] Unlike hospice, hospital palliative care is provided simultaneously with all other appropriate disease-directed treatments.[3]

Hospital palliative care programs have been shown to improve physical and psychological symptom management, caregiver well-being, and family satisfaction,[2,5,6] and small, single-site studies suggest that palliative care programs may reduce hospital and intensive care unit (ICU) expenditures by clarifying goals of care and assisting patients and families to select treatments that meet those goals.[10-15] This study was undertaken to estimate the effect of palliative care consultation programs on hospital costs.

METHODS

We used hospital administrative data to compare hospital costs of patients receiving palliative care consultation matched by propensity score[16-18] with patients receiving usual care from 2002 through 2004.

Hospital Palliative Care Reduces Costs

Cost and ICU Outcomes Associated with Palliative Care Consultation in 8 U.S. Hospitals

	Live Discharges			**Hospital Deaths**		
Costs	**Usual Care**	**Palliative Care**	**Δ**	**Usual Care**	**Palliative Care**	**Δ**
Per Day	$867	$684	$183*	$1,515	$1,069	$446*
Per Admission	$11,498	$9,992	$1,506*	**$23,521**	**$16,831**	**$6,690***
Laboratory	$1,160	$833	$327*	$2,805	$1,772	$1,033*
ICU	**$6,974**	**$1,726**	**$5,248***	**$15,531**	**$7,755**	**$7,776*****
Pharmacy	$2,223	$2,037	$186	$6,063	$3,622	$2,441**
Imaging	$851	$1,060	-$208***	$1,656	$1,475	$181
Died in ICU	X	X	X	**18%**	**4%**	**14%***

