



THE CASE FOR HOSPITAL PALLIATIVE CARE

Improving Quality. Reducing Cost.



“The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians’ failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.”¹ — ERIC CASSELL, MD

Palliative care is the medical subspecialty focused on preventing, treating and relieving the pain and other debilitating effects of serious and chronic illness.

Palliative care is not dependent on prognosis and can be delivered at the same time as curative treatment. The ultimate goal: to improve quality of life for patients and families facing serious illness.

Palliative care programs support the primary physician and the patient by providing:

- **Time** to devote to intensive family meetings and patient/family counseling.
- **Expertise** in managing complex physical and emotional symptoms such as pain, shortness of breath, depression and nausea.
- **Support** for resolving questions and conflicts between families/patients and physicians concerning care goals, DNR orders and treatment requests.
- **Coordination** of care across health care settings.

time

expertise

support

coordination

Different from Hospice and “End-of-Life” Care

Until a decade ago, palliative care in the United States was typically available only to patients enrolled in hospice. But today palliative care is no longer limited to end-of-life care. Palliative care programs are found in hospitals, offering treatment to patients suffering from serious, complex illness regardless of prognosis. Patients may also receive palliative care services along with curative treatment.

Of course, palliative care is also available to patients nearing the last months of life; for them, palliative care dovetails with hospice to provide necessary treatment and services.

A New Paradigm for Managing Serious and Chronic Illness

Thanks to modern medicine, people are living longer with serious, chronic and complex illness. But today’s health care system is fragmented and difficult to navigate—just when the medical needs of chronically ill patients are growing at a rapid rate. Add to this scenario the fact that today’s health care consumers, especially baby boomers, are aging—and age brings increased health care demands.

A new and better paradigm is clearly called for, one that can meet these new demands. Palliative care *is* the new paradigm. It provides interdisciplinary coordination and team-driven continuity of care that best responds to the episodic and long-term nature of chronic, multifaceted illness. And because palliative care efficiently utilizes hospital resources and delivery systems, it provides patients, medical institutions, the health care system and clinicians with an ongoing, effective and inclusive solution to a growing and difficult challenge.

A RISING
TREND

53 percent
of hospitals with more than
50 beds
reported the presence of a palliative care program in 2006.

Source: Goldsmith B, Dietrich J, Du Q, Morrison RS. Variability in access to hospital palliative care in the United States. *J Palliat Med.* 2008 Oct;11(8):1094-102.

PALLIATIVE CARE IS APPROPRIATE AT
ANY POINT IN A SERIOUS ILLNESS



PALLIATIVE CARE
COUNTS

In its annual ranking of hospitals,
U.S. News & World Report
includes the presence of palliative care services in its evaluation criteria.

**Hallmarks of a
New, Vital Trend:
Expert Symptom
Management,
Communication and
Coordination**

Palliative care provides continuity of care and a level of coordination that responds to the episodic and long-term nature of serious and chronic illnesses. These are the pillars of palliative care:

- Improve the quality—while lowering the cost—of hospital care.
- Improve quality of life for patients and families struggling with serious and chronic illnesses with which they might live for years, including heart and lung disease, diabetes, cancer and Alzheimer's disease.
- Handle time-intensive family/patient/physician meetings.
- Coordinate care for patients and families dealing with many doctors and a fragmented medical system.
- Support patients and families struggling with serious illness and complex decisions.
- Provide specialty-level assistance to the attending physician for difficult-to-treat pain and other symptoms, including nausea, shortness of breath, fatigue, constipation and depression.
- Support the attending physician and discharge planning staff to efficiently transition patients to care settings that best fit patients' needs.
- Improve patient and family satisfaction with the hospital, overall medical treatment, physicians and the health care team.
- Improve physician and nurse satisfaction and retention by providing support and guidance during emotionally overwhelming clinical situations.
- Help meet Joint Commission accreditation standards.

