Research Into Practice: Building Bridges, Effecting Change
Collaborative Vision and Mission: CAPC+NPCRC

Vision:
- All patients with serious illness and their families will have access to quality palliative care throughout the disease course and across care settings

Mission:
- To ensure that patients and families know to request palliative care
- To ensure that medical professionals have the knowledge and skills to provide palliative care
- To ensure that hospitals and other healthcare institutions are equipped to deliver and support quality palliative care
A Collaborative Process

Identification of Need/Evidence Gap

Translate Research into Technical Assistance Products

Research to Address Knowledge Gap

Pilot Test Tools

Evaluate

Promote and Influence Policy

Modify, Disseminate, and Assist with Adoption

Enhance Consumer Education and Knowledge
Knowledge Translation: NPCRC ➔ CAPC

• Cost savings associated with palliative care teams
• State-by-state report card on palliative care teams
• National registry of palliative care teams
Cost Savings Associated with Hospital Palliative Care Consultation

• Designed and conducted to:
  – Identify and quantify cost-savings that palliative care programs provide to hospitals
  – Apply propensity score and instrumental variable methods to palliative care research
  – Provide national normative cost data for hospitals
  – Examine cost savings across different systems of care (Medicare, Medicaid, VA)
The Research

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

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**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 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18,427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $279 and $4908 in direct costs per admission ($P = .003) and $374 in direct costs per day ($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 $4908 in direct costs per admission ($P = .003) and $374 in direct costs per day ($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 models 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.
Hospital-Based Palliative Care Consultation: Effects on Hospital Cost

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Abstract

Context: Palliative care consultation teams in hospitals are becoming increasingly more common. Palliative care consultation teams differ in quality of care for patients with advanced disease. Less is known about its effect on hospital costs.

Objective: To evaluate the relationship between palliative care consultation and hospital costs in patients with advanced disease.

Design, setting, and patients: An observational study of 3321 veterans hospitalized with advanced disease between October 1, 2004, and September 30, 2006. The sample includes 606 (18%) veterans who received palliative care and 2715 (82%) who received usual care. Study participants were divided into two groups: the usual care group and the palliative care group.

Main outcome measures: We studied the costs and intensive care unit (ICU) use of palliative care and usual care for patients in five Veterans Affairs hospitals over a 2-year period. We used an instrumental variable approach to control for unmeasured characteristics that affect both treatment and outcomes.

Results: The average daily total hospital costs were $646 for those receiving palliative care compared to $751 in usual care ($p<0.001). Palliative care consultations were 45% less likely to be admitted to ICU during the hospitalization than usual care patients ($p<0.001).

Conclusion: Palliative care consultation teams differ in quality of care for patients with advanced disease. Hospital costs and less utilization of intensive care compared to usual care patients receiving usual care. Selection on unobserved characteristics plays an important role in the determination of costs.

Introduction

Recent studies suggest that hospital care received by patients with serious and life-limiting diseases is characterized by high levels of untreated pain and other symptoms despite the availability of care. Furthermore, patients have expressed preferences.1,2 Treatment decisions in prior studies at similar sites are therefore a challenge to maintain existing eligibility requirements, benefit levels and provider payments.3 The increasing costs of the Medicare system endanger not only the health of the nation, but also the health of the country's economy.4 The Congressional Budget Office projects that Medicare spending will increase by 97% ($630 billion) in 2019 to $1.4 trillion in 2024.5

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 2006-07 data to determine the effect on hospital costs of palliative care consultation for patients enrolled in Medicaid at two 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 equated to $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 consultative teams 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 potentially range from $84 million to $152 million annually (assuming that 3 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.
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.

Media Outreach

- Crain’s New York.com: “Better and Cheaper Care” 9.12.08
- Forbes.com: “Better care of sickest patients can actually save hospitals money, says biggest study of its kind” 9.8.08
- Reuters: “Special care teams help U.S. Patients, hospitals” 9.10.08
- Modern Healthcare.com: “Study finds cost-savings with palliative care” 9.10.08
- US News.com: “Palliative care programs could boost hospitals’ bottom line – Better treatment of sickest patients can save more than $300 a day, a study says” 9.12.08

Estimated Reach from All Sources: 3,000,000 views
Access to Palliative Care Teams

• Designed and conducted to:
  – Examine state-wide variation in access to palliative care
  – Examine access to palliative care clinical training

• Collaboration between CAPC, NPCRC, American Hospital Association
Variability in Access to Hospital Palliative Care in the United States

Benjamin Goldsmith, B.A., Jessica Dietrich, M.P.H., Qingling Du, M.S., and R. Sean Morrison, M.D.