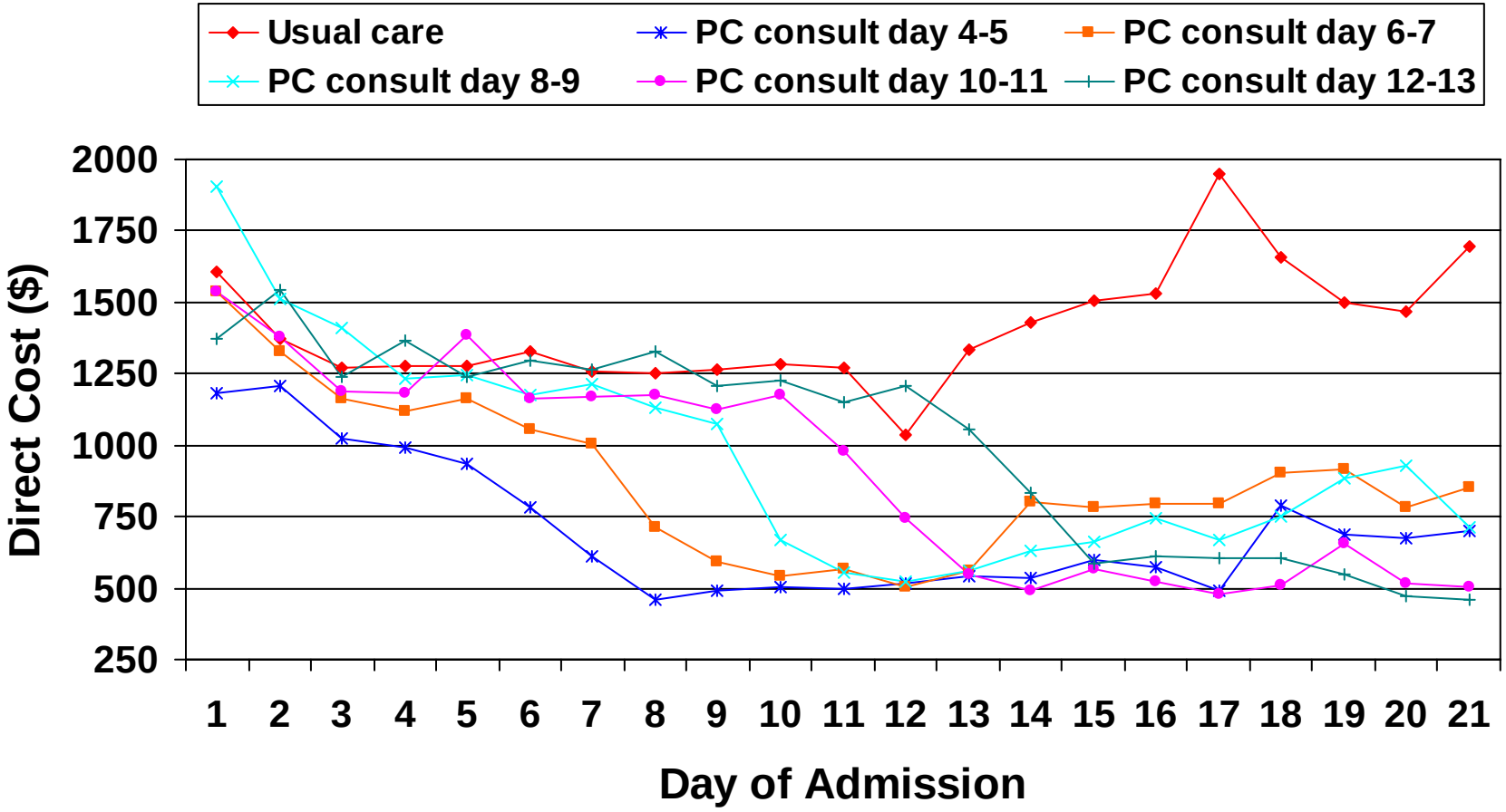
*p<.001
**p<.01
***p<.05

Morrison, RS et al. Archives Intern Med 2008;

Costs go down within 48 hours of palliative care consultation but go up in matched usual care patients

Mean direct costs/day for patients who died and who received palliative care consultation compared to matched usual care patients

Morrison, RS et al. J Amer Geriatr Soc 2007;55:S7



"It is thornlike in appearance, but I need to order a battery of tests."

THE WALL STREET JOURNAL.

WEDNESDAY, MARCH 10, 2004 ~ VOL. CCXLIII NO. 48 ~ ★★ $1.00

Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	$2,267	$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
Total	**$12,319**	**$5,313**

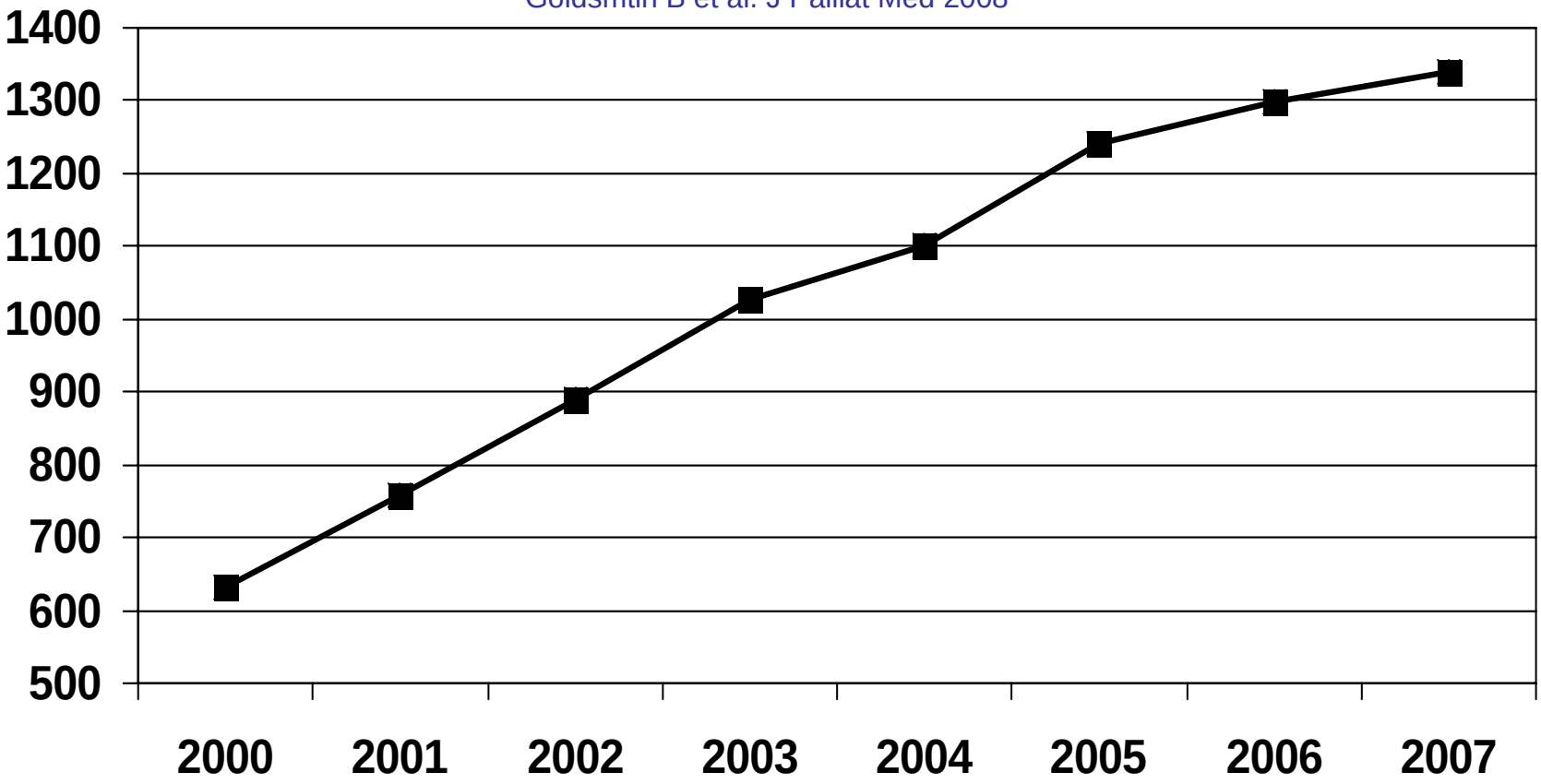
Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center