Hospitals are starting
palliative care programs
at a rapid pace.

expertise
quality
time
coordination
support

Building the Hospital of the Future

Consider these facts and statistics:

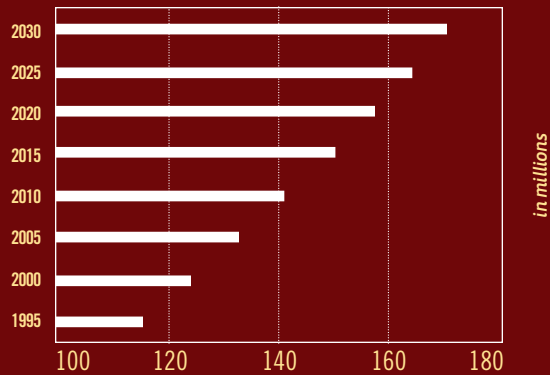
- American hospitals are filling rapidly with seriously ill and frail adults. By 2030, the number of people in the United States over the age of 85 is expected to double to 8.5 million.
- Most people facing serious illness will end up in the hospital at some point in their illness.
- Palliative care reduces long lengths of stay, high costs per day and the often futile high utilization of critical care and other hospital resources.

Forward-looking hospitals understand that palliative care is a “triple win”—as beneficial to the patient as it is for the physician as it is for the hospital. The most visionary and practical hospitals are taking action. Over the past five years, the number of academic, community and faith-based hospitals offering palliative care services has soared. The American Hospital Association reports that more than 53 percent of American hospitals with at least 50 beds had a palliative care program as of 2006. Palliative care programs are now the rule, and not the exception.

The conclusion is simple and inevitable: the hospital of the future must successfully deliver high-quality care for its most complex patients while remaining fiscally viable. Palliative care is essential to achieving the goal of excellent yet cost-effective care.

THE NUMBER OF PEOPLE WITH CHRONIC CONDITIONS IS INCREASING RAPIDLY

Source: Shin-Yi and Green, RAND, October 2000.



The sickest

10% of the U.S. population

accounts for

64% of health care

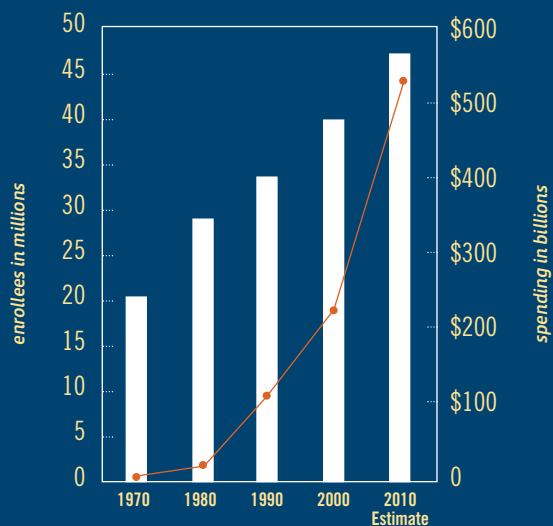
expenditures.

Source: S. H. Zuvekas and J. W. Cohen. Prescription Drugs and the Changing Concentration of Health Care Expenditures. *Health Affairs*, Jan/Feb 2007 26(1):249-57.

BURDEN OF CARE: GROWTH IN MEDICARE ENROLLMENT & SPENDING

Source: Center for Medicare and Medicaid Services

■ Enrollment (left scale)
● Spending (right scale)



**Palliative Care
Programs Maximize
Hospital Efficiency
and Lower Costs**

Palliative care programs have been shown to:

- **Lower costs for hospitals and payers.** The data are in. Palliative care programs in hospitals require a relatively low start-up investment. Palliative care provides a clear, effective and immediate system of care for “outlier patients” (those with the highest-intensity needs within an inpatient population) by matching them with appropriate health care resources and transitioning them to optimal care settings. Palliative care programs also reduce overall resource and ED/ICU utilization. Direct costs for palliative care programs are more than offset by the financial benefit to the hospital system.
- **Merge quality with efficiency.** Replacing futile, burdensome interventions with patient-centered palliative care improves the patient and family experience and strengthens satisfaction with the hospital. Hospitals can better plan daily resource use by following a clear and effective care plan, in the process reducing costs for redundant, unnecessary or unwanted tests and pharmaceuticals.
- **Transition patients to appropriate levels of care.** Ensuring that patients are more quickly transitioned to appropriate levels of care reduces the length of a patient’s hospital stay, especially in the ICU.

