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

Old

Life Prolonging Care

Medicare Hospice Benefit

New

Life Prolonging Care

Hospice Care

Bereavement

Dx → Death

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

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

Wright et al. JAMA 2008;300:1665-73.
Association between cost and quality of death in the final week of life (adjusted P = .006)

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

<table>
<thead>
<tr>
<th></th>
<th>Total (N=332)</th>
<th>End-of-Life Discussion</th>
<th>Adjusted OR (95% Confidence Interval)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care received in the last week</td>
<td>332</td>
<td>123 (37.0)</td>
<td>209 (63.0)</td>
<td></td>
</tr>
<tr>
<td>ICU admission</td>
<td>31 (9.3)</td>
<td>5 (4.1)</td>
<td>26 (12.4)</td>
<td>0.35 (0.14-0.90)</td>
</tr>
<tr>
<td>Ventilator use</td>
<td>25 (7.5)</td>
<td>2 (1.6)</td>
<td>23 (11.0)</td>
<td>0.26 (0.08-0.83)</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>15 (4.5)</td>
<td>1 (0.8)</td>
<td>14 (6.7)</td>
<td>0.16 (0.03-0.80)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>19 (5.7)</td>
<td>5 (4.1)</td>
<td>14 (6.7)</td>
<td>0.36 (0.13-1.03)</td>
</tr>
<tr>
<td>Feeding tube</td>
<td>26 (7.9)</td>
<td>11 (8.9)</td>
<td>15 (7.3)</td>
<td>1.30 (0.55-3.10)</td>
</tr>
<tr>
<td>Outpatient hospice used</td>
<td>213 (64.4)</td>
<td>93 (76.2)</td>
<td>120 (57.4)</td>
<td>1.50 (0.91-2.48)</td>
</tr>
<tr>
<td>Outpatient hospice ≥1 wk</td>
<td>173 (52.3)</td>
<td>80 (65.6)</td>
<td>93 (44.5)</td>
<td>1.65 (1.04-2.63)</td>
</tr>
</tbody>
</table>

Abbreviation: ICU, intensive care unit; OR, odds ratio.
<sup>a</sup>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.

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

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Fenrol, PhD; J. Brian Cassel, PhD; Melissa Coast-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 2,906 palliative care patients who were discharged alive, 2,630 palliative care patients (90%) were matched to 1,842 usual care patients, and of the 2,388 palliative care patients who died, 2,278 (95%) were matched to 2,124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $169 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 $4,098 in direct costs per admission (P < .003) and $574 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 model 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

METHODS

We used hospital administrative data to compare hospital costs of patients reported in a palliative care consultation program with patients receiving usual care.
## Hospital Palliative Care Reduces Costs

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

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

*p<.001

**p<.01

***p<.05

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

“It is thornlike in appearance, but I need to order a battery of tests.”
Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

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Care, Not Cure

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

<table>
<thead>
<tr>
<th></th>
<th>NON-PCU</th>
<th>PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and chemotherapy</td>
<td>$2,267</td>
<td>$511</td>
</tr>
<tr>
<td>Lab</td>
<td>1,134</td>
<td>56</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>615</td>
<td>29</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>1,821</td>
<td>731</td>
</tr>
<tr>
<td>Room &amp; nursing</td>
<td>4,330</td>
<td>3,708</td>
</tr>
<tr>
<td>Other</td>
<td>2,152</td>
<td>278</td>
</tr>
<tr>
<td>Total</td>
<td>$12,319</td>
<td>$5,313</td>
</tr>
</tbody>
</table>

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
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

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)

Choose another national map:
State-by-State Report Card

Grade
A B C D F
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

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)
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.”