Access to Hospital Palliative Care Programs in the United States

AHA survey data

Goldsmtih B et al. J Palliat Med 2008



Where you live matters

- Highly variable access to palliative care
- 33% of all hospitals
- 50% of hospitals with > 50 beds
- 80% of hospitals > 300 beds
- (+)predictors: >50 beds, teaching, cancer program, higher educational level
- (-)predictors: <50 beds, south, public or sole community provider, for profit hospitals

Goldsmith B et al. J Palliat Med 2008

CENTER TO ADVANCE PALLIATIVE CARE

NATIONAL Palliative Care RESEARCH CENTER

AMERICA'S CARE OF SERIOUS ILLNESS:
A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals

Download Report
Data Tables
Methodology
FAQ
Resources
Glossary
Acknowledgments
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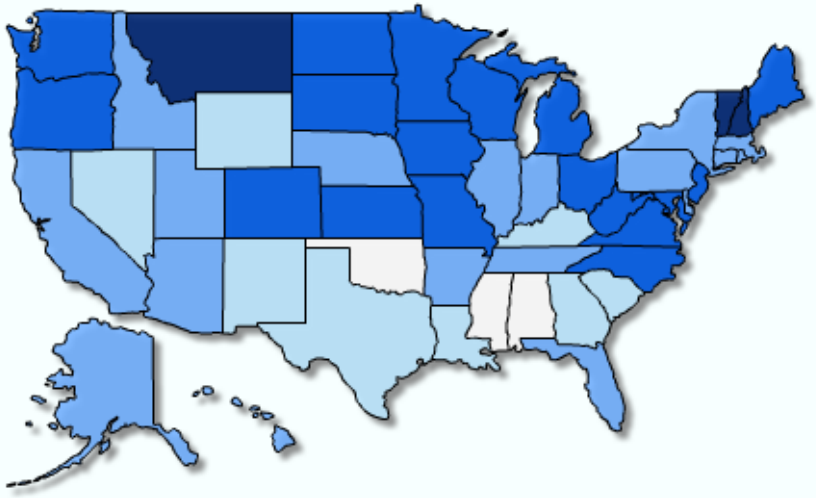
To learn more about palliative care, visit:

get Palliative care.org

To read the study, visit:

Journal of Palliative Medicine

How Does Your State Rate?



