A Business Case for Providing Palliative Care Services Across the Continuum of Care

Chronic illness is becoming a chronic problem.

More and more adults are faced with life limiting or progressively worsening chronic diseases. In fact, 90 million people in the U.S. live with at least one chronic illness, and seven out of ten die from chronic disease.\(^1\) By 2030, there will be 72.1 million older adults in the U.S.\(^2\) To meet their needs, the health care system will have to deliver high-quality care to the sickest patients, often with the most complex needs.

The U.S. health care system has invested in more medical resources, acute care hospitals, and intensive care units (ICUs) to manage chronically ill patients under the assumption that more intensive management will result in better care and greater patient satisfaction. The growing palliative care movement is challenging this assumption, demonstrating that palliative care can help lesson the pain of chronically ill patients, treat their symptoms more effectively, support their psychological and social needs better, and provide support with complex medical decision-making. It not only improves an individual’s care but also reduces related health care costs.

What is palliative care?

The American Board of Medical Specialties officially recognized palliative medicine as a subspecialty in 2006. Palliative care is a system of care that improves a patient’s quality of life through management of their pain and other symptoms. It includes hospice care but, unlike hospice care, which is designed to meet the needs of those approaching the last stages of life, palliative care is appropriate at any stage of a progressively chronic illness and often is provided along with curative treatments.

Successful palliative care programs use a variety of delivery systems from consultation to inpatient beds, and can be provided in the hospital, clinic, home, nursing home or hospice facility. At the core is a multidisciplinary team of health care providers—physicians, nurses, social workers, clergy, family and other caregivers—that helps the patient and their family members navigate through an often-complex health care system.

Palliative care results in patient benefits

One million Americans die each year without palliative services\(^3\) These individuals can
benefit from palliative care’s ability to:
- Provide care consistent with patients’ preferences and values
- Relieve pain and other physical, emotional and psychological suffering
- Provide better outcomes
- Help patients complete prescribed treatments
- Help both patient and family with difficult decision making
- Boost patient and family satisfaction
- Facilitate smoother and safer transitions to other appropriate care settings
- Reduce medical costs

Pain can slow the healing process. Untreated, it can result in unnecessary suffering, longer hospital stays, medical complications, and decreased patient satisfaction. According to the Center to Advance Palliative Care, palliative care relieves pain and symptoms, helps patients complete prescribed treatments, aids in difficult decision making and ultimately improves clinical outcomes.²

In addition, in 2008 the Journal of Palliative Medicine reported on an inpatient randomized controlled trial designed to measure the impact of an interdisciplinary palliative care service on patient satisfaction, clinical outcomes, and cost of care for six months post-hospital discharge.³ The trial found that patients receiving palliative care had greater satisfaction with their care and providers. It also found longer hospice stays, more advance directives upon discharge from the hospital, reduced ICU admissions on subsequent hospitalizations, and lower total health care costs. Most importantly, it found no difference in overall survival. Patient satisfaction in this trial was attributed to addressing the patient’s and family’s need for information and encouraging them to participate in care decisions that reflect their personal values and preferences.

A Health Affairs’ article noted that the percentage of patients who rate their hospitals poorly and give low scores on other measures of the patient experience is directly correlated with the overall intensity of inpatient experience, higher Medicare spending, greater resource use, and more end-of-life care.⁵ The authors noted that their “study suggests that efforts to encourage better coordination of care, rather than simply training more physicians or spending more money, holds the key to future health care reform.”⁴

Likewise, The Commonwealth Fund’s case study from Mount Sinai Medical Center reports that as a result of palliative care consultation:
- 65 percent of palliative care patients’ family members said their emotional or spiritual needs were met, compared to 35 percent of usual care patients’ family members, and
- 67 percent of palliative care patients’ family members reported confidence in their competence to participate in the care of the dying person, compared to 44 percent of usual care patients’ family members.
The Dartmouth Institute reported that nearly 55 percent of the total cost of care for Medicare beneficiaries during the last two years of life occurred in an acute care hospital setting.\textsuperscript{1} Palliative care, on the other hand, decreases length of stay, especially in ICUs, thus reducing costs. In 2007, Critical Care Medicine reported that a Medical Intensive Care Unit (MICU) study found that a proactive palliative care consultation was “associated with a significantly shorter MICU length of stay in this high-risk group without any significant differences in mortality rates or discharge disposition.”\textsuperscript{5}

