“How to change a culture to make it easier to promote and provide palliative care.”

Patrick J. Coyne MSN, ACHPN,ACNS-BC,FAAN,FPCN
Palliative Care Director
Medical University of South Carolina
Specialist Palliative Care elements:
- Patient-centered, family-oriented
- Expert symptom management
- Excellence in communication & care planning

1. Process Measures
   - Who: Team & recipient characteristics
   - What: Symptom management, patient / family meetings
   - When: Timing of palliative care relative to other events
   - Where: Locations, settings
   - How: Expertise, algorithms, techniques, time spent
   - How much: Volume, frequency, duration, intensity of PC

2. Outcome Measures
   
   Primary impact is on the patient
   A. Prevention & relief of pain and other symptoms
   B. Clarification of prognosis and goals of care
   C. Changes to kind and setting of care provided

   Secondary impact is on those around patient
   D. Family – less confused, more satisfied, better coping
   E. Nurses, doctors – appreciate specialist help, less distress

   Tertiary impact is on institutions, systems
   F. Providers and payors – Fiscal and operational changes
      - Frequency, intensity, duration, costs, revenues
      - Different settings, entities
   G. Assist hospital or other provider / setting with overall quality & performance metrics

Cassel JB. The importance of following the money in the development and sustainability of palliative care. Palliat Med 2013 27(2) 103-104.
<table>
<thead>
<tr>
<th>Study</th>
<th>Survival</th>
<th>Patient Experience</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brumley, 2007 (1/3 ca)</td>
<td>=</td>
<td>+++</td>
<td>-$7550/person</td>
</tr>
<tr>
<td>Gade, 2008 (1/3 ca)</td>
<td>=</td>
<td>+++</td>
<td>-$4885/person</td>
</tr>
<tr>
<td>Bakitas 2009 (Cancer)</td>
<td>Longer, 5.5 mon, NS</td>
<td>+++</td>
<td>=</td>
</tr>
<tr>
<td>Temel 2010 (lung ca)</td>
<td>Longer, 2.7 mon, S</td>
<td>+++</td>
<td>Greer J, JPM 2016</td>
</tr>
<tr>
<td>Higginson 2012 (MS) [look for much larger RCT soon]</td>
<td>=</td>
<td>++++++ C+</td>
<td>-$2700/person/12 wks</td>
</tr>
<tr>
<td>Zimmermann, 2014 (Cancer)</td>
<td>=</td>
<td>+++</td>
<td>=</td>
</tr>
<tr>
<td>Higginson 2014 (dyspnea, most cancer)</td>
<td>Longer, S, 15/100 at 1000 days for non-cancer = for lung ca</td>
<td>+++</td>
<td>-$325/person for cancer Better QOL dominates cost-effectiveness</td>
</tr>
<tr>
<td>Sidebottom, 2015 (CHF)</td>
<td>=</td>
<td>++++, C+</td>
<td>=</td>
</tr>
<tr>
<td>Bakitas 2015 (Ca)</td>
<td>Longer, 6.5 mon, S</td>
<td>=,+; C+</td>
<td>=</td>
</tr>
<tr>
<td>Ferrell, 2015 (Lung Ca)</td>
<td>Longer 6 mons NS</td>
<td>++++, C+</td>
<td>=</td>
</tr>
<tr>
<td>Grudzen, 2016 (Cancer patients in ED)</td>
<td>Longer, 5.2 mons, NS</td>
<td>+++</td>
<td>=</td>
</tr>
</tbody>
</table>
Documented Impact of Inpatient Palliative Care Consultation

- Proven benefits of INPATIENT palliative care with referral to hospice if indicated
  - Better symptom control
  - Less distress in patients, caregivers
  - Equal survival

- Lowered costs per day by 10-50% in the hospital
- Increased utilization/referral to hospice
- Lowered hospital re-admission rates if enrolled in hospice or followed by PC (5% vs. 25%)
- $5-7000 savings per person at Kaiser Permanente (2006 $)
Cancer patient symptoms are improved by PC consultation or transfer

Memorial Symptom Assessment Scale, Condensed
30 pts with at least 2 consult days and symptoms >0
Khatcheressian J, et al. Oncology September 2005
# Savings from PC Inpatient Consultation

The consult service generates considerable, reproducible cost savings compared to usual care. Every vertically integrated HMO uses PC (Kaiser, Sutter Health, MGH Partners, etc.)