The majority of hospitals today are losing money treating Medicare and Medicaid patients, while growing government shortfalls are jeopardizing hospitals’ financial health.

Investment in chronic care management will be key in controlling future costs. The good news is that just as palliative care programs provide higher-quality care for patients, they also provide a better bottom line for hospitals.



**REDUCING
HOSPITAL COSTS**

On average, palliative care consultation
is associated with

**reductions of \$1,700
per admission**

for live discharges and

**reductions of \$4,900
per admission**

for patients who died in the hospital.

This means savings of more than

**\$1.3 million for a
300-bed community hospital**

and more than

**\$2.5 million for the
average academic medical center.**

Source: Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with U.S. hospital palliative care consultation programs. *Arch Intern Med.* 2008 Sep 8;168(16):1783-90.

Improving Clinical Outcomes

Studies have consistently shown that patients with life-threatening illness experience untreated pain and other symptoms; lengthy hospitalizations involving unwanted, often futile and costly medical treatments; and low overall family satisfaction—particularly with the quality of their hospital care.²⁻⁹

- Palliative care consult services are associated with reductions in symptoms, high family satisfaction with overall care and greater emotional support, as compared with usual care.
- Palliative care interventions in the ICU have consistently demonstrated reduced length of stay and reduced hospital cost.
- Palliative care helps patients complete treatments, including rehabilitation. Pain and other symptoms result in complications and slower recovery for patients. Studies show that cancer patients receiving palliative care during chemotherapy are more likely to complete their cycle of treatment, stay in clinical trials and report a higher quality of life than similar patients who did not receive palliative care.
- Studies show that palliative care programs increase the rate of hospice referral for patients whose disease is nonresponsive to curative intervention or who determine that the burdens of treatment outweigh their benefits.

Joan Clark is a 72-year-old woman who was admitted to the ICU with dementia, stage 4 pressure ulcers and fever. Surgical treatment and repeated courses of antibiotics did nothing to alter her ulcers' progression, and fever and pain persisted. Two weeks into her hospitalization, Mrs. Clark was agitated, moaning and refusing dressing changes because of pain.

On day 15 of her hospitalization, her nurse case manager called for a palliative care consultation. The palliative care team met with the patient's two daughters, who were her health care proxies. It quickly became clear that the daughters did not understand the severity of their mother's illness, nor were they fully aware of the reasons for her rapid decline. After two family meetings, however, the team worked with the patient's daughters and granddaughter to develop a plan of care that focused on maximizing Mrs. Clark's comfort and sense of security. The plan included transferring her back to a nursing home, initiating a low dose of morphine for her ulcer pain, spoon feeding for comfort and implementing a "do not resuscitate" order.

Two days later, Joan was discharged to a nursing home. Two months later she was interactive and comfortable. Her family expressed tremendous satisfaction, and they visit Mrs. Clark daily in the nursing home.

