Palliative Care's Positive Outcomes

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Comforting care for serious illness meets quality goals

An 89-year-old practicing psychoanalyst is admitted to the hospital for scleroderma and progressive kidney failure. She declines hemodialysis. The nephrology team calls the palliative care team to assess the patient's capacity to refuse dialysis and to ensure that she is not suicidal. The palliative care team assesses the patient and determines that her decision is rational and that she understands the potential consequences of her actions. The team recommends a plan of care that will address the patient's symptoms and discusses this with the nephrologist. The patient is discharged home with hospice on Day 5 of her hospital stay. While her nephrologist's prognosis had been just days to weeks, she does well at home for four months, remaining in active clinical practice for much of that time. When she recognizes her death is approaching, she says goodbye to her patients, her son and her friends, then dies quietly at home three days later.

Hospital palliative care honors a patient's self-determination, improves physician-patient communication and addresses the needs of those with advanced illness, but is not tied to a specific prognosis. It also can link patients to hospice care, which provides excellent symptom management and support for patients and their families in their choice of location. Finally, because the care for this patient was patient-centered, beneficial, timely, safe, equitable and efficient, it meets the standards for quality care as defined by the National Quality Forum and the Institute for Healthcare Improvement.

What is Palliative Care?

Palliative medicine is a fast-growing medical specialty; programs are in place at more than 80 percent of hospitals with more than 300 beds. It's no wonder why: It enhances patient and family satisfaction with hospital care, improves health care quality and, according to a recent study published in the New England Journal of Medicine, can help to prolong survival for patients with lung cancer. All this comes at a fraction of the cost of usual care. Studies demonstrate that palliative care programs can save hospitals millions of dollars per year.

Before reviewing the evidence for these claims and providing a possible road map for the future, let's define hospital-based palliative care. Palliative medicine is an umbrella term for all forms of hospice and palliative care. Palliative care is medical care focused on relief of symptoms including pain, fatigue, anxiety and depression; expert communication with patients, families and other health professionals about goals of care and plans to achieve those goals; and coordination of care across the many settings in which persons living with serious and chronic illness are seen. Unlike hospice, palliative care is not restricted to the last six months of life nor does it require foregoing other treatments such as another course of chemo or participation in a clinical trial.

Employing the same principles of preventing and alleviating suffering, and providing patient- and family-centered care, hospital palliative care programs serve patients based on need and are offered independent of prognosis, whether the goal of care is cure (such as for acute leukemia); life prolongation (for example, heart failure or chronic lung disease); or a peaceful and dignified death (ideally with hospice for those who are clearly and predictably dying), regardless of disease type.
Palliative care teams can engage with cancer patients at any point from diagnosis onward to help minimize the burden of pain, nausea and other symptoms; help preserve options and choices; clarify patients' and families' values and wishes and how those relate to their care in the hospital and after; and improve communication among various specialists and sites of care.

**Palliative Care's Value Equation**

For 10 years, the Center to Advance Palliative Care at Mount Sinai School of Medicine, New York, and its Palliative Care Leadership Centers around the country have been helping hospitals implement successful, sustainable palliative care programs. Palliative care teams and hospital leaders learn the many aspects of increased value in these programs.

The tremendous overall value that palliative care brings to a hospital is derived from several areas: shorter ICU lengths of stay, enhanced patient and family satisfaction, enhanced quality of care and even longer survival, increased efficiency and satisfaction of other specialists, reduced costs per hospital day (tests, nursing, pharmaceuticals, supplies) and better coordination and management of patients outside of the hospital.

Palliative care's positive outcomes touch on some of the most important challenges facing hospitals today: Minimizing unnecessary costs (especially under fixed-payment reimbursement); addressing ICU bottlenecks; keeping specialists busy and happy; keeping patients and families safe and satisfied; minimizing readmission rates; and planning for further bundling of payments for care in multiple settings, across multiple episodes.

The evidence for these claims has been published in numerous journals. A review of three of them follows.

**Palliative care improves quality.** Hospitals' imperative to increase and sustain the highest level of quality never has been greater. Think of patients with advanced diseases, multiple co-morbidities, and significant pain and other symptoms. They may represent only 5 to 7 percent of total admissions, but they're almost always the most expensive, typically undergoing long and costly hospital stays and particularly vulnerable to such adverse events as health care-acquired infections, pressure ulcers, medication errors and rapid-cycle readmissions. To compound the problem, these patients are scattered all across the hospital. Palliative care teams offer a "quarterback" support and coordination function, providing expertise in care across all specialties and inpatient units to the most complex and high-risk patients.

Palliative care brings strengths in two areas that long have been weak spots in American hospital care: State-of-the-art techniques for managing pain and other symptoms; and the time and expertise needed for long, often difficult patient and family meetings about prognosis, goals of care, and the patient's wishes and values.

Numerous studies and meta-analyses have demonstrated that palliative care improves pain and symptom management, emotional and spiritual support, communication, and patient and family satisfaction.

**Palliative care reduces costs.** By talking with patients, their families and physicians about what is happening, realistic treatment options and their pros and cons, palliative care teams help to weigh the benefits and burdens of the choices in the context of patient-centered goals and values. A fully informed patient and family who have been given the necessary time and support to come to terms with an illness often, though not always, choose to receive further care at home. This usually leads to higher quality care, often at lower expense, as in the following example.