<table>
<thead>
<tr>
<th>Representative Studies</th>
<th>Palliative care CONSULT savings compared to usual care</th>
</tr>
</thead>
</table>
| Morrison SR, et al. JAMA Int Med 2008 8 centers with established PC consult programs | *14% direct cost savings, alive discharges; -$2374 in 2014 dollars  
*22% direct cost savings, decedent discharges; -$6871 in 2014 dollars |
| Penrod J, et al. J Palliat Med 2010 VAMCs that had established PC consult programs | 38% direct cost savings for PC patients, overall, compared to matched patients not seen by PC |
| Starks et al. J Palliat Med 2013 1815 PC patients and 1790 comparison patients at 2 academic hospitals | costs were lower for all PC patients by 13% ($2141), and for survivors by 19.1% ($2946) |
| Tangeman JC et al. J Palliat Med 2014 1004 patients in Western NY hospitals, propensity matched PC or not | 16% reduction, $35,824, compared to $42,731 for standard care, $6907 less |
| May P, et al. J Clinic Oncol 2015 (Meier, Smith, et al 5 center RO1) | 24% reduction in direct costs if patient seen by the end of the 2nd day, -$2,280  
14% reduction in direct costs if patient seen by 6 days, -$1312 |
| May P, et al. Health Affairs 2016 (Meier, Smith, et al 5 center RO1) | PC consultation within 2 days gave a  
- 22% reduction in direct costs, with 2-3 co-morbidities  
- 32% lower costs with 4 comorbidities |

**Summary:** 10-25% savings in direct costs across all studies  
With better symptom control
The cost per day is reproducibly reduced as the goals change. JH data.

<table>
<thead>
<tr>
<th>Chg Bucket</th>
<th>Pre-transfer</th>
<th>PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Charge</td>
<td>Net Allowable</td>
</tr>
<tr>
<td>Drug</td>
<td>252</td>
<td>164</td>
</tr>
<tr>
<td>Lab</td>
<td>518</td>
<td>361</td>
</tr>
<tr>
<td>O.R.</td>
<td>178</td>
<td>126</td>
</tr>
<tr>
<td>Other</td>
<td>293</td>
<td>213</td>
</tr>
<tr>
<td>Radiology</td>
<td>475</td>
<td>331</td>
</tr>
<tr>
<td>Routine</td>
<td>2,366</td>
<td>1,535</td>
</tr>
<tr>
<td>Supplies</td>
<td>362</td>
<td>264</td>
</tr>
<tr>
<td>Therapies</td>
<td>318</td>
<td>197</td>
</tr>
<tr>
<td>Unregulated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>4,762</td>
<td>3,190</td>
</tr>
<tr>
<td>Loss per day</td>
<td>-1572</td>
<td></td>
</tr>
</tbody>
</table>
# Savings from PC Inpatient Consultation

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**Summary:**  
10-25% savings in direct costs across all studies  
With better symptom control
## Savings from Inpatient PC units

PCUs reliably improve care and satisfaction, reduce costs.

*More people go home with hospice, too.*

<table>
<thead>
<tr>
<th>Study</th>
<th>Palliative care CONSULT savings compared to usual care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith TJ, et al. JPM 2003</td>
<td>50-60% savings in the final days of life</td>
</tr>
<tr>
<td>Smith TJ, et al. WSJ 2004</td>
<td>Over 50% savings for decedents</td>
</tr>
<tr>
<td>Albanese JPM 2013</td>
<td>Savings from APCU was $848,556, over half of which came from ICU to APCU transfers. $4060/case.</td>
</tr>
<tr>
<td>Nathaniel JPM 2015</td>
<td>mean of patients' average direct cost per day was $687 less while on the PCU than before (P &lt; 0.001)</td>
</tr>
</tbody>
</table>
We showed that palliative care programs save money for hospitals and health systems...