Percentage of mid-size and large hospitals with a palliative care program (50+ beds)
(Click on a state for more details)

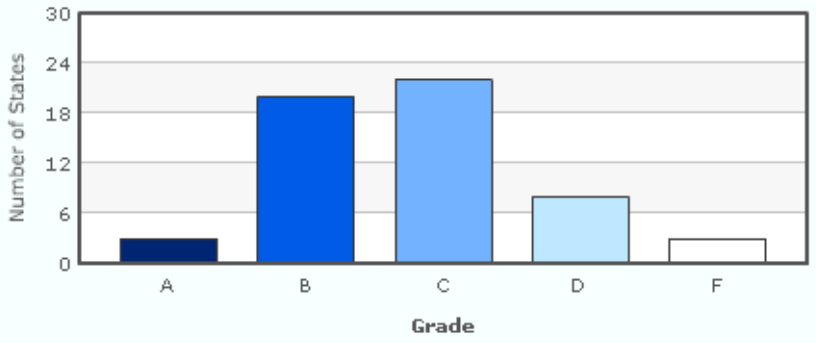
United States

C

[Choose State]

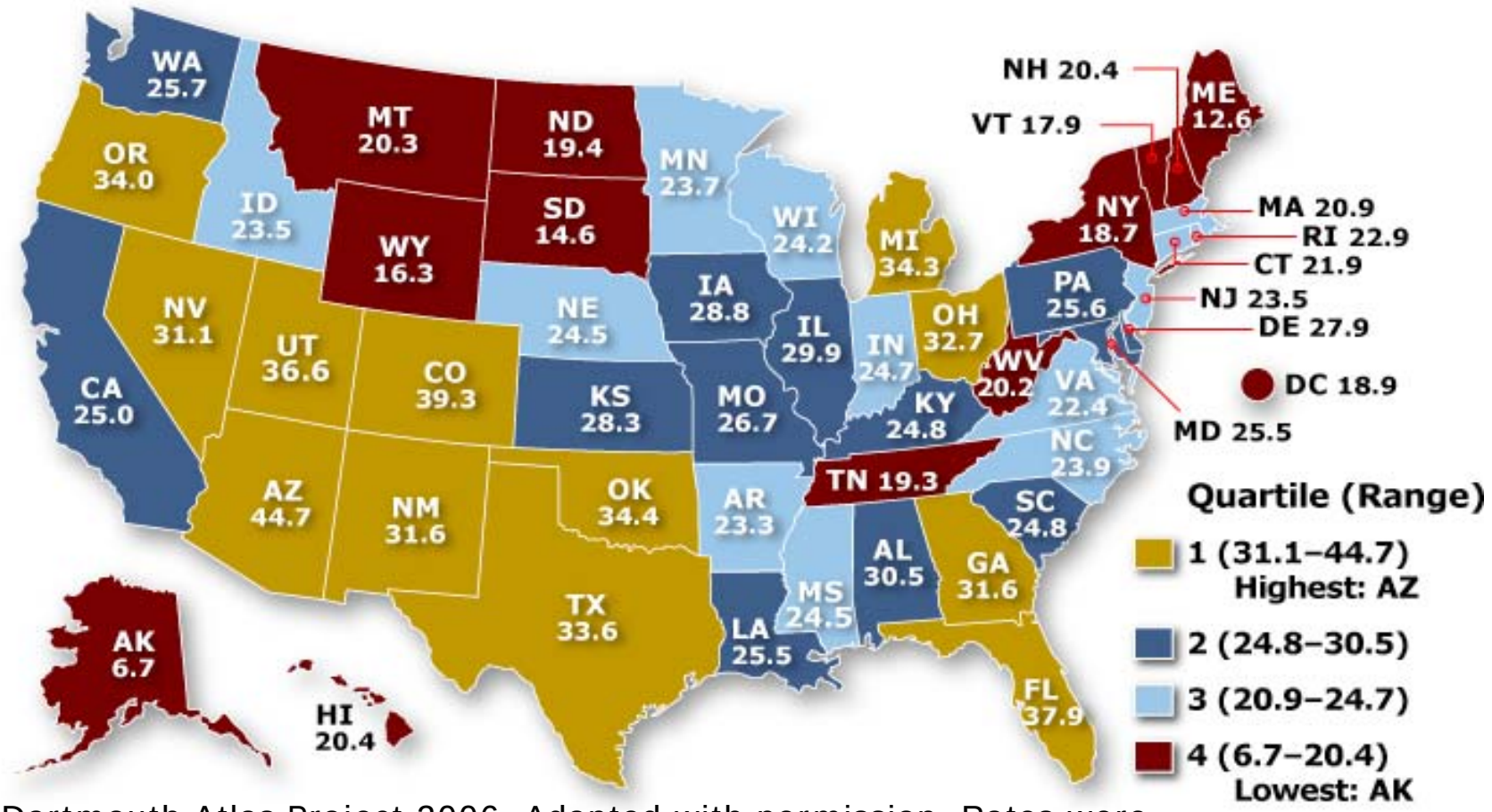
Choose another national map:

State-by-State Report Card



Wide State-by-State Variation in Hospice Use

% Using Hospice During Last 6 Months of Life
Fee-for-Service Medicare Beneficiaries with
Severe Chronic Illnesses Who Died During 2000–2003



Data: Dartmouth Atlas Project 2006. Adapted with permission. Rates were adjusted for differences in age, sex, race, and prevalence of 12 chronic illnesses. Excludes Medicare beneficiaries enrolled in managed care plans.

Correlates to Access to Palliative Care

- Lower hospital mortality
- Fewer ICU admissions and days during last 6 months
- Fewer ICU admissions in last hospital stay

Workforce

- In 23 states + DC no access to graduate medical education in palliative care
- Oncologists: 1 for every 145 patients with new cancer dx
- Cardiologists: 1 for every 71 heart attack victims
- Palliative medicine: 1 for every 31,000 people with serious advanced illness

How can we ensure that all seriously ill Americans have access to quality palliative care?

Supportive policies:

1. Assure access to care- Build workforce and incent doctors and hospitals to deliver palliative care
2. Assure quality of care- Populate all medical schools with trained faculty, create a workforce pipeline via postgraduate subspecialty training in palliative medicine, set aside funds for research to address pressing problems of human suffering and how best to provide relief.

Policies to improve access to palliative care

1. **Financial incentives to doctors+nurses** who provide palliative care
2. **Financial incentives to hospitals** that provide palliative care (Norway model)
3. **Hospital accreditation** requirement

Policies to improve quality of palliative care

1. **Research:** Allocate funding to NIH for research in palliative medicine;
2. ***Palliative Care Training Act*** reintroduction sought to increase numbers of palliative medicine faculty at the nation's 125 medical schools
   http://www.govtrack.us/congress/bill.xpd?bill=s109-1000
3. **Post graduate training-** adjust caps so that palliative medicine fellowships are funded.

"No institution is doing everything right. But we found 10 that are using innovation, hard work and imagination to improve care, reduce errors and save money.

Determined people . . . are transforming the way U.S. hospitals care for the most seriously ill patients. The engine of change is palliative medicine.

'The field is growing because it pays attention to the details,' says Dr. Philip Santa-Emma … 'It acknowledges that even if we can't fix the disease, we can still take wonderful care of patients and their families'."

Newsweek *Fixing America's Hospital Crisis*
October 9, 2006

Life is pleasant. Death is peaceful. *It's the transition that's troublesome.*

– **Isaac Asimov**
US science fiction novelist & scholar (1920 - 1992)

Art Buchwald, Whose Humor Poked the Powerful, Dies at 81
By RICHARD SEVERO
Published: January 19, 2007, New York Times

- As he continued to write his column, he found material in his own survival. *“So far things are going my way,”* he wrote in March. *“I am known in the hospice as The Man Who Wouldn’t Die. How long they allow me to stay here is another problem. I don’t know where I’d go now, or if people would still want to see me if I weren’t in a hospice. But in case you’re wondering, I’m having a swell time — the best time of my life.”*