Finally, chronically ill patients endure a complex and confusing medical system. Care is often fragmented and stressful, especially for elderly patients unable to coordinate their own care. Care is better coordinated when multidisciplinary care teams provide palliative care along with usual care. These teams can help patients with complex illnesses transition between care settings and remain independent longer. According to a New England Journal of Medicine article, patients trust and expect their doctors to lead. It said, “In their practices, physicians can help patients understand when a more conservative path is likely to be as safe as a more intensive and higher-cost path.”\textsuperscript{8}

**Palliative care helps reduce health care costs**

How the present health care system attempts to manage the chronically ill patient contributes to the staggering costs of health care. For example:

- 25 percent of Medicare expenses are paid for patients in the last year of life.\textsuperscript{1}
- 20 percent of cancer patients receive chemotherapy in the last 14 days of life.\textsuperscript{1}
- Most expenses involve hospital stays and hospital readmissions costs, including ICU expenses in the last year of life.\textsuperscript{1}

This makes a very strong case for using palliative care, according to the Center to Advance Palliative Care\textsuperscript{2}, as studies show palliative care decreases length of hospital and ICU stays, eases patient transitions between care settings, and increases hospital compliance with care quality standards. Researchers report that the number of programs in US hospitals with 50 or more beds increased from 658 (24.5 percent) to 1,486 (58.5)—a 125.8 percent increase from 2000-2008.\textsuperscript{3}

As the baby boomers age, hospitals are using more resources caring for patients with complex illnesses at high cost. The majority of Medicare beneficiaries spend time in a hospital during the last year of their life. Of the $491 billion spent by Medicare in 2009, 27 percent was spent on acute care (in-patient hospital) services. And, 10 percent of the sickest beneficiaries accounted for 57 percent of the total spending by Medicare.\textsuperscript{15}

The Center to Advance Palliative Care reports that with fixed/DRG payments (e.g. Medicare), hospital costs for caring for patients are often higher than the reimbursement because of long lengths of stay and high resource utilization. It said, “By establishing goals of care, reducing
symptom burden and supporting physicians through difficult decisions, direct costs and ICU length of stay will be reduced.” It estimates that for every palliative care consultation, a hospital can expect to reduce insufficiently reimbursed costs by about $1,400 per patient on average.

According to a study in Critical Care Medicine, “Early palliative care intervention in patients with multiple-organ system failure and global cerebral ischemia was associated with substantial institutional cost savings generated through decreased length of stay in ICU and avoidance of often costly, non-beneficial treatments.” It reported that the MICU length of stay was 5.72 days in the intervention group and 14.12 in the usual care group, a statistically significant difference of 8.40 days (p = 0.004).

An Archives of Internal Medicine report on a study with eight hospitals using palliative care programs indicates they:

- Saved $279-$374 per day per palliative care patient
- Saved $1,700 to $4,900 on each admission of a palliative care patient
- Reduced pharmacy, laboratory and ICU costs by more than $1.3 million/year

The Center to Advance Palliative Care reported on a 300-bed hospital with 809 palliative care patient cases per year. Savings due to reductions in direct costs per case were $2.4 million. Increase in net income was $2.1 million.

**Importance of Advance Directives on Patient Care and Costs**

The Archives of Internal Medicine reported in the “Coping with Cancer” study that “patients with advanced cancer who reported having end-of-life conversations with physicians had significantly lower health care costs in their final week of life. Higher costs were associated with worse quality of death.” The study also found:

- Patients who had not talked with their doctors were more likely to be resuscitated, intubated or put in intensive care. Those who had talked to their doctors chose more palliative care with lower costs.
- Patients with treatment did not live longer but suffered more at the end of life.
• If the national percentage of patients having end-of-life discussions with their doctors were increased to 50 percent, annual cost savings could exceed $76 million based on the number of cancer deaths annually in the United States.

The Gunderson Lutheran Health System offers an end-of-life program that includes palliative and hospice care. It makes advance directives available for all patients and ensures that health care professionals comply with the patient’s treatment choices.

Gunderson reported that patients with advance directives used $2,000 less in physician and hospital services in the last six months of life. The program reduced hospital costs $3,500 per patient in the first 15 months. It increased admissions to hospice care by 32 percent, reduced hospital readmission rates to 6 percent (vs. 18 percent in a controlled population), and had higher satisfaction scores from families of patients.13

Based on 2007 Dartmouth Atlas Study Methodology, the Gunderson program saw reimbursement per deceased patient at $7,500 less than the national average, reimbursement per day $230 less, and hospital days per deceased patient 10 days less.