A High-Volume Specialist Palliative Care Unit and Team May Reduce In-Hospital End-of-Life Care Costs

THOMAS J. SMITH, M.D., PATRICK COYNE, R.N., M.S.N., BRIAN CASSEL, Ph.D., LYNNIE PENBERTHY, M.D., ALISON HOPSON, R.N., M.S.N., and MARY ANN HAGER, R.N., M.S.N.

ABSTRACT

**Background:** Current end-of-life hospital care can be of poor quality and high cost. High-volume and/or specialist care, and standardized care with clinical practice guidelines, has improved outcomes and costs in other areas of cancer care.

**Methods:** The objective of this study was to measure the impact of the palliative care unit (PCU) on the cost of care. The PCU is a dedicated 11-bed inpatient (PCU) staffed by a high-volume specialist team using standardized care. We compared daily charges and costs of the days prior to PCU transfer to the stay in the PCU, for patients who died in the first 6 months after the PCU opened May 2000. We performed a case-control study by matching 38 PCU patients by diagnosis and age to contemporary patients who died outside the PCU cared for by other medical or surgical teams, to adjust for potential differences in the patients or goals of care.

**Results:** The unit admitted 237 patients from May to December 2000. Fifty-two percent had cancer followed by vascular events, immunodeficiency, or organ failure. For the 123 patients with both non-PCU and PCU days, daily charges and costs were reduced by 66% overall and 74% in “other” (medications, diagnostics, etc.) after transfer to the PCU ($p<0.0001 for all).

Comparing the 38 contemporary control patients who died outside the PCU to similar patients who died in the PCU, daily charges were 59% lower ($5,304 ± 5,850 to $2,172 ± 2,250, $p=0.005), direct costs 56% lower ($1,441 ± 1,438 to $632 ± 690, $p=0.004), and total costs 57% lower ($2,538 ± 2,918 to $1,095 ± 1,153, $p=0.009).

**Conclusions:** Appropriate standardized care of medically complex terminally ill patients in a high-volume, specialized unit may significantly lower cost. These results should be confirmed in a randomized study but such studies are difficult to perform.
Then, we hit the mainstream...

**THE WALL STREET JOURNAL.**

*Final Days*
Unlikely Way to Cut Hospital Costs: Comfort the Dying

$7000 less in last 5 days of life if PC involved.
With equal survival.
And better symptom control.

“I want to send a team down to learn how to do this palliative care....”
Do the spiritual assessment, call the chaplain, and have a Goals of Care/EOL discussion if appropriate

Is religion or spirituality important to you? Would you like to see a chaplain?

Generates referral to Pastoral Care

- 87% of patients want us to know their spiritual needs; 6% of us ask. Balboni M, et al. *J Clin Oncol.* 2013 Feb 1;31(4):461-7

The benefits of a PC consultation continue after people leave the hospital

- More hospice referrals: 57% vs. 27% at JHH if PC saw the person. (Highet, Shieh, Smith, JEM in press)
- In New York State Medicaid patients, 10-X increase in hospice referrals. (Morrison SR, Health Affairs 2011)
- Over 3-X increase in hospice referrals if PC consulted in New York State Hospitals.
- In MGH NSCLC randomized trial, hospice use was the same but almost 3 times longer. (Greer JA et al, JCO 2012)
  - Median 9.5 days vs. 24 days with PC
  - 33% vs 60% used hospice for < 7 days, a marker for POOR CARE (QOPI and NQF)
- 30-day readmission rate is cut from 15% to 10%, and if a “goals of care” discussion the 30-day readmission rate risk is 5%. (O’Connor NR, JPM 2015)
- 5-fold reduction in 30 day readmits, 1% versus 5%.
- 5% 30-day readmission rate versus a 25% rate for matched patients who did not go home with hospice.
- Hospice saves Medicare $8600 per person
The benefits of a PC consultation in the OUTPATIENT cancer office are similar