Abstract

Background: Hospital palliative care programs provide high-quality, comprehensive care for seriously ill patients and their families.

Objective: To examine geographic variation in patient and medical trainee access to hospital palliative care and to examine predictors of these programs.

Methods: Primary and secondary analyses of national survey and census data. Hospital data including hospital palliative care programs were obtained from the American Hospital Association (AHA) Annual Survey Database for fiscal year 2006 supplemented by mailed surveys. Medical school-affiliated hospitals were obtained from the American Association of Medical Colleges, Web-site review, and telephone survey. Health care utilization data were obtained from the Dartmouth Atlas of Health Care 2008. Multivariate logistic regression was used to identify characteristics significantly associated with the presence of hospital palliative care.

Results: A total of 52.8% of hospitals with 50 or more total facility beds reported hospital palliative care with considerable variation by state: 40.9% (444/1092) of public hospitals, 20.3% (84/413) of for-profit hospitals, and 26.8% (160/594) of Medicare sole community providers reported hospital palliative care. A total of 84.5% of medical schools were associated with at least one hospital palliative care program. Factors significantly associated (p < 0.05) with hospital palliative care included geographic location, owning a hospice program, having an American College of Surgery approved cancer program, percent of persons in the county with a university education, and medical school affiliation. For-profit and public hospitals were significantly less likely to have hospital palliative care when compared with nonprofit institutions. States with higher hospital palliative care penetration rates were observed to have fewer Medicare hospital deaths, fewer intensive care unit/cardiac care unit (ICU/CCU) days and admissions during the last 6 months of life, fewer ICU/CCU admission during terminal hospitalizations, and lower overall Medicare spending/enrollee.

Discussion: This study represents the most recent estimate to date of the prevalence of hospital palliative care in the United States. There is wide geographic variation in access to palliative care services although factors predicting hospital palliative care have not changed since 2005. Overall, medical students have high rates of access to hospital palliative care although complete penetration into academic settings has not occurred. The association between hospital palliative care penetration and lower Medicare costs is intriguing and deserving of further study.
The CAPC Product

PALLIATIVE CARE

DID YOUR STATE MAKE THE GRADE?

If you or someone you know suffers from a serious or chronic illness, getting palliative care is a lot easier in some states than others. So why does it matter? Because palliative care is one of the fastest growing trends in healthcare when it comes to improving quality of care while also reducing costs. And yet, yea%, or the public is unfamiliar with the term. However, when informed about palliative care, 92% say they would likely consider it for a loved one with serious illness.

A State-by-State Report Card on how well America cares for the seriously ill, conducted by the Center to Advance Palliative Care and the National Palliative Care Research Center, gave the following states an...

GRADE OF “A”

Maryland
Minnesota
Nebraska
Oregon
Rhode Island
Vermont
Washington

What is Palliative Care?

- Specialized medical care that focuses on relief from the symptoms, pain, and stress of a serious or chronic illness—whatever the diagnosis.
- Improved quality of life for both patient and family.
- Appropriate at any age and any stage in a serious illness.
- Can be provided along with curative treatment.
- Delivered by a team of physicians, nurses and other specialists who work together with a patient’s own doctor to provide an extra layer of support.
- Better-coordinated care, fewer days in the ICU and shorter hospital stays resulting in substantial cost savings.

To find out how your state did or if your Congressional District made the 100% Club, meaning every hospital in your district has a palliative care team, or just to learn more about palliative care and its benefits, visit CAPC.org/reportcard.

*Data from a Public Opinion Strategies national survey of 1,000 adults aged 18 and up.

REPORT CARD

AMERICA’S CARE
OF SERIOUS ILLNESS

A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals
The Media Outreach

“Palliative Care Expanding in Hospitals”
- Forbes, 10/6/11

“Nation Gets 'B' for Hospital Support Care”
- WebMD, 10/6/11

“Advocates push for expansion of palliative care”
- Politico, 10/5/11

“Palliative Care State-by-State Report Card Released to Congress”
- Sacramento Bee, 10/5/11

“Utah's 'comfort care' gets a C from palliative care advocates”
- Salt Lake Tribune, 10/5/11

“Minnesota ranks at top in care of very sick”
- Star Tribune, 10/5/11
Quality Metrics for Palliative Care Teams

• Purpose
  – To develop a national database of key structure and process measures in order to promote palliative care benchmarking
  – To understand the core structures and processes of palliative care programs
  – To allow individual hospitals to compare their programs to national averages for similar hospitals

• Methods
  – Qualitative and quantitative interviews with key constituents (program directors, hospital administrators)
  – Survey of existing PCLC programs to populate the database
  – Database development
  – Ongoing recruitment of hospitals with palliative care programs to further database development
Operational Features for Hospital Palliative Care Programs: Consensus Recommendations

David E. Weisman, M.D. and Diane E. Meier, M.D.