A 69-year-old man with advanced lung cancer, sepsis, pleural effusions and co-morbidities was brought to the hospital's emergency department by his family when he had become unresponsive. The ED team sought input from both the pulmonary/ICU team and the palliative care team. Following joint consultations, the family chose to pursue a time-limited trial of ICU care to see if he could recover from a possible pneumonia. All agreed that
if the patient did not improve after two to three days in the ICU, he would be moved to the acute palliative care unit for intensive symptom control and support for the family.

After just two days in the ICU, the family saw that their loved one was not improving, and he was transferred to the palliative care unit. Too symptomatic to return home with hospice care, he remained in the palliative care unit for three days. The family was profoundly grateful for the care and the safe, peaceful and comfortable time they had together during his last days.

The palliative care team helped to provide positive, high-quality care options that allowed a better alternative to the ICU for this patient and his family. The team's timely involvement when treatment decisions were being made in the ED is a key factor in achieving this outcome. While not every hospital will group palliative care-appropriate patients in a designated geographic unit, any team that can make it to the ED to provide a consult can help to manage a family's expectations regarding the effective use of the ICU.

This is how palliative care teams across the nation have reduced the cost of care for hundreds of patients per hospital per year. A recent study involving eight hospitals and three years' worth of hospital admissions demonstrated significant savings for a typical 300-bed community hospital. Records provided by the palliative care teams at these hospitals were matched to the hospital admission data, allowing identification of those who received palliative care consultation and when, and simultaneous identification of similar patients who did not receive any palliative care involvement.

Compared with the non-palliative care patients to whom they were carefully matched statistically, the cost per day for palliative care patients was dramatically lower; this was found both for decedents and patients who survived to hospital discharge. Among survivors, for example, the cost per day for palliative care patients was $183 lower (about $1,500 per admission) than their usual care counterparts. Researchers concluded that for an average 400-bed hospital containing an interdisciplinary palliative care team that sees 500 patients a year (300 live discharges and 200 hospital deaths), these figures translate into a net savings of $1.3 million per year after adding physician revenues ($240,000) and subtracting personnel costs ($418,000). The findings were the same at all types of hospitals across the country. Reduced cost per day largely driven by reduced ICU utilization has been replicated widely.

Other research has demonstrated that palliative care involvement also can have long-term effects on a patient's subsequent ED visits and rehospitalizations in the weeks and months following the first consultation. While reduced utilization has been more of a concern for such integrated systems as the Veterans Administration and Kaiser Permanente, a reduction in readmissions will be a goal for most hospitals as Medicare begins to tie reimbursement to readmission rates.

Palliative care prolongs survival. Researchers at the Dana-Farber Cancer Institute recently completed a randomized, controlled trial in which palliative care was added to standard cancer care for patients with advanced non-small-cell lung cancer. The palliative care group of patients had improved mood and quality of life, reduced health care utilization and a 2.7-month survival advantage compared with control group patients receiving only cancer care. As one palliative care physician says, "People usually live longer when they're more comfortable." This was not the first study to show that hospice or palliative care involvement may prolong life, but it was the first rigorously conducted, randomized controlled trial to demonstrate that palliative care can prolong survival among cancer patients when delivered concurrently with usual cancer care.

The Future of Palliative Care

Given these dramatic outcomes in quality, costs and survival, it is no surprise that palliative care programs have been started in many large hospitals in the country. However, the inverse is also true; most small hospitals do not have such programs in place. Fewer than half of all hospitals with more than 50 beds have reported having a
palliative care program on the AHA Annual Hospital Survey. It is estimated that existing programs may be seeing only 1.5 percent of hospital admissions, while at least 5 to 7 percent of admissions are in need of palliative care involvement. Therefore, much greater growth is still possible both within and across hospitals.

If access to palliative care were increased from 50 to 90 percent of U.S. hospitals, and if those programs were staffed adequately to serve 5 to 7 percent of admissions in those hospitals, the financial and quality impact would be immense.

Some of what the field needs to achieve that kind of expansion is already in place. There is a critical foundation: Palliative medicine is now an American Board of Medical Specialties-approved subspecialty, with an American Board of Internal Medicine board-certification exam. The Accreditation Council for Graduate Medical Education now certifies postgraduate palliative medicine fellowship training programs. This is the training platform necessary to expand the palliative care workforce to the level needed by the American people. In addition, we need to expand the incentives for physicians to join this specialty, using such tools as loan forgiveness and career-development support.

Technical assistance materials already are in place via the Center to Advance Palliative Care (available at www.capc.org), with several different distribution channels including three-day national seminars, two-day intensive team trainings at one of eight Palliative Care Leadership Centers, webinars and e-learning platforms. The Joint Commission is considering release of a hospital Palliative Care Certificate Program as a means of assuring and recognizing the quality these patients need and expect. Trustees are encouraged to consider developing a palliative care program if their hospital doesn't already have one, and to ensure that it has adequate resources to fulfill its potential in terms of quality and cost of care.

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Sidebar - Learn More about Palliative Care


Technical Assistance for Developing Hospital Palliative Care Programs: Center to Advance Palliative Care at www.capc.org

This article first appeared in the March 2011 issue of Trustee magazine.