- Scibetta, Rabow and colleagues (JPM 2016) 922 decedents, 297 (32.2%) had palliative care referrals, with 93 (10.1%) receiving early referrals and 204 (22.1%) late referrals. Early palliative care was predominantly delivered in the outpatient setting (84%) while late palliative care was mostly delivered in the hospital (82%).
- Early palliative care patients had lower rates of inpatient admits (33% versus 66%, p < 0.01), ICU (5% versus 20%, p < 0.01), and
- ED utilization (34% versus 54%, p = 0.04) in the last month of life.
- Direct costs of inpatient care in the last 6 months of life for patients with early palliative care were lower compared to late palliative care ($19,067 versus $25,754, p < 0.01), while direct outpatient costs were similar ($13,040 versus $11,549, p = 0.85).
- $5198 less per person who had an early PC consultation
Meta concepts

• Healthcare is funded in a variety of ways
• Fundamentally the US healthcare system is rooted in “fee-for-service” third-party reimbursement in which you get paid more for doing more
• Palliative care often uses a “less is more” philosophy, and thus a special business case for PC had to be developed, Value based care
• The relevance of any given principle in this business case depends on degree of financial risk for costly care, and payor mix or revenue models
• Partnering with the entity that is at most financial risk for costly care can be a good way to pay for program / personnel
• Financial outcomes are secondary to clinical outcomes (next slide)
There are substantial savings
“Better care at a cost we can afford”

<table>
<thead>
<tr>
<th>Financial impact</th>
<th>$/year</th>
<th>5 year total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP PCU Margin</td>
<td>100,000</td>
<td>500,000</td>
</tr>
<tr>
<td>IP PCU Cost savings per Case, daily loss 59% less</td>
<td>1,336,000</td>
<td>6,680,000</td>
</tr>
<tr>
<td>PC IP Consult Cost Savings per Case $2,374 for patients discharged alive, and $6,871 for decedents, 11% died</td>
<td>2,530,000</td>
<td>12,650,000</td>
</tr>
<tr>
<td>PC OP Consult Cost Savings per case</td>
<td>1,632,172</td>
<td>8,160,860</td>
</tr>
<tr>
<td>$5198/case x 314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice referrals Cost Savings per case, $3000/case x 800</td>
<td>2,400,000</td>
<td>12,000,000</td>
</tr>
<tr>
<td>Professional fees, 50% collection rate</td>
<td>474,000</td>
<td>2370,000</td>
</tr>
<tr>
<td>Total impact</td>
<td>8,472,172</td>
<td>42,360,860</td>
</tr>
</tbody>
</table>

Does not count
- Lost revenue from chemo, other services
- Backfill revenue
- Increased ICU bed days
- Grants and contracts
- Good will, better satisfaction scores
- Less costly turnover as moral distress reduced in staff, esp. ICUs
There are substantial savings possible
“Better care at a cost we can afford”

New York Medicaid Patients: $84-252 million annually if most received PC

For US Medicaid (the other 84% of the US) savings could be $525,000,000 - $1,575,000,000

Medicare 2013: 1,904,640 deaths
1/3 in the hospital
Only 1/2 used hospice

If the others did, @$8600/person savings, US would save $8,189,952,000

THE CARE SPAN
Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

ABSTRACT: Patients facing serious or life-threatening illnesses account for a disproportionately large share of Medicaid spending. We examined 2004-07 data to determine the effect on hospital costs of palliative care team consultations for patients enrolled in Medicaid at four New York State hospitals. On average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. These reductions included $4,098 in hospital costs per admission for patients discharged alive, and $7,563 for patients who died in the hospital. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals than the matched usual care patients. We estimate that the reductions in Medicaid hospital spending in New York State could eventually range from $84 million to $252 million annually (assuming that 2 percent and 6 percent of Medicaid patients discharged from the hospital received palliative care, respectively), if every hospital with 150 or more beds had a fully operational palliative care consultation team.
Principles of the business case for PC

1. Patients with progressive, life-limiting diseases [and their families] are at-risk for pain, suffering, and death; SPC helps prevent or improve those outcomes.

2. Patients with progressive, life-limiting diseases often have potentially avoidable ED visits and hospital admissions in last months of life.

3. Hospitalizations towards the end of life tend to be lengthy and costly; these can result in negative net margin for hospitals, in both fee-for-service and risk-based models.

4. Hospitals are penalized by payors for high 30-day readmission rates, 30-day mortality rates, and similar measures; significant portion of this is driven by care at EOL.

