How to Change a Culture to Make It Easier to Promote and Provide Palliative Care

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Medical University of South Carolina
Remember your message varies depending on your audience!!
Health Care Spending

- Health care spending in the U.S. is appropriately concentrated on the sickest and neediest patients: the top 5% of spenders account for nearly 50% of all health care costs. This group is characterized not only by the presence of one or more serious medical illnesses, but also by functional dependency (needing another person to get through the day), cognitive impairment, frailty, and heavy reliance on family and other caregivers. Contrary to common belief, the majority of people in this highest-cost, highest-need group are living with a serious illness. Only 11% of them are in the last twelve months of life. (CAPC, 2019)
PATIENT EXPERIENCE: Twenty-two percent of people with a serious illness reported that hospital staff were not responsive to their needs, 23% reported receiving conflicting information from different health professionals, 21% would not recommend their hospital to someone else who has the same illness, and less than 50% were asked what their personal preferences would be if a critical situation should arise.

HEALTH CARE COSTS: Thirty-seven percent reported having used up all or most of their savings dealing with their health and medical condition, even though 91% reported having health insurance. Twenty-three percent reported being unable to pay for necessities like food, heat, or housing.

CAREGIVER DISTRESS: More than one-third of those who received help from a family caregiver noted strains and burdens on their caregivers, including emotional stress, physical stress, financial issues, and poorer health.
## Biggest Concerns For Patients With Serious Illness

**%Biggest/ One of Biggest Concerns**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors might not provide all of the treatment options or choices available</td>
<td>58%</td>
</tr>
<tr>
<td>Doctors might not talk and share information with each other</td>
<td>55%</td>
</tr>
<tr>
<td>Doctors might not choose the best treatment option for a seriously ill patient’s medical condition</td>
<td>54%</td>
</tr>
<tr>
<td>Patients with serious illness and their families leave a doctor’s office or hospital feeling unsure about what they are supposed to do when they get home</td>
<td>54%</td>
</tr>
<tr>
<td>Patients with serious illness and their families do not have enough control over their treatment options</td>
<td>51%</td>
</tr>
<tr>
<td>Doctors do not spend enough time talking with</td>
<td>50%</td>
</tr>
</tbody>
</table>

ACS 2011
Language makes a difference. Palliative care should be positioned as care for patients with serious illness not advanced illness. Advanced illness is perceived to be more closely aligned with terminal illness.
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>+++++</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
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>-785</td>
</tr>
</tbody>
</table>
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
# 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.

Daily charges were 59% lower, total costs were 57% lower.

$2358 -> $1095

P=0.009
We hit the mainstream...

“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

Productivity is a “Dependent” Variable

Track and report program metrics that demonstrate:
- Consistency
- Reliability
- Quality aligned with NCP guidelines

- Location & travel time
- Patient needs
- MD culture
- Collaborators/roles

- Staffing mix
- Role clarity and teamwork
- Schedules & Norms
- Systems & Tools
- Recruit/training

- New Consult Volume
- IDT Staffing

- Non-billable work
- Teaching (academic)
- Education & Outreach
- Change Process Projects

- Follow-up Capacity
- Speed to action
- Coverage (weekends?)
- Communication & Handoffs

- Counting other “Value Added”? Effectiveness (Impact)
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>$/year</th>
<th>$/year, 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>1,632,172</td>
<td>8,160,860</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
On average, palliative care consultation is associated with reductions in direct hospital costs of more than $3,000 per admission, and for the sickest patients with four or more diagnoses, these cost savings are closer to $4,800 per admission.
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
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.
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

<table>
<thead>
<tr>
<th>Month</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mo</td>
<td>140</td>
</tr>
<tr>
<td>5 mo</td>
<td>153</td>
</tr>
<tr>
<td>4 mo</td>
<td>191</td>
</tr>
<tr>
<td>3 mo</td>
<td>224</td>
</tr>
<tr>
<td>2 mo</td>
<td>295</td>
</tr>
<tr>
<td>1 mo</td>
<td>758</td>
</tr>
</tbody>
</table>
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
# Inpatient PC cost savings

<table>
<thead>
<tr>
<th>PCU: Direct admits</th>
<th>PCU: Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Net Margin</td>
<td>Direct costs avoided</td>
</tr>
<tr>
<td>206</td>
<td>315</td>
</tr>
<tr>
<td>$491,665</td>
<td>$1,138,998</td>
</tr>
</tbody>
</table>

+ 

<table>
<thead>
<tr>
<th>PC Consults: Early Engagement</th>
<th>PC Consults: Later Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Net Margin</td>
<td>Direct costs avoided</td>
</tr>
<tr>
<td>209</td>
<td>419</td>
</tr>
<tr>
<td>$765,919</td>
<td>$537,996</td>
</tr>
</tbody>
</table>

= 

## Total Inpatient Program

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

Full fiscal impact VCU inpatient program, FY11
OP PC Reduces Costs

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)
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**

- 39%: Clinical revenue
- 23%: Physician practice subsidy
- 11%: Hospital subsidy
- 11%: Donations/grants
- 16%: Other
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??????
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><em>Only 37% had that discussion.</em> 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

As of 2019, 72% of hospitals with fifty or more beds report a palliative care team, up from 67% in 2015 and 7% in 2001. These hospitals currently serve 87% of all hospitalized patients in the U.S., an increase from 82% in 2015.

CAPC 2019
To Conclude 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

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