In a case study of palliative care services performed at Mount Sinai Medical Center, physicians began requesting palliative care consultations earlier in their patients’ hospital stay. The earlier referrals led to improvements in multiple symptoms. For example, 32 percent of patients at their initial consult reported having moderate or severe pain. This dropped to 5.5 percent of patients at time of discharge. Discomfort, another symptom evaluated, dropped from 32 percent to 8 percent in the same time period6

**Operational Benefits**

Palliative care can help hospitals and clinics use scarce resources more effectively. In the hospital, there is improved efficiency and throughput, resulting in additional beds for post-operative surgical patients, and it reduces ICU staffing needs in low-capacity systems.

Flexible use of palliative care also supports the primary care physician in the following ways:

• Care coordination
• Patient-family communication
• Pain and symptom management (using palliative care specialty services for complex cases)
• Coordination of safe and effective discharge planning
• Overall improvement of patient satisfaction
Challenges of using a palliative care focus in primary and specialty care

In general, palliative care is a paradigm shift for health care providers who are trained to save lives by nearly any means possible, no matter the cost or likelihood of success. In addition, cost, staffing and system design were the three biggest obstacles uncovered by an Institute for Clinical Systems Improvement (ICSI) steering committee study of 52 medical organizations.\textsuperscript{14}

Cost: Reimbursement mechanisms are generally not available for palliative care delivery. Health plans typically don’t reimburse for time spent on care coordination and shared decision-making. However, implementing palliative care requires low start-up costs and can have an immediate impact, especially on cases with the highest intensity needs, overall resource use and ICU utilization, according to the Center to Advance Palliative Care. “Direct program costs are more than offset by the financial benefit to the hospital system.”

Staffing: The Center to Advance Palliative Care also noted that a hospital with a fully staffed palliative care program can reduce insufficiently reimbursed cost by $1,400 per case for every palliative care consultation. This supports the ICSI belief that savings can be realized with the use of palliative care delivered upstream in the outpatient and primary care settings as well.

Program Design: Palliative care can be applied to patients with life-limiting or progressively chronic diseases. Because it can be difficult to decide when palliative care should begin, it often occurs too late. Patients don’t always have a primary care physician to guide the process. Disagreements between physicians over care plans can ensue. In addition, different cultural perspectives due to race, ethnicity and religion may add to confusion and mistrust. Addressing these issues early and involving patients and their families in the decision-making process is helpful. Decision aids will need to be created for use across all stages of palliative care.

The literature suggests various models for palliative care via, inpatient or outpatient consultation, throughout the hospital or dedicated inpatient beds or unit, through primary care or outpatient specialty clinics. Some hospitals have programs that combine an inpatient palliative care unit with a contract for inpatient hospice care.

The ICSI Initiative

While hospitals are far and away the most likely care setting where patients are introduced to palliative care, the Center to Advance Palliative Care says palliative care is needed in all settings.

Mount Sinai Hospital found that the earlier palliative care consultations occurred, the higher the patient satisfaction and the lower the costs of care. ICSI has created a model that encourages
palliative care to be initiated as early as possible in a patient’s illness trajectory as part of usual care within primary and specialty care, and where referrals are made to a palliative care specialty program when the patient’s needs exceed the scope of the primary or specialty care provider. ICSI believes introducing palliative care’s interdisciplinary team approach as part of usual care upstream to the hospital setting will similarly improve the quality and satisfaction with the care experience while simultaneously lowering the total cost of care for patients with chronic or potentially life-limiting illness. LiLLIE (living with a life limiting illness every day) is the acronym for this initiative.

The ICSI model identifies who should receive care and when, with a goal of involving patients and their families in decisions, supported by other caregivers. ICSI believes palliative care should provide coordinated care and identify what should be considered minimal services and stages.

ICSI’s efforts are supported by a grant from the Robert Wood Johnson Foundation, which provided funding for creation of the LiLLIE model and for ICSI to identify or create decision aids that will enable shared decision-making with palliative patients. Funding also supported a pilot to test infrastructures and processes that help patients and their families participate in the process, provide feedback, and share perceptions on shared decision-making.

ICSI has put all elements of palliative care together into a model that can be piloted by both primary and specialty care. (Visit www.icsi.org for more details.) This includes referral to palliative care specialty for more complex patients that require a more intensive focus.

References

3. Center to Advance Palliative Care, April 5, 2010
6. Foubister V. Case Study: Proving and Then Improving the Value of Palliative Care Services at Mount Sinai Medical Center. The Commonwealth Fund, 2004-2009.

About ICSI

ICSI is an independent, non-profit organization that helps its members deliver evidence-based health care services to people in Minnesota and surrounding states. ICSI is composed of 55 medical groups representing nearly 9,000 physicians, and is sponsored by five Minnesota and Wisconsin non-profit health plans. Its demonstrated collaborative and innovative processes enable ICSI to unite diverse stakeholders in the health care system to deliver patient-centered and value-driven care.