5. Outpatient & home-based PC reduces ED visits and hospitalizations in the months before death.

6. Inpatient PC programs reduce the cost of hospital admissions that do occur.

7. In the fee-for-service model, third party revenue for PC services covers a fraction of the cost of a multi-disciplinary PC team, so subsidies are needed.

8. The value of cost-savings and operational impacts from inpatient and outpatient PC usually exceeds program investments (positive return-on-investment).

9. All health systems can evaluate opportunities and impact for PC.
Principle #2: Frequency of hospitalizations at EOL

Admissions spike in final month of life
Analysis of decedent admission patterns, VCU, FY10-12

- Kidney
- Liver
- Neuro
- HIV
- COPD
- CHF
- Cancer

6 mo 5 mo 4 mo 3 mo 2 mo 1 mo

- 140
- 153
- 191
- 224
- 295
- 453
- 758
- 105
EOL hospitalizations long, costly

**Annual Medicare inpatient net margin by month**

- **Total loss these 2 conditions, 2 months preceding death = $900,000 annually**

**Analysis of EOL utilization patterns, VCU, FY10-12**
Outpatient PC, which is usually initiated earlier in the disease-course than inpatient PC, is good for patients and can reduce utilization of expensive, invasive care in the months before death, when such care is not aligned with patient preferences.

- Brumley R et al, Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care, J Am Geriatr Soc. 2007 Jul;55(7):993-1000.
- Greer, JA et al, Effect of early palliative care on health care costs in patients with metastatic NSCLC, J Clin Oncol 30, 2012 (suppl;abstr 6004)
Inpatient PC cost savings

<table>
<thead>
<tr>
<th>PCU: Direct admits</th>
<th>PCU: Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Net Margin</td>
</tr>
<tr>
<td>206</td>
<td>$491,665</td>
</tr>
</tbody>
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\[+\]

<table>
<thead>
<tr>
<th>PC Consults: Early Engagement</th>
<th>PC Consults: Later Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Net Margin</td>
</tr>
<tr>
<td>209</td>
<td>$765,919</td>
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\[=\]

<table>
<thead>
<tr>
<th>Total Inpatient Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>Financial Impact</td>
</tr>
<tr>
<td>Avg. Impact / Case</td>
</tr>
<tr>
<td>1,149</td>
</tr>
<tr>
<td>$2,934,578</td>
</tr>
<tr>
<td>$2,554</td>
</tr>
</tbody>
</table>

Full fiscal impact VCU inpatient program, FY11
Clinical revenue covers only a fraction of the cost of a full multi-disciplinary team

- Goals-of-care consultations time consuming
- Some members of the inter-disciplinary team do not bill

Funding Sources for VCU PC Program

- Clinical revenue: 39%
- Physician practice subsidy: 23%
- Hospital subsidy: 11%
- Donations/grants: 11%
- Other: 16%
Hospital gets positive R.O.I. *

- Net financial impact of PC program at VCU Health System in FY2011: $2.9 million ($2,554 per case)
- Net hospital + physician group unreimbursed contribution to PC payroll at VCU Health System in FY2011: $520,000 ($453 per case)
- Ratio: 5.6x return-on-investment
- Confirmation: Morrison (2008) indicated 4.8 return-on-investment (that 8-hospital study did not include VCU Health System data)

* Return On Investment
Why containing costs helps hospitals for PC-relevant cases

• In systems with global budgets, like HMO-owned hospitals, safety-net systems, etc., there is a direct financial reward for providing efficient (lower cost) inpatient care

• In hospitals that have a predominantly fee-for-service (FFS) revenue model, avoiding/reducing costs has a positive effect because of the typical case mix for PC-relevant cases
  – Medicare over-represented (case rate payment)
Translating quality into finances more broadly