Providing Quality Care That Patients Want

People with serious illness want the types of services that palliative care provides—and they expect today’s hospitals to deliver these services.¹⁰⁻¹³

- **Patients want vigorous treatment of their pain and other symptoms.** Pain is the most common and widely feared symptom of hospital patients. Untreated pain results in medical complications, increased length of hospital stay, unnecessary suffering, increased use of health care resources and decreased patient satisfaction. More than 90 percent of pain episodes and other symptoms can be effectively treated with standard analgesic therapies provided and closely monitored by a palliative care team.
- **Patients want relief from worry, anxiety and depression.** These are the leading symptoms of patients with serious illness. Palliative care clinicians treat these symptoms, allowing patients and their families to enjoy the best possible quality of life.
- **Patients and families want close communication about their care over time.** Patients want a voice in their care. They and their families want clear, ongoing communication about what to expect and how to plan for their treatment and their future. Communication is central to the treatment approach provided by palliative care.
- **Patients want well-coordinated care and transitions.** Palliative care teams help patients and families navigate the health care system, including locating and accessing home health services, nursing homes, hospice and more.

- **Patients want support for family caregivers.** Seriously ill patients are concerned with reducing burdens on their loved ones and want help involving their family in care decisions. Trained palliative care professionals have expertise in patient/family/medical team dynamics.
- **Patients want a sense of safety in the health care system.** Recent surveys show concern among patients about the possibility of medical errors and lack of coordination and communication about their care during their hospital stays. Palliative care patients report that their care is closely monitored and well communicated.

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coordination

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support

a sense of safety in
the health care system

safety

PALLIATIVE CARE:
PROVIDING QUALITY CARE
THAT PATIENTS WANT

**Interview with
DIANE E. MEIER, MD**

*Director,
CENTER TO ADVANCE
PALLIATIVE CARE*

How did you become interested in palliative care?

After years of working as a geriatrician in a teaching hospital in New York City, I witnessed patients with serious and advanced illness try in vain to navigate the complexities of our health care system. I saw the physical and emotional toll it took on them and their families, and I saw stress in doctors and other health care staff who just did not have time to provide all the help these patients needed. At the same time, the field of palliative care began achieving national attention, providing me with a constructive means of response to the problems I was seeing.

What types of services do you provide?

Palliative care teams provide consultation services to physicians who manage highly complicated patients in a very time-pressured setting. We also make sure that patients get meticulous attention to pain and symptom issues throughout the day in the hospital. We spend a great deal of time ensuring good communication with everyone: the patient, the family, the primary doctor and nurse, all the consulting physicians and the rest of the interdisciplinary health care team. This level of communication is absolutely necessary to provide quality, coordinated care.

How do you work with a patient's primary care physician in the hospital?

The primary care team is our client. We're not here to take over care of the patient, but rather we aim to support the primary attending physician. We serve as the eyes, ears and hands of physicians who work all day in their own practices, but who nevertheless have patients who are very sick and in the hospital. This means helping them coordinate care and often conducting repeated, lengthy family meetings to help patients and families discuss their situations and arrive at important care decisions.

What special skills do palliative care professionals need?

Quite frankly, palliative care requires skills that are not always taught in medical school but are crucial to working with patients with advanced, chronic illness. Most important, palliative care professionals need rigorous training in symptom identification and management. They also need training in how to communicate difficult information under very painful circumstances. This is hard for all of us, and is therefore often avoided, but patients need a very clear understanding of what is going on with their bodies and the implications for their care. Lastly, palliative care professionals must have a genuine ability to work on a team that typically includes a doctor, nurse, social worker and a member of the clergy. The team approach ensures that the stresses and responsibilities of this work are shared.

How is palliative care paid for?

Hospitals bill for inpatient days under traditional Medicare/Medicaid or commercial insurance. Physicians (and in some states, advanced practice nurses) bill for palliative care consultation services under Medicare Part B and commercial insurance.

However, billing revenue cannot match the program costs due to the time-intensive nature of the clinical work. Philanthropy should be sought as a significant contributor to the palliative care program financial plan.

Finally and most importantly, hospitals contribute direct funds to support palliative care program staff, typically providing 50 percent or more of the overall program funding. This investment will be amply repaid through cost avoidance, the reduction in direct costs resulting from palliative care's ability to clarify goals and reduce unnecessary ICU days, pharmaceuticals, X-ray and laboratory costs. The typical return on investment is between two to three dollars saved for every one dollar invested in program costs.