Abstract

Hospital palliative care programs in the United States are growing in number, scope, and sophistication. The nation’s major public-private partnership organization charged with advancing the quality of health care, the National Quality Forum (NQF), developed a Framework for Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report. This framework establishes a set of 26 preferred practices associated with quality palliative care. In an effort to provide supportive operational details about specific features necessary for program sustainability and growth, and to help guide hospitals starting new or strengthening existing palliative care programs, the Center for the Quality Improvement of Palliative Care (CAPC) convened a consensus panel to develop recommendations for key operational features for hospital programs. Twenty-two recommendations are grouped into 12 domains and include “must-have” and “should-have” features. The recommendations can be used for strategic planning of new or established hospital-based palliative care programs.

Introduction

The growth of hospital palliative care programs has been rapid in the past 10 years, with just under 1300 hospitals reporting some type of program as of 2006. Although palliative care programs are increasingly recognized as an essential element of comprehensive inpatient medical and surgical services, the process of starting, growing, and sustaining a program so that it is fully embedded in the culture and practice of a hospital is a serious challenge, requiring strong leadership and dedication by key staff and receiving hospital administrators. For almost 10 years, the Center to Advance Palliative Care (CAPC) and its six Palliative Care Leadership Centers (PCLC) have provided outreach and technical assistance to hundreds of hospitals during the start and growth of their palliative care programs. Through this experience, the CAPC staff, consultants, and Palliative Care Leadership Centers faculty have learned what is helpful to, and what hinders, program development.

The National Quality Forum (NQF), A Framework for Preferred Practice for Palliative and Hospice Care Quality, developed in 2006, has been a key resource for helping legitimate palliative care practice and provides a clear set of 26 practices necessary for delivery of quality palliative care (Table 1). The purpose of this report is to support the NQF preferred practices with a set of specific operational details necessary for sustainable high-quality hospital palliative care programs (hereafter referred to as “programs”). To this end, a consensus panel of CAPC staff, consultants, and Palliative Care Leadership Centers faculty convened in the winter of 2008 to answer the question, “What operational details are essential, for sustainability, for hospital palliative care programs?” The panel had interdisciplinary representation from academic and community hospital settings, single hospitals and large health systems, and from programs coordinated by hospice agencies and hospitals (Table 2).

The consensus panel worked over a 3-month period debating operational details, and eventually recommended consensus within 12 discrete but comprehensive domains. Within each domain, one or more recommendations have been made as either a “must-have” or “should-have” program feature. The panel recognized the wide range of hospital size (some program elements will be difficult to implement for smaller hospitals) and that larger hospitals have a responsibility for a greater scope of services. It is expected that new programs, or programs from small hospitals, will be able to meet all the must-have recommendations as program inception. However, the recommendations should serve as benchmarks and goals for all programs to strive for as soon as possible. We suggest that these recommendations be used as a starting point for strategic planning by existing programs and as a template for program development. Users should look upon these recommendations as a work in progress, as the field matures, we anticipate future refinement will be needed.

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Welcome to the National Palliative Care Registry™

The Registry was created by CAPC and the NPCRC to guide local palliative care leaders in the development and sustainability of their programs. By submitting your data online, you will help standardize structures and processes of care and demonstrate the reach and impact of palliative care in the nation’s hospitals and beyond.

Contribute to the growth of palliative care. Become part of it’s DNA!

Want to register your program? Already started your registration? Not sure if your program is registered?

Register Now Log In Search Programs

When you register your program, you'll be able to:

- Receive a premium listing in the www.getpalliativecare.org Provider Directory. Your listing will be highlighted and will have more complete information than a regular listing

- Track your program’s structure and operation, year after year

- Be included in CAPC and NPCRC prevalence studies

- Generate in-depth, customized reports comparing your program to your peers’ through Palliative Care COMPARE™ (COMING 2010)
National Quality Forum: Palliative Care is One of Six National Priorities for Action

A Vision for World-Class, Affordable Healthcare

The current economic crisis highlights the imperative to transform America’s healthcare system, and the opportunity to do so has never been greater. The National Priorities and Goals address the greatest challenges facing the healthcare system: eliminating harm, eradicating disparities, reducing disease burden, and removing waste.

Through the National Priorities and Goals, the Partners are working to bring about safer, more affordable patient-centered healthcare. The collective action of the Partners on these six

http://www.nationalprioritiespartnership.org/Priorities
New in 2008

Joint Commission Certification for Palliative Care Programs

Recognizing palliative care programs that make exceptional efforts to improve delivery of care