<table>
<thead>
<tr>
<th>Quality outcome</th>
<th>Financial metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved satisfaction</td>
<td>• HCAHPS scores → VBP score → increase reimbursement</td>
</tr>
<tr>
<td>Reduced length of stay per admit</td>
<td>• Free up beds → other admissions → additional revenue</td>
</tr>
<tr>
<td></td>
<td>• Greater profitability when payers using DRG (case rate) or per diem reimb</td>
</tr>
<tr>
<td>Reduced cost per day</td>
<td>• Greater profitability when payers using DRG (case rate) or per diem reimb</td>
</tr>
<tr>
<td>Avoid (make unnecessary) some hospitalizations</td>
<td>• Free up beds → other admissions → replace or increase revenue</td>
</tr>
<tr>
<td></td>
<td>• Reduce 30-day re-admission penalty</td>
</tr>
<tr>
<td>Avoid (make unnecessary) hospitalizations near EOL</td>
<td>• Above two bullets</td>
</tr>
<tr>
<td></td>
<td>• Improve 30-day mortality → VBP score → increase reimbursement</td>
</tr>
<tr>
<td>Survival, safety, quality</td>
<td>• Reputation → referrals</td>
</tr>
<tr>
<td></td>
<td>• Managed care contracting → reimb</td>
</tr>
<tr>
<td></td>
<td>• Patient, family, community, staff loyalty</td>
</tr>
</tbody>
</table>
PALLIATIVE CARE TRIGGER TOOL

- Code status changed to DNR
- Conflict about stopping/starting life-prolonging treatment (e.g. dialysis, chemotherapy)
- Goals of care or code status discussion needed and/or surrogate or proxy distressed about decision-making
- Uncontrolled symptoms (pain, nausea, dyspnea, insomnia, fatigue, weight loss) that interfere with quality of life
- Marked decrease in functional status/ADLs in last 60 days
- Considering PEG tube placement
- Admitted from extended-care facility with ADL dependence or chronic care needs (St John Health System)

- ? Who can call a consult?????
Palliative Care Growth in the U.S.

- In 2012, hospital programs were serving over 6 Million patients each year.
- Palliative care prevalence and # of patients served has nearly tripled since 2000.
- **100%** of the U.S. News 2014 – 2015 Honor Roll Hospitals Have a Palliative Care Team.
- **100%** of the U.S. News 2014 – 2015 Honor Roll Children’s Hospitals Have Palliative Care Teams.
We Can Improve Care and Reduce Costs by What We Do and Don’t Do.

<table>
<thead>
<tr>
<th>Doctors do not always make good transitions to end of life care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When a patient is dying discuss what the future holds.</strong></td>
</tr>
<tr>
<td>Only 37% had that discussion. If they did…</td>
</tr>
<tr>
<td>- No difference in mental health or worry;</td>
</tr>
<tr>
<td>- 52% as likely to have heroic measures</td>
</tr>
<tr>
<td>- 4% ventilation</td>
</tr>
<tr>
<td>- 27% ICU</td>
</tr>
<tr>
<td>- 3.46 x DNR</td>
</tr>
<tr>
<td>- 2x hospice</td>
</tr>
</tbody>
</table>

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

Smith TJ, Hillner BE. Bending the cost curve in cancer care.
Palliative Care Studies Show Reduced Costs

A number of studies show statistically significant savings – in addition to better care

Comprehensive 2014 literature review of studies 2002-2011
- 46 studies in total, 31 using US data
- 5 US studies examined impact of hospital-based palliative care on health-care expenditure
- Consistent results across studies finding palliative care was associated with significantly lower inpatient costs

Hughes M, Smith TJ. *Annu Rev Public Health* 2014
The Growth of Palliative Care in the United States
Vol. 35: 459-475

Palliative Med February 2014 vol. 28 no. 2 130-150
Palliative Care Value Proposition Pyramid

- Satisfaction
- Clinical Quality
- Mortality Reporting
- Readmission
- Case Costs, Bed use (LOS & ICU)
- Hospice and other community linkages
- Payor specific incentives
- Patient Centered Care
- Clinic-based care
Why Palliative Care is a Solution

- **Improves patients’ quality of life**
  - Reduces pain and other symptoms
  - Addresses patients’ goals

- **Improves family satisfaction/well-being**

- **Reduces resource utilization and costs**
  - Matches treatments to goals
  - Allows provision of higher quality care in appropriate, often less costly, settings
The randomized trial evidence for PC alongside usual care:


Emergency Department-Initiated Palliative Care in Advanced Cancer: A Randomized Clinical Trial.