DIANE E. MEIER, MD

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How does a hospital implement a palliative care program?

After many years of helping hospitals start palliative care programs, CAPC has identified the following key steps:

1. Seek out early guidance from CAPC and avoid reinventing the wheel: www.capc.org.
2. Form an interdisciplinary planning committee of key stakeholders: hospital administration, chronic disease management staff, physicians, nursing, social work, discharge planning, chaplaincy and finance managers.
3. Gather facts to document the current problems in the care of seriously ill patients: data on pain and symptom management, length of stay, cost per day and patient/family satisfaction data.
4. Review the literature on palliative care program impact and clinical service models.
5. Develop a business plan and implementation action plan.

Are there standards to define the optimal palliative care program components?

In 2004, a national consensus panel was formed to define the components of a quality palliative care program, including such issues as staffing, clinical services and quality monitoring. Based on these standards, the National Quality Forum has developed a list of 38 Preferred Practices in Hospice and Palliative Care for health care settings.

Are there palliative care resources available for patients and families?

Yes. GetPalliativeCare.org provides clear palliative care information. Key components of the site include a Palliative Care Directory of Hospitals, links to other resources and a detailed definition of palliative care and how it differs from hospice care.

Endnotes

1. Cassell EJ. The nature of suffering and the goals of medicine. *N Engl J Med*. 1982 Mar 18;306(11):639–45.
2. Delgado-Guay MO, Parsons HA, Li Z, Palmer LJ, Bruera E. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team. *Cancer*. 2009 Jan 15;115(2):437–45.
3. Field BE, Devich LE, Carlson RW. Impact of a comprehensive supportive care team on management of hopelessly ill patients with multiple organ failure. *Chest*. 1989 Aug;96(2):353–6.
4. Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. *J Palliat Med*. 2008 Mar;11(2):180–90.
5. Gelfman L, Meier DE, Morrison RS. Does palliative care improve quality? a survey of bereaved family members. *J Pain Symptom Manage*. 2008 Jul;36(1):22–8.
6. Higginson IJ, Finlay IG, Goodwin DM, et al. Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *J Pain Symptom Manage*. 2003 Feb;25(2):150–68.
7. Manfredi PL, Morrison RS, Morris J, Goldhirsch SL, Carter JM, Meier DE. Palliative care consultations: how do they impact the care of hospitalized patients? *J Pain Symptom Manage*. 2000 Sep;20(3):166–73.
8. Pierucci RL, Kirby RS, Leuthner SR. End-of-life care for neonates and infants: the experience and effects of a palliative care consultation service. *Pediatrics*. 2001 Sep;108(3):653–60.
9. van Staa AL, Visser A, van der Zouwe N. Caring for caregivers: experiences and evaluation of interventions for a palliative care team. *Patient Educ Couns*. 2000 Aug;41(1):93–105.
10. Desbiens NA, Wu AW. Pain and suffering in seriously ill hospitalized patients. *J Am Geriatr Soc*. 2000 May; 48(5 Suppl):S183–6.
11. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA*. 1999 Jan 13;281(2):163–8.
12. Steinhauser KE, Christakis NA, Clipp EC, et al. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*. 2000 Nov 15;284(19):2476–82.
13. Wolfe J, Grier HE, Klar N, et al. Symptoms and suffering at the end of life in children with cancer. *N Engl J Med*. 2000 Feb 3;342(5):326–33.

THE CENTER TO ADVANCE PALLIATIVE CARE (CAPC) provides health care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings. CAPC is a national organization dedicated to increasing the availability of quality palliative care services for people facing serious illness.

CAPC is supported by a consortium of funders including the Robert Wood Johnson Foundation. Direction and technical assistance are provided by Mount Sinai School of Medicine, New York City.

To learn more about CAPC tools, training and technical assistance, visit www.capc.org or call 212.201.